Family Health Nursing - selected topics

Edited by
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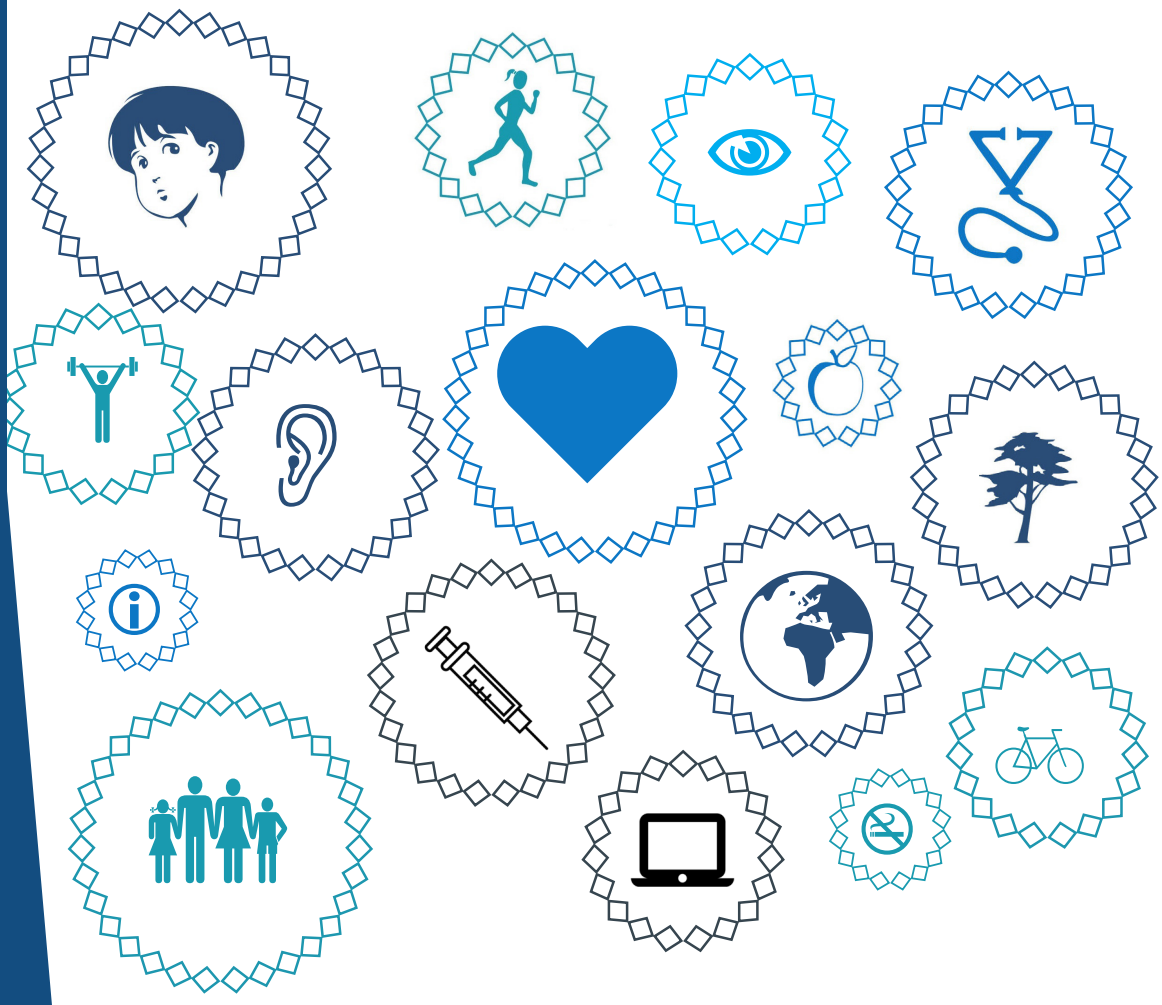

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FAMILY HEALTH NURSING
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Preface

The book **"Family Health Nursing – Selected topics"** is the one of results of international cooperation within the project "Family Health Nursing in European Communities" (FamNrsE), which concerned the care of family health and was financed from the "Life Long Learning Programme, Education and Culture DG" . The project was implemented in the period from October 1, 2011 to September 30, 2013.

The "Family Health Nursing in European Communities" project was covered with patronage by the European WHO Office and preceded by two-year pilot studies (2001 – 2003), conducted in Scotland according to the WHO guidelines. The report from these studies established the subsequent steps in the development of nursing in Scotland. Simultaneously, the report showed that two years is too short a period to determine and undertake complex actions which would cover both the education of nurses and the development of a new model of nursing practice. The studies confirmed that the potential of a new approach to nursing practice directed towards care of health of the entire family should continue to be developed and discovered. At the same time, in many European countries, including Poland, considerable development has taken place in the concept of a 'new type of nurse'; however, under various names: environmental nurse, PHC nurse, family nurse, district nurse, etc.

The main goal of the project 'Family Health Nursing in European Communities' was the construction of common university education programmes which would serve the preparation and implementation in Europe of the specialty: 'Family Health Nursing', based on the theoretical essentials and competences of nurses in partner countries. The detailed goals of the project are:

1. Development of the definition of 'Family Health Nursing' in partnership countries in order to harmonize the scope of competences of nurses according to the education standards in individual countries.
2. Development of modules of education in family health nursing specialty on the levels of licentiate and Master of Arts; pilot implementation and evaluation.
3. Defining common standards of education and standards of practical preparation of family health nurses for performing the occupation.
4. International exchange of knowledge and experiences concerning occupational competences and scope of tasks of family and environmental nurses in partner countries in order to provide a high level of health care.
5. Promotion and intensification of cooperation based on partnership, between decision-makers, academic circles and nurses practicing their occupation on the European level.

The main coordinator of the project is the University of the West of Scotland. Several institutions engaged in the education of nurses from several countries of the European Union have joined the project:

- University of Economics and Innovation, Lublin, Poland;
- Research Institute of the Red Cross, Austria;
- Witten University, Germany;
- Escola Superior de Enfermagem do Porto, Portugal
- University of Medicine and Pharmacy, Craiova, Romania;
- Lucian Blaga University, Sibiu, Romania;
- College of Nursing, Jesenice, Slovenia.

Professional nurses' organizations were also partners cooperating within the project, which joined the project after it had already started:

- Polish Nursing Association, Poland;
- Deutscher Berufsverband für Pflegeberufe, Germany;
- Ordem dos Enfermeiros, Portugal;
- Romanian Nursing Association, Romania;
- University of Rome, Italy;
- College of Community Nursing, Portugal;
- Family Nurse Project, Portugal;
- University of Alicante, Spain.

The conference summing-up the project was held in the beginning of September 2013 at the University in Porto, Salão Nobre of Instituto Ciências Biomédicas Abel Salazar. The output of the project in the form of common university education programmes and implementation in Europe of the specialty 'Family Health Nursing' will be popularized both in partner countries and the remaining countries of Europe.

Target groups of the project 'Family Health Nursing in European Communities' were as follows:

- entities operating in the field of management and promotion of health care,
- health care institutions, health care facilities,
- academic staff,
- nurses,
- the societies of EU countries participating in the project.

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Introduction

Florence Nightingale, while formulating her concept of nursing mentioned, among nurses' tasks, the popularization of personal hygiene and hygiene of surroundings in workers' environments, as well as teaching baby care to mothers (Nightingale, 1860)[1]. The performance of these tasks required cooperation with the families, and at that time, such a cooperation was postulated by William Rathbone (1819–1902). According to him, to the tasks of a nurse providing home care for a patient also belong assistance to the family in the area of hygiene and health care. In 1859 he wrote: '… it occurred to me to engage (…) nurse, to go into one of the poorest districts of Liverpool and try, in nursing the poor, to relieve suffering and to teach them the rules of health …' These words are considered as the origin of the 'institution' of a district nurse, which is essentially equivalent to the contemporary concept of a community nurse, or family nurse.

At the beginning of the 20th century, in a completely different social and cultural reality, the Association for Tuberculosis Control in Lvov, which was functioning on the territory of Poland occupied by Russia, employed the first nurse to visit the ill at their homes, the task of whom was: visit families, their lodgings and households, teach, instruct about methods of maintaining hygiene, observance of hygienic principles, and preparing meals. This nurse was concerned with solving the social and material problems of a family, and these were the difficult duties of a family caregiver (Wrońska, 1991)[2].

The tasks of a nurse are a derivative of the adopted concept of nursing. The best known theories are 1) Florence Nightingale's environmental theory, 2) Virginia Henderson's needs theory, 2) Dorothy Orem's concept of self-care deficit, and the concepts of 3) Colista Roy's 'coping', and 4) Betty Neuman's 'stress'. Zofia Kawczyńska-Butrym, performed a synthetic analysis of the tasks of a family nurse in selected concepts of nursing (Kawczyńska-Butrym, 1995).[3] In each of these theories, the scope of a nurse's

[1] Nightingale Florence. "Notes On Nursing What It Is, And What It Is Not" D. Appleton And Company, New York, 1860.

[2] Wrońska I. Pielęgniarstwo Polskie 1921–1939 [Polish Nursing 1921–1939]. Norbelinum, Lublin 1991.

[3] Kawczyńska-Butrym Z. Podstawy pielęgniarstwa rodzinnego [Fundamentals of family nursing], PZWL, Warszawa 1995.

tasks may be indicated which also cover the needs of a family, and not only an individual patient. Kawczyńska- Butrym analyses also the tasks of a family nurse according to the adopted definition of health: from the understanding of health as 'absence of disease', which practically omits the problem of interaction between a nurse and a patient's family, to health perceived as an independent and creative life, also in the presence of disease or disability, where a nurse becomes an adviser, consultant and family assistant.

In today's world a number of key forces — poverty, increased globalization, climate change, political unrest — affect health and contribute to challenges in service planning and delivery. These challenges shape the environments in which nurses are delivering PHC and include:

- The rising costs of health care.
- Increasing consumer expectations and demands.
- Changing demographics and ageing populations.
- Nursing and other health worker shortages.
- Legislation and/or political will to fully utilise nursing's potential.
- Social conflict and unrest which destabilise services and constrain resources.
- Natural and manmade disasters.
- Endemic and pandemic disease, as well as new and reemerging ones.
- The surge in chronic diseases.
- Making a shift to communitybased care.

Many of these global health issues are not new. They have been cumulated over past policies and practice. To be better able to create and deliver effective PHC and other services, we need to understand the effects of these factors on overall health delivery and outcomes. 80 % of chronical diseases will be preventable if PHN could have possibility to take responsibility for the health management in PHC (Delivering Quality, Serving Communities, 2010).[4]

Currently, the World Health Organization (WHO) considered a family as a special area of health activities, which exerts an essential effect on human health. It was considered that a direct promotion and prophylaxis effect on a family, and in consequence, on its individual members, is the most effective solution from the aspect of permanent improvement of health. However, in the present practice, health care services on the level of the environment are provided based on a traditional medical model – constantly embedded in the concept of health as an absence of disease or disability.

A change of this model of health care should lead to an increase in the health potential of society, and is the priority of activities of the WHO. According to this

[4] Delivering Quality, Serving Communities: Nurses Leading Chronic care. ICN 2010/PTP 2010: 5

approach, a family becomes a type of 'institution', an element of health care, and an entity performing tasks with respect to its members. These are primarily tasks in the area of prophylaxis and health promotion, and in a further perspective, also therapeutic and rehabilitation tasks. In this understanding, family health care may be considered as a component of the public health care system, both from the national and international aspects.

At the end of the last century, the WHO proposed a 'new type' of practicing the occupation of a nurse, which would be a support for local communities. The role of a 'nurse of the new type' consisted in the provision of assistance for individuals, families and communities in coping with disease, regaining health, and enhancing health. According to this concept, both the nurse and the family physician were presented as key elements of primary health care (PHC). Although in Europe there are differences in the way of understanding primary health care, at the same time, it is commonly agreed that in this area medical and nursing services based on narrow specialities are not an adequate solution.

International Council of Nurses indicates that primary health care (PHC) is the first point of contact with the national health system for individuals, families and communities, bringing health care as close as possible to where people live and work. The goal of universal access to health services through primary health care was enshrined by WHO and member states in the Declaration of AlmaAta, which highlighted the "gross inequality in the health status of people particularly between developed and developing countries as well as within countries," To address these issues, WHO focused on PHC as the key to achieving the goals of its 1977 strategy Health for All by the Year 2000. Fifteen years later governments reconfirmed this in Riga. In 2008 primary health care has been ranked high on the global health agenda again. ICN is celebrating nursing's leadership and advocating for greater nursing involvement in PHC, as the key strategy in achieving universal access and better health for the world's people (Delivering Quality, Serving Communities , 2008).[5]

A family health nurse is responsible for planning and rendering a complex nursing care for the individuals, their families, local communities with emphasis on the location of delivering care: health promotion, prevention of illnesses, diagnostic, therapeutic and rehabilitation services.

The aim of this book is preparation of nurses to professional organizing and providing care for healthy and ill persons in different age groups in their family context.

[5] Delivering Quality, Serving Communities: Nurses Leading Primary Health Care. ICN 2008/PTP 2008: 3-8

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THE FAMILY AS A CLIENT

OVERVIEW

The importance of the family within society and in relation to the development of an individual cannot be denied. The impact and potential of the family in terms of health care and health promotion is significant.

Section 1 of this unit focuses on the importance of the family, the basic unit of society, as an educational environment, and underlines the role it plays in the development of the child, the development of personality and the establishment of mental health. It considers various theories and approaches to the family and the influence of inter-family relationships. The stages of family life and the functions of the family are explored, also, a distinction is made between different types of family. Multiculturalism is examined and the importance, for the health professional, of being multiculturally aware is highlighted.

Section 2 focuses on the changing family in the modern world. It highlights the global changing demographic situation and explains the stages of demographic transformation. Changes within the modern family are explored in this context, the reasons for these changes are considered and the future and value of the modern family is also contemplated.

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1. The family and its impact on the development of an individual

1.1. Introduction

The World Health Organization promotes the concept that good health starts at home. Thus, it stresses the importance of health care administered by non-medical professionals (family members, neighbours, acquaintances and self-help groups). The family, as the bedrock of human society, has fulfilled numerous functions in the sphere of health, for centuries. Awareness of the importance of the family's role in nurturing children is essential in order to raise the level of health education in children and adults (Lewicki, 2009).

The family, as a social unit, exists in all societies. The family provides the first and the most important educational environment, and it also constitutes the environment which has the most long-lasting influence on an individual: it affords the basic environment for human development.

In a family, the child first begins to develop emotionally through contact with the mother, and then establishes relationships with other people and gains initial experiences of coexisting and cooperating within a social environment.

Being part of a family tends to provide optimal living conditions and allows family members to fully develop their potential abilities. Such accomplishments are defined by the norms and rules of behaviour that exist in every family and, as a result of the clear differences between families, a feeling of identity as a part of a distinct social group, (described by many psychologists as a small social group), is created.

Belonging to a family unit encourages openness in interpersonal relationships, which is essential in a developing individual. A child who has a close relationship with his or her parents will grow up in a safe and secure environment and will develop straightforward and direct ways of communicating with others. A child surrounded by love and kindness creates a positive image of themselves (Niebrzydowski, 1999).

The small social group of the family unit is of critical importance to the process of shaping an individual's social personality – it is the main social area through which the influence of broader environments and different cultures spread. The family hands down values, norms and behavioural patterns to the individual (Ziemska, 1979).

In this subsection, the definition of the family is reviewed, the functions of the family and the stages of its existence are presented, also, the phenomenon of multiculturalism and the role of the family in shaping personality and pro-health attitudes are proposed.

1.2. The family as a social unit

The International Classification for Nursing Practice (ICNP) defines the family as *'Group: A social unit or collective whole composed of people connected through blood, kinship, emotional or legal relationships, with the unit or whole being seen as a system, greater than the sum of its parts'.* (International Council of Nurses – ICN, 2011).

Notwithstanding the belief that the family as a unit of care has always been a focus of nursing (Whall, 2007). The **family** is a unity of interacting persons related by ties of marriage, birth or adoption, whose central purpose is to create and maintain a common culture which promotes the physical, mental, emotional and social development of each of its members (Duvall, 1971).

Early family social science theorists adopted the following traditional definition in their writing: *'The family is a group of persons united by ties of marriage, blood, or adoption, constituting a single household; interacting and communicating with each other in their respective social roles of husband and wife, mother and father, son and daughter, brother and sister; and creating and maintaining a common culture'* (Burgess & Locke, 1953).

The U.S. Census Bureau defines a family as two or more people living together who are related by birth, marriage, or adoption (Tillman & Nam, 2008).

Reuben Hill, a sociologist, described the family as a group of interrelated persons forming a living system and changing over time as they acted, reacted, and met the challenges of separation, loss, and reunion that resulted from wartime challenges. This early research identified stress within the family due to such adjustments which often resulted in a decrease in the ability of the family to function, and in disorganization and crisis within the family (Hill, 1949).

The family is a basic and primal social group of great practical importance both for the individual and society: its ability and scope to advise and socialize young generations are the basis for the existence and proper functioning of society (Cheal, 2003). The proper functioning of society and the proper functioning of families living in that society are integrally connected (Cheal, 1996).

1.3. Theories of the Family

Family systems theory is more than a therapeutic technique. It is a philosophy that searches for the causes of behaviour, not in the individual alone, but in the interactions among the members of a group. The basic rationale is that all parts of the family are interrelated. Furthermore, the family has properties of its own that can only be identified by examining the relationships and interactions among all members.

The family systems approach is based on several basic assumptions:

- Each family is unique, due to the infinite variations in personal characteristics and cultural and ideological styles.
- The family is an interactional system whose component parts have constantly shifting boundaries and varying degrees of resistance to change.
- Families must fulfil a variety of functions for each member, both collectively and individually, if each member is to grow and develop.
- Families pass through developmental and non-developmental changes that produce varying amounts of stress affecting all members.

Grand and middle range theories

Family theories are explanatory frameworks that provide different ways of understanding families. There are two levels of academic theorizing in family studies – grand theories and middle range theories. Grand theories are universal and not culturally specific or locally contextualized. Middle range theories look at different aspects of family life, such as child development theories, socialization theories and parent-child relations theories. Middle range theories are very contextually informed and are often grounded theories, that is, constructed by the people who undergo the experiences being studied.

Family systems theory

Family systems theory emphasizes the whole of the family, but focuses on member relationships and interactions and on the functional status of the system in order to address needs and goals, and to sustain its members. Family systems theory has evolved, over the last few decades, out of sociology, psychology and family sciences. While sociologists were initially concerned with describing what they had discovered from structural, functional or developmental perspectives, the ideas have now melded and family systems theory has become a more general approach. A key feature of the family systems approach, especially when it is used in family therapy, is that of a unitary conceptualization of the family, a whole that is different from the sum of its parts (Whall & Fawcett, 1991).

Minuchin's theory

Minuchin's theory is an open systems approach to the family as a unit rather than the sum of the individuals within that unit. The family functions at its optimal level when it has the flexibility to adapt and the ability to restructure itself as new demands are encountered.

Principles:
- The family is a system with transactional patterns.
- Family system functions are affected by its subsystems.
- Family subsystems are comprised of individuals, either temporarily or permanently.
- Family members can be a part of one or more systems and have different roles in each.
- Subsystems are hierarchically organized with power structures within and between them.
- Stress in one part of the system affects other parts of the system.
- Families are characterized by qualities of cohesiveness and adaptability.
- Changes in family structure relate to changes in individual behaviours.
- Individuals are influenced by and influence constantly reoccurring interactions.
- Individuals reflect the system of which they are a part.

Minuchin suggests that the whole of the family must be considered. He proposes that understanding should develop from an acknowledgment of evolving and unpredictable patterns, as change occurs in response to internal and external forces. Change, from Minuchin's viewpoint, is more probabilistic and less cause and effect, as growth and change are experienced simultaneously (Minuchin, 1974).

The Circumplex Model

The Circumplex Model, used to describe marital and family systems, has evolved from Minuchen's concepts and uses the two central dimensions of cohesion and adaptability. The model identifies a total of 16 marital and/or family systems.

Key constructs of the Circumplex Model are:
- the dimensions of cohesion, adaptability and communication,
- a taxonomy of family types (balanced, mid-range, extreme),
- aspects of family adjustment (stress factors, ability of the family to cope, family resources).

The Circumplex Model focuses on normal patterns of family interactions and emphasizes family strengths rather than weaknesses. According to this model, families can be disengaged, separated, connected or enmeshed. Enmeshment refers to the

degree of intensity in system relationships and a certain closeness among members that tends to discourage individuation, autonomy and difference. In contrast, members of disengaged families live together, but have divisive communication, and tend to have more independent members who view themselves as more detached from the family (Olson, Russell, & Sprenkle, 1989).

Feminist Theories

Feminist theories assume that privilege and power are inequitably distributed based upon gender, race and class. A discussion about feminism begins with a consideration of sexism, a view of social reality where male perspectives have ruled in shaping the social, political, economic and intellectual environments (Eichler, 1988). According to Ackelsberg and Diamond, feminism aims to transform our understanding so that male and female qualities, reason and emotion, thought and experience, and individuality and connectedness are integrated into the life experience of men and women (Ackelsberg & Diamond, 1987).

Four core assumptions underlying feminist perspectives (McPherson, 1983):

- Age, class, race, ethnicity, disability and sexual orientation define women and other groups.
- Personal experience leads to political or social action in order to promote change and bring about justice.
- Multiple realities exist.
- Issues are holistic and contextua.

1.4. Stages of family life

The stages an individual goes through during life are not the only type of growth. It is also important to understand that the **family** itself has its own stages of development. The developmental phases of a family are referred to as the stages in a **family life cycle**.

Table 1-1. Stages of family life

STAGES (PERIODS)	CYCLES	DESCRIPTION OF PROBLEMS
1.Starting up a family (marital stage – without children)		• A single person has to accept the presence of another adult who often has different habits. • Different marital roles are created and acted out (the role of a wife, husband, housewife, head of the family). • Relationships between original and new family members are created.
2.Child rearing (parental stage – with children)	a) kindergarten - from birth till the start of primary school	• Dealing with the child's physical and mental development • Necessity of creating new relationships which make it possible to balance the attention given to individual family members, job commitments and child-care provision • Dealing with the difficulties of combining the role of husband/wife with the role of father/mother • Adjusting to new relationships which enables families to be fully involved in child rearing
	b) primary school – the child at school	• The child's difficulties in adjusting to a new environment and school discipline • Focusing on the child's problems to allow for marital roles to be realized
	c) adolescence – the family life cycle is hard to define as it depends on the individual traits of the offspring	• The family's role is to support development, shape identity and promote the independence of the child as well as being responsible for the child's well-being. • Contact with peer groups and identification with other non-socially accepted influences
3.The child's independence (marital stage without children)	The child leaves home for school, university or in order to start up their own family.	• Broadening the scope of freedom and responsibility of the young adult • Maintaining the home as a place of support for the young adult • Developing hobbies and interests • Undertaking employment • Mutual evaluation of marital bonds and their ability to endure • Dealing with the decreasing efficiency and independence of elderly grandparents
4.Independent again (marital-retirement stage)	Phases 4 and 5 constitute more than half of the family lifespan.	• Recreating marital bonds after children leave home and after death of parents • No support from parents (due to death) • Maintaining hobbies • Establishing social contacts • Sustaining inter-generational bonds
5.decline of the family		• Sustaining integrity despite the decrease in the efficiency of family members • Planning the division of wealth

1.5. Functions of the Family

The family provides a set of functions that is important for the needs of the individual family members and for society as a whole. The **family** provides the individual with the necessary environment for development and interaction; it also provides new and socialized members for society.

Four Major Functions of a Family (Friedman, 1981):

1. **Physical Function** – It provides a safe, comfortable environment necessary for growth, development and rest/recuperation.
2. **Economic Function** – It provides financial aid for its members, as well as meeting the monetary needs of society.
3. **Reproductive Function** – This function is met by the birth of children.
4. **Socialization Function** – This function is of major importance and includes teaching; transmitting beliefs, values, attitudes and coping mechanisms; providing feedback and imparting guidance in problem solving.

The **family** is the basic unit of society. Families exist in all sizes and configurations and are essential to the health and survival of the individual members and to society as a whole. As the primary group for the individual, the family serves as a buffer between the needs of the individual and the demands and expectations of society. The role of the family is to meet the needs of society (Taylor & Chatters, 1989).

The characteristic feature of the family is its ability to fulfil different functions which form a homogenous, complex whole and which cannot be fulfilled by the separate members of the family working independently. Any disruption to one of the functions of the family leads to a breakdown in the proper functioning of the family as a whole (Steel, Kidd, & Brown, 2012).

The term 'family function' embraces the aim of family life, as well as the activities and tasks performed by the family in order to satisfy the members' needs.

The basis for distinguishing family functions can be defined as:

- an analysis of the family as a group and social institution - institutional and personal functions,
- the characteristics of continuity and permanency along with any changes in these areas - important and incidental functions (Adamski, 1982).

Institutional functions (the family as a social institution):
- procreative (biological) - giving birth to offspring, guaranteeing the biological continuity of society and at the same time satisfying the sexual needs of spouses,
- economic - providing family members with the necessary living conditions and material goods,
- protective - helping family members in different life situations when they are not able to satisfy these basic needs themselves,
- educational (socialization) - introducing family members into a broadly understood social life and developing their mother tongue, moral values, behaviour patterns and cultural values,
- stratificational - guaranteeing a certain status to family members and placing them in a certain class or social stratum.

Personal functions (the family as a social group):
- marital – satisfying the intimate needs of spouses,
- parental – satisfying the emotional needs of parents and children,
- brotherly – satisfying the emotional needs of siblings.

Important functions (first-rate – inalienable family functions):
- procreative,
- socialization,
- love.

Incidental functions (minor):
- economic,
- protective,
- stratificational,
- recreational,
- religious,
- integrational.

Tyszka divides family functions into (Tyszka, 2003):
- biomental – procreative, sexual,
- economic – material-economic, protective-control,
- social-determining – stratificational, legislative-control,
- sociopsychological – socialization-educational, cultural, religious, recreational-sociable, emotional-expressive.

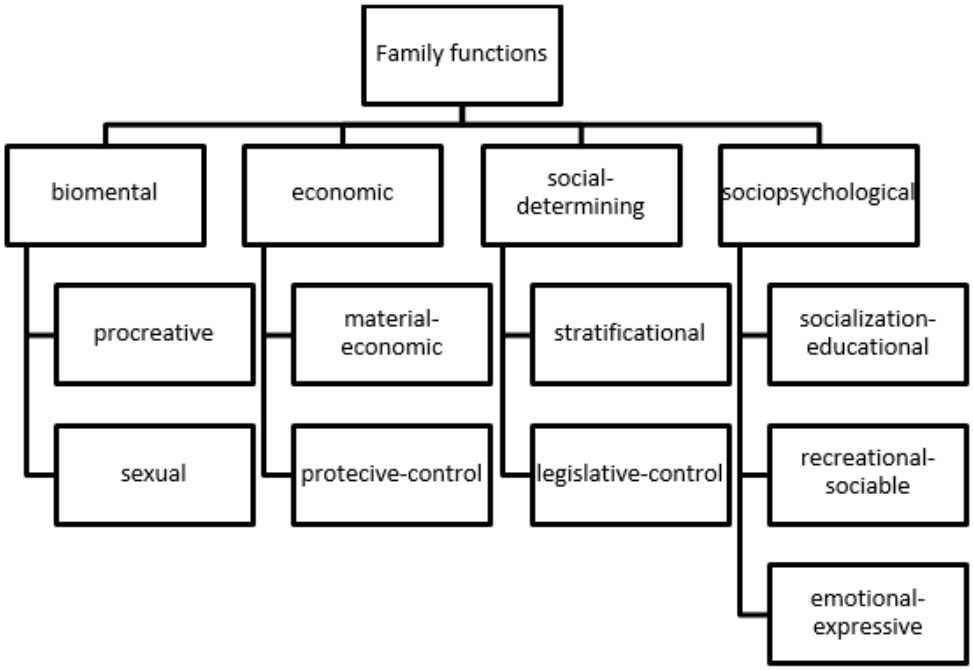

Figure 1-1. Family functions according to Tyszka.

Okoń singles out four basic family functions:

- procreative - resulting from man's instinct to satisfy his sex drive and have a child, and his motivation for marriage and starting a family,
- educational – the consequence of the procreative function: the family participates in socializing the child in all of its phases - from early care until the child becomes independent – and provides the child with a good start in life,
- economic – running a household and satisfying the material needs of family members, which determines the fulfilment of the procreative and educational functions,
- care - for aspects of the members' lives; behaviour, culture, health, life difficulties (Okoń, 2017).

Adamski proposes three types of family functions (Adamski, Sujak E, Półtawska, Drążek, Fujałkowski, & Braun-Gałkowska, 2009):

- functions only fulfilled by the family – cannot fluctuate (procreation),
- invariable or slightly variable functions, generally inside the family (connected to the emotional sphere and relating to the creation of family bonds),
- functions influenced by the family but shared with other institutions (rearing and educating children, providing care for particular family members, the sphere of economic activity, the system of values and norms, worldview).

1.6. Types of families

Although traditional families are still the most common family type, at present, there are many other socially acceptable ways to form a family beyond the traditional idea of a married mother and father raising children.

Table 1-2. Traditional vs. Non-Traditional Families

TRADITIONAL FAMILY	NON-TRADITIONAL FAMILY
Nuclear family – one parent, living in the same household, first marriage families, blended or step-parent families	Unmarried parent (usually mother) and child living alone
Nuclear family – husband, wife and children living together First marriage, blended or step-parent families	Unmarried couple and child living together, usually within a common law marriage
Nuclear family – husband and wife living alone, childless or children living alone	Cohabiting couple – unmarried couple living together
Single-parent family – female or male head of the family as a result of a divorce, separation or death	Same sex persons living together as partners
Extended family – parents, grandparents and children living together	
Empty nest families – older couples living alone (Ram and Hou, 2003) children at college children with a family of their own	

Source: Nurses are always there for you: Caring for Families. Information and Action Kit, 2002, 6.

1.7. Multicultural diversity of families

Culture is dynamic and refers to a group of people who have the following characteristics (Maurer & Smith, 2009):

1. a shared pattern of communications,
2. similarities dietary preferences and food preparation,
3. common style of dress,
4. predictable socialization patterns,
5. a shared sense of beliefs.

According to Lenninger, culture refers to the learned and shared beliefs, values and lifestyles of a group that are generally transmitted from one generation to the next and influence people's thoughts and actions. An integrated part of daily living, culture has many hidden properties and leads to multi-ethical decisions that give meaning and purpose to life (Leininger & McFarland, 2006).

The family health nurse (FHN) should be aware that there are non-ethical cultures such as those based on an occupational or profession, socioeconomic background (poverty, affluence), sexual orientation, age (adolescence, old age), disability (blindness, visual impairment) and shared life experiences (homelessness or engagement in war). The nurse should recognize the concept of culture and its importance in health care (Maurer & Smith, 2009).

It is vitally important that the FHN who works with multicultural families demonstrates cultural competence. Cultural competence requires that organizations and their personnel have the capacity to: (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of individuals and the communities they serve (Cross, Bazron, Dennis, & Isaacs, 1989).

The knowledge and skill of the FHN in conducting comprehensive cultural assessments guides them in providing competent care to people from diverse cultures.

Cultural competence is a developmental process at both the individual and organizational levels. With appropriate support, individuals can enhance their cultural awareness, knowledge and skills over time. Such cultural strengths exist within organizations or networks of professionals but often go unnoticed and untapped (Mason, Benjamin, & Lewis, 1993).

Cultural competency is the ability to work effectively across cultures in a way that acknowledges and respects the culture of the person or organization being served (Hanley, 1999).

In order to strengthen their relational practice, nurses should understand that their cultural competence begins by reflecting on their own prejudices, and having a deep awareness of how their own culture has informed their worldview, including any biases they might have. Refugee families may comprise a subset of those with limited or no English abilities that community and public health family nurses will serve. Although it is important to understand the background and perspective of all families, refugee families may have an added dimension to consider, such as surviving war or disaster, or enduring devastating trauma such as torture, rape or watching family members or others die. Some families may be suffering from post-traumatic stress disorder, depression or both, and this may intensify the life challenges they face. In order to understand the context of the family's wellbeing, nurses need to be aware of such circumstances.

Family Cultural Assessment Tool (Purnell & Paulanka, 1988), (Spector, 2000):

1. Who is the head of the household? Who has the final say? For example, some families are patriarchal, while others are more matriarchal.
2. Does the family operate with specifically assigned roles, or are the roles less defined? Who is responsible for maintaining health? For example, some families have clear distinctions with regard to what men and women are expected to do.
3. Do family members exhibit inherent or taboo behaviours? For example, some families act prescriptively in some ways, such as by purging their children with laxatives, others display restrictive behaviour such as prohibiting dating without a chaperone.
4. What are the family's goals for its members?
5. What is the cultural significance of the children, elderly family members and the extended family?
6. To what extent does the family accept different lifestyles?
7. How does the family respond to the idea of living with a partner outside of marriage? How does it react to homosexuality or divorce?
8. What are the family's health-related behaviours?
9. What does the family do to promote and maintain health? To prevent illness?
10. What home remedies are used?

Ethnicity

Ethnicity is multi-dimensional and usually encompasses one or more of the following: shared origins or social background; shared culture and traditions that are both distinctive and maintained between generations, and also lead to a sense of identity within the group, examples include a common language or religious tradition (Gill, Hinrichsen & DiGiuseppe, 1998). Ethnic groups have been identified by skin colour, the country of birth, name analysis, family origins and by self-identification.

Several methods used to allocate individuals to ethnic groups are discussed briefly below:

a) **Skin colour** — This is subjective, imprecise and unreliable. For example, colour cannot distinguish between the majority 'white' group (i.e. British, Scottish) and the minority ethnic groups (e.g. Polish, Kurdish, Turkish).

b) **Country of birth** — This is commonly used as a proxy for ethnicity. A question about the individual's country of birth has been included in each census since 1841. However, it does not take into account the children of migrants, that is, second generation migrants who do not view themselves as immigrants.

c) **Name analysis** — South Asian names are distinctive and relate largely to religions in which endogamy (marrying within one's own group) is the norm. The validity of identifying ethnicity by this method has been shown to be high; however, this will diminish with increasing exogamy (marrying a person belonging to another ethnic group).

d) **Family origin** — This method of allocation is based on the country of origin and so it should be straightforward. However, the difficulty with this approach occurs when individuals state that they have mixed family origins.

e) **2001 census question on ethnic groups** — The question does not deal adequately with people of mixed parentage, most of whom have one ethnic minority parent and one white parent. Another issue is that the 'white other' group conflates a number of groups which have distinct cultural, geographical and religious heritages, e.g. those of Greek/Greek Cypriot, Turkish or Eastern European origins.

Communication
Communication is a term than encompasses much more than just verbal exchanges. Non-verbal communication, in the form of body language, silences and signals, play a large part in successful communication. However, these forms of communication are also subject to cultural and individual differences. As various forms of non-verbal communication are influenced by cultural and individual considerations, it is not possible to provide a list of do's and don'ts beyond highlighting the need for sensitivity in any exchange.

The quality of client-provider interaction has a profound impact on the ability of patients to communicate symptoms to their health care provider and to adhere to the recommended treatment. It also has an impact on the patient's feelings about being respected (or disrespected) as an individual, a member of a family and a member of a cultural group.

Religion
Religion still plays a major role in many people's lives. Religious beliefs have a considerable impact on attitudes toward many procedures in hospital: organ transplantation, birthing practices, death and dying, diet, gender issues, abortion and modesty issues to name just a few. Religious beliefs have an impact on what medicines or procedures a person can accept and when he or she can accept them, they also affect what a patient or client will eat, and who should be consulted in the decision making process regarding medical treatment.

Role of food
Food has a cultural significance in terms of gaining and maintaining health. In some cultures, including some Asian and Latin American cultures, people believe in the hot and cold theory of food and disease: they believe that a combination of hot and cold food will lead to an imbalance in the body and, therefore, to disease.

1.8. The role of the family in shaping pro-health behaviours

A healthy family is a group which preserves its ability to develop and function despite ongoing changes inside and outside the family. In such a family, the possibility of fulfilling present functions is not only maintained, but the healthy family also prepares

for the future in terms of establishing a culture of good health, creating effective relationships between its members, generating the possibility and capacity for procreation and nurture, and anticipating the rearing of future generations (Bożkowa & Sito, 2003).

The family home is the **first educational environment** in which the process of socialization occurs, behaviour patterns are shaped and procedures to protect against illness and disease develop. The slogan of the WHO, 'Health Starts at Home', emphasizes the role of the family in shaping a healthy lifestyle.

Parents are the first educators of their children with regard to health. In the family, in the process of socialization, the child associates good health with physical activity, a nutritious diet, and physical, mental and environmental health.

The activities undertaken by children are learned, these may take the form of habitual behaviours that demonstrate the habits and practices associated with the health of their parents (Bilski, 2010). Children reflect the habits of their parents and display behaviours assimilated at home. This strong tendency to imitate people from their closest environment demands irreproachable behaviour patterns from family members.

This educational process continues in the course of everyday life – during work, play, rest, recreation, and while participating in social and cultural life.

The effects of this educational influence depend on:
- family structure and interpersonal relationships,
- the manner in which all family members fulfil their roles,
- the level of awareness parents have concerning the educational role they have in the family towards their child.

Health education which is directed at gaining knowledge about health, and at shaping abilities and pro-health attitudes, is one of the most important determinants of the health of the family and its members.

1.9. The role of the family in shaping personality

Personal traits are formed and shaped alongside physical development throughout the lifetime of an individual. The most important effect on an individual's personality comes from the manner in which that individual is brought up and the influence exerted by the social group in which the individual lives and interacts.

The factors influencing mental traits are:
- inherent anatomical and physiological features,
- the activity of the individual,
- an individual's environment,
- an individual's upbringing.

These factors are closely connected and their interrelation leads to greater differences and complexities in individuals and, as a consequence, in their behaviour.

The activities of an individual play a vital role in enabling that individual to understand reality of their situation and to consciously exert an influence over the form of that reality.

The environment is a relatively permanent system of the elements surrounding human beings and is important in terms of their life and behaviour. People and other entities in diverse and varied relationships with each other constitute the elements of the environment, and every person is an element of his or her own environment.

The environment plays a vital role in shaping an individual's personality in terms of assimilating behaviour norms, accepting or rejecting particular social roles, crystallizing one's attitudes and creating a perception of oneself. An individual's upbringing plays a great part in influencing their observations, views and judgments, skills, habits, interests and knowledge of the world (Jarosz, 1988).

The basic environment for human development is provided by the family, and the evolution of personality is an aim and a consequence of positive developmental processes.

There is no doubt that a family is able to function properly and can shape the desired personal traits of its members if due care is taken of the mental health of all its members. Moreover, the optimization of development is the best way of achieving mental health.

Dąbrowski wrote *'Do not look for mental health, look for development and you will find both'.* Mental health may be defined as the ability to develop optimally, to realize and create the self. It involves reaching a certain quality of life through experiencing oneself as the subject of one's actions. Having and developing respect towards an appropriate hierarchy of values and for other human beings is one of the most important demands of mental health (Dąbrowski, 1996).

Factors connected with the mental health of family members (Lewicki, 2009):
- control over one's life,
- the ability to problem-solve,
- school and work achievements,
- special abilities as well as mental and intellectual capabilities,

- a sense of humour, a sense of one's value and dignity, and the ability to fulfil one's intellectual needs,
- past and current mental disorders and psycho-social ability.

The condition of mental health and, thus, the creation of a healthy personality are dependent on the fact that parents and other adults of influence have an understanding of the children's potential and allow them to develop that potential. They must have a positive attitude towards the independent development of children and young people, as well as towards the development of every individual. Parental attitudes influence the processes that happen in the family such as fulfilling particular needs, and shaping and creating essential personality structures.

A harmonized family life neutralizes negative factors which can threaten the disintegration of personality. It maintains an essential emotional balance and creates conditions for expressing the personality traits of family members (Ziemska, 1986).

Ziemska included the approval and acceptance of the child, cooperation with the child and an acknowledgment of the child's rights as features that freely lead to the creation of positive attitudes (Ziemska, 1979).

2. The family in the modern world

2.1. Introduction

In modern societies, we are dealing with the process of the emancipation of the family from society. While the family of the past was a small unit in which specific behaviour patterns defining mutual interactions applied to all its members, nowadays we may observe the deformalization of its structure. Family relationships are becoming more personal and emotional and family functions, especially the social ones, and its forms are subject to transformations in a constantly changing modern world. These days, especially in the cities, multigenerational families living together are less common. Young people aspire to become independent, often postponing the moment of starting up their own family until they become financially stable.

The most common type of family in modern society is the nuclear family – a small family consisting of parents and their offspring. The contemporary extended family takes a slightly different form from that of the past: it constitutes a union of nuclear families who have a certain dependence on one another (e.g. sharing responsibility for looking after elderly parents) while at the same time maintaining economic and household separation. The family's dwelling place, which conditions the family's relationship with its environment, remains a very important feature. Village and small-town families are still closely connected to local communities, they are influenced by distant relatives and have close relationships with their neighbours. City families are more isolated from their environment. This, on the one hand, guarantees their anonymity, but at the same time it means that there is a lack of support in critical situations. Such families are forced to depend on formal institutions.

Changes in the family have occurred, these were mainly due to the impact of two processes – industrialization and urbanization, these were the reasons why many families altered their working and dwelling environments. Due to the dispersion of family members, the ties of kinship were loosened. In modern times, children usually only know their grandparents and parents' siblings because large extended family get-togethers for holidays or anniversaries are now a thing of the past. People are preoccupied with their day-to-day lives and have less time to maintain close contact with their relatives. Communication between spouses and parental contact with children is limited to the exchange of information which is essential for efficient time management. Time spent on ordinary conversation, companionship and having a leisurely meal together is severely curtailed.

Family members tend to shut themselves away, have no contact with each other and subsequently drift apart. This is not the result of ill will but rather, it is a consequence of social change. At present, we have to deal with the crisis of the family in modern societies more frequently. This crisis manifests itself in several ways; the prevalence of divorce, young people's reluctance to get married and have children and in the increasing popularity of cohabitation. The decrease in the importance of the role of the family in the modern world is highly visible and has become an irrefutable fact. For the time being, that seems to be the price that we must pay for modernity and the influence that rich Western societies enjoy. It is important to trust that this situation is only temporary because it seems unimaginable that such a fundamental social group, based on a strong, centuries-old tradition should cease to exist. The crisis of the modern family is closely connected to the current financial situation of many families. In the family of the Industrial Age, the positions and roles of individual members have little to do with the old dependence system and the privileged role of the father. In a family based on partnership, the man and the woman share rights and responsibilities in family life. Overall, this has been a positive change and may be viewed as an opportunity to protect family bonds. In the optimal situation, where both partners earn similar amounts of money, divide their duties equally and support each other, the family life can be salvaged. Unfortunately, the reality often looks very different. Unequal financial input to the household budget can breed conflict, especially when it is the woman who earns more. There are increasing percentages of unemployed people with low self-esteem in our society and some of them may transfer the disappointment and frustration they feel to their loved ones, this too has a negative influence on the family's ability to sustain emotional bonds. Mutual grudges, accusations, seeking comfort in addictions, indifference, and parents withdrawing from participation in their children's or their partner's lives, can gradually lead to family disintegration.

The direction for further change in the family depends on many external factors as well as the emotional engagement and individual motivation necessary to manage the task of being a husband, a wife, a mother or a father. Sociologists emphasize that in all societies there are at least three functions that can only be performed by the family and are necessary for the effective development and functioning of any society - procreation, socialization and the creation of a loving atmosphere. As a consequence, society cannot exist without the family therefore, despite the many adversities it must face, the family will survive (Polakowska-Kujawa, 2007).

The most frequently discussed hazards facing the modern family are: unemployment, poverty, homelessness, divorce/separation and addiction. All of these negative factors threaten the condition of the family as a whole and are the reasons for its breakdown, at the same time they can negatively influence each of its members as individuals (Chmielewska, 2012).

From theoretical discussions about the family and research which has been conducted into this vital social group, it is clear that an important aspect of family life is the issue of family **roles**. The change in the scope of the tasks being fulfilled by women and men is an important element of the changes being experienced by the modern family. The main changes are the increased participation of men in family life and the increased participation of women in the workforce (Ziemska, 1979).

The traditional ideal of the family has been largely abandoned: marriage is no longer perceived as a necessary condition for family life by a sizable proportion of the general public; lone parenthood is common; the existence of homosexual couples is habitually regarded as acceptable (Schaffer, 2013). The modern family is still undergoing changes. Both the husband and wife, and even the children, now have jobs. The modern family has less and less control over the lives and functioning of its members. However, the transformation of the modern family has not changed the fact that it is still the basic environment for preparation for living in society.

2.2. Demographic situation

Since the end of the twentieth century, the world has been undergoing profound demographic changes that have influenced the social and economic spheres of various countries to differing extents. These changes have occurred more rapidly and are more visibly in countries which are highly developed economically and which, in the last decades of the twentieth century, have experienced a substantial improvement in health due to better living conditions and nutrition.

A special importance should be attributed to the role preventive vaccinations. As a result of various vaccination programs, the average life span has steadily increased since the 1950s. This was due to a decreasing mortality rate, initially for infants and children, and later for the victims of disease.

While at the beginning of the 1950s, the expected average lifespan at the time of birth was 47 years, by 1995 it had increased to 65 years. It is predicted that by 2020 over a billion people will be over 60 years old, and two thirds of those people will be living in economically developed countries where the number of people over 85 is increasing fast.

A decrease in the reproduction rate may be observed in developed countries, and this has led to a decrease in the number of young working–age people who are forced to support a growing number of people over 65. The reproductiveness index in these countries is significantly below 2.1 which is the value that ensures the maintenance of population size. In the countries of the European Union and in Japan, people are living longer and longer and fewer and fewer children are being born.

This transition from a period of the dominance of high mortality and high reproductiveness to a period of decreasing premature mortality and low reproductiveness is called the **demographic transformation.**

Stages of demographic transformation
These stages are also called the phases of demographic transformation.

Phase 1 – This phase is characterized by a relatively low, but extremely positive birth rate which results from a very high number of births and a very low number of deaths. This phase is typical of less developed countries. In the most primitive ones, which are not supported by advanced medical science, people die from minor conditions and contagious diseases can spread freely. A mass population drop does not occur due to the uncontrolled birth rate. The countries belonging to this group are mainly African countries, e.g. Ethiopia, Bangladesh.

Phase 2 – The transition from the first to the second phase takes place when effective medical care is more widely available. This is the so-called demographic explosion phase. Containing epidemics and limiting the infant mortality rate results in a decreasing death rate, while the number of births is still high. Consequently, the birth rate greatly increases. At present, this phase may be observed in Pakistan, the Indies, Egypt and Nigeria.

Phase 3 – This happens when a previously excessive number of births is reduced to a medium, moderately positive level and the number of deaths is low. This is the case in countries such as Brazil and Mexico.

Phase 4 – This phase is typical of developed countries, e.g. Spain, Japan, the societies of which undergo the process of getting old. This is the result of a zero or negative birth rate caused by a decreasing number of births and an increasing number of deaths.

Phase 5 – Poland, as well as Hungary, Bulgaria and Ukraine, can be placed in this phase. The number of births and deaths is equal. In the event of even a small increase in the number of deaths, the birth rate immediately decreases and societies are affected by the process of aging.

Practically the whole of Western Europe can be placed in demographic transformation phase 4 or 5, which means that European societies are aging. However, this phenomenon is being, in a particular way, corrected due to the migration balance. As a result, the total population growth of Western Europe is positive. The rich countries of Europe attract residents from the poorer parts of the world, e.g. Africa and Asia. The emigrants are usually young, which is contributing to a lowering of the average age of Europeans. The reasons for such unfavourable demographic phenomena in these poorer countries are due to the deterioration of living conditions and economic

problems. The 21st century is being called 'the century of aging societies'. This situation is forcing certain governments, mainly those of economically developed countries, to introduce speedy changes in pro-family, social and health policies. It is also forcing them to make changes to their pension schemes and to open their borders to allow the immigration of a young workforce from poor countries. The process of population aging is happening everywhere but the current demographic structures of individual countries differ significantly leading to diverse social-economic and cultural situations. The most important factor is not the fact that societies are aging but the rate at which it is happening (Majsterek, Stankiewicz-Choroszucha, Targowski, & Wdowiak, 2005).

The countries of Western Europe and Japan are at the forefront of demographic change. In these countries, one may observe the constant increase in the average lifespan measured at birth which doubled in the 20th century, the increase in longevity and the steady decrease of the elderly mortality rate. The decrease in the number of disabled and the increase in the physical activity of senior citizens may also be observed. The number of people over 60 is growing at a speed never recorded before and is causing the so-called 'population greying' phenomenon in the European Union, Japan and North America. Currently, one in five European citizens has reached the age of 60 and by 2025 one-third of the population is expected to be over 60.

The acceleration of aging in society and more particularly, in countries like Great Britain, the USA or Canada is being camouflaged by the immigration of young people to these countries, whereas it is visible in Japan, which has restrictive immigration laws. The decrease in fertility is also accelerating the process of aging in our societies.

It is estimated that by 2050 there will be 420 million people over 85 at a global level, while in 1997 there were only 65 million. They will be better educated, more aware of health-oriented behaviours and better prepared for an independent life. They will reach late old age in better health than their parents. The abovementioned premises may evoke a general anxiety as far as the permanence of the foundation of the family is concerned. However, it is acknowledged that the vast majority of infants are born within marriage, thereby forming a new social unit – the family (Wojtczak, 2009).

This fact gives us a positive – despite the many hazards and difficulties – perspective concerning the survival of the family as a social unit which is formed by entering into an official or religious, culturally recognized relationship. Procreative functions are also fulfilled by informal relationships (cohabitation). However, this is a phenomenon which is only common in some regions and countries, for the most part it is influenced by reformed churches which are independent of Rome. In such areas, a higher percentage of extramarital births may be observed. In Europe, by contrast, France is a Catholic country in which cohabitation and extramarital births are a common occurrence. The leaders, however, are the Scandinavian countries (Iceland, Sweden,

Norway and Denmark) where over 40% of children were born outside of marriage at the beginning of the 1990s. It is worth emphasizing that, throughout the 1980s, the percentage of extramarital births significantly increased in all European countries.

The fertility rate is very different in comparison to the birth rate (the number of births of live infants per 1000 people) throughout the world. In economically developed regions, maintaining the current level of birth rate in the future will not provide a comparative fertility rate. Undeveloped regions, especially the poorest countries, most of which (32) are located in Africa, have very high birth rates as well as 100% fertility. On a positive note, it should be mentioned that a decrease of early fertility in women between 15 and 19 years of age has been observed in some countries in that continent.

One of the most important characteristics of the contemporary demographic situation is also the inequality with regard to the death of inhabitants living in different parts of the world. This disparity can be illustrated by using parameters that define the average life expectancy of an infant. These numerical values provide reference points with regard to the extent of mortality in the area discussed.

Inequality with regard to death, as a result of the different values of the probability of death in a given year, can and does occur in any age group. However, this phenomenon is most dramatic in the case of infants. In today's world, which is sometimes referred to as a 'global village', the maximum annual infant death rate (the number of deaths of infants younger than 1 year per 1000 live births, e.g. Afghanistan - 67, Mali – 159), are more than three times higher than the minimal ones (Japan – 4, Finland, Switzerland and Iceland – 5). This fact, if societies are aware of it, does not contribute to a feeling of security among the inhabitants of economically underdeveloped countries, especially in Africa, where three-digit death rates are a common phenomenon (United Nations, 2017).

In summary, the human factor is the basis for social-economic development. The effective development of population conditions leads to economic progress without disruption. All demographic shifts create the necessity to constantly adjust to the changing numbers and structure of the population. In order to guarantee stable socioeconomic conditions, care should be taken to ensure the effective development of the individual, family and the population as a whole.

2.3. The dynamics of change in the functioning of the family

The situation of the family in the modern world is diverse in many aspects: culture, religion, fertility, structure and the function it fulfils depending on the stage of socioeconomic development of different societies. Although each of these aspects is

important, the basic factor of diversification follows the route of the development of the family in pre-industrial society and the family in industrial society.

The pre-industrial family is a multigenerational family (more than two generations living together): extended (many relatives), numerous (a lot of children - the number of children in the family is regulated by the natural fertility of the women) and patriarchal (the authority in the family is the responsibility of the father). In addition to meeting the needs of procreative and socializing functions, the pre-industrial family also fulfils crucial economic, social-support and social-control functions. The pre-industrial family can be further subcategorized as small (nuclear) and big (multigenerational).

A marital relationship may be defined by the number of people in that relationship: monogamous (socially sanctioned relationship based on a sexual relationship between a man and a woman) or polygamous (group, polyandrous and polygynous). A marriage may also be defined by a person's choice of spouse: endogamous (marriage to a person in the same social group) or exogamous (marriage to a person outside their social group).

The motives for marriage may be economic or prestigious. At the present time, there is a greater degree of acknowledgment that defining the term 'family' and drawing an accurate picture of a typical family is not easy. The development of our civilization has led to a change in the traditional family model. In prehistoric times, the family was based mainly on an economic relationship, where the man was the leader, and the woman was a hard-working housewife who stayed at home to take care of the chores of cleaning, cooking and bringing up children. The children, in turn, remained at home and helped their mother. Several families might band together into larger groups but then these groups would disperse again into their constituent families whenever there was a shortage of food. The establishment of the modern family should be attributed to the Israelites, as well as to Greek and Roman civilizations, where ancient religious norms contributed to the existence of the patriarchal system. Consequently, the modern nuclear family does not have much in common with the old way of life, as most human needs can be satisfied outside the home (Kosowska-Syczewska & Jakubczak, 1967).

Changes caused by industrialization and globalization have led to far-reaching changes in family life. Firstly, the family stopped being a centre of production. This resulted in the necessity to look for provisions outside the family circle. Women were also integrated into work outside the home, by undertaking paid work either to increase the family budget or to achieve economic independence. Such independence was stimulated by higher levels of education among women and by the attainment of equal legal rights for men and women. On the basis of these macro-structural changes, the structure and functions of the family have been changed as well. The bonds

of the extended family have been untied; the family has been reduced to two generations. Large families are no longer practicable and this, in turn, has contributed to a significant decrease in the size of families (Tyszka, 2005).

Among the many determinants which have stimulated the changes in the structure and functioning of the family, an important role has been played by the reform of the political system and the spheres of socioeconomic life in which the biggest transformational changes have occurred: the labour market situation and the development of a market economy. These changes have in turn influenced the transformation which has occurred in the socioeconomic structure of the household, they have had an impact on the living conditions of the family and are reflected in emerging new income sources, leading to a diversification in the financial situations of many families as well as satisfying the needs of family members. However, certain changes have also lead to new dangers in the form of unemployment, poverty and marginalization. There have also been changes in the sphere of state interventionism through, among other means, the basic tool of social policy – social benefits.

The modern family, as a cultural environment, may be discussed in the context of new features as well as certain aspects that relate to the past. As a specific educational-cultural environment it consists of several elements: the social structure of the family, the number of children in the family, financial and living conditions, the compatibility of the intellectual levels of the parents, the career paths of the parents and their level of their socialization, their ways of spending time together and the family's cultural and social life.

Contemporary families are influenced by two conflicting processes. On the one hand, their behaviour patterns, life styles and ways of thinking are influenced by the social structures with which they are linked; on the other hand, global culture, transmitted by the media, influences them as well. It could be said that the lure of educational achievement is leading the child to rear himself or herself. Parents fulfil their educational roles if the child sets out on the road to self-education, which means taking full responsibility for himself or herself and his or her actions according to religious, moral and social ideals (Giddens & Sutton, 2013).

Surveys have shown that most families do not develop independently and live on the verge of biological survival. Some alarming phenomena are as follows (Giddens & Sutton, 2013):

- Increasing financial inequality in society is leading to the financial deficiency of young and growing families.
- Poverty spreads due to unemployment and high fertility levels (37% of the young population are brought up in such conditions).
- Housing crisis emerges.

A return to the older perception of the traditional family is not credible. Modern sexual relationships and marriages will never replicate those of the past. *'Men and women of today, if they want to be alone, do not risk the social disapproval which used to be expressed towards a bachelor or especially a spinster. Cohabiting couples no longer fear social exclusion (…) and do not risk the hostility that used to be expressed in the past.'* (Slany, 2002).

In turn, the disappearance of the traditional family life model – both within and outside industrialized societies – is a cause of concern for those worried about the 'disintegration' of the family. This is an important feature of globalization. The changes concerning family life often meet resistance and even evoke a longing for the good old days. The single fact that most of us – regardless of whether we try to resist change or not – often think about those days and how things used to be emphasizes how much has happened in our lives over the last few decades. Since we are considering the past, there is no practical solution other than to compare our idealized past to our current situation and make conclusions about how things might have been. Therefore, the most important consideration is to actively participate in the changing world and to react to these changes (Kopacz & Woźniak, 2010).

2.4. Factors influencing family change

The issues connected with family change and the decreasing birth-rate have always interested researchers – especially demographers and sociologists. It must be emphasized that an analysis of the procreational sphere is not possible without taking into consideration the influence of a broader socioeconomic context. This impact consists of several factors which are shaping developed countries.

Numerous changes which are occurring in the economic, social-cultural and personal spheres of countries paint a picture of an emerging post-modern society.

According to Kluzowa and Slany, we can differentiate between two types of factors influencing pro-family changes: **external** – those connected with the impact of broadly understood social, cultural, political and economic determinants, and **internal** – those dealing with the intimate, emotional and primal nature of the family and its existence (Kluzowa & Slany, 2004).

The **external factors** include radical social changes, expressed by the transition from traditional to postmodern society. The link between macro-structural changes and family transformation is influenced by a number of processes occurring in the post-industrial age.

These processes are as follows (Tyszka, 2003):

- lower participation in the production sector of the economy,
- significant growth in both the material and non-material services sectors,
- the gradual disappearance of manual labour and the growth of jobs, including high qualification jobs, within the white-collar sector,
- widespread dissemination of advanced knowledge,
- dynamic growth in the number of scientists and scientific institutions – scientists have started to play a leading role in the development of the most important features of modern civilization (technology, work and economic activity, high-tech computerization, advances in information technology, the education of professionals in key and developmental fields),
- automation of production,
- multiple enhancements of information flow in global societies, their macrostructures and mesostructures on a world scale ('global village'),
- mass development of supranational production and service institutions building towards international integration,
- concentration on the space industry which created a basis for intense conflict between cultures,
- rapid onset of social atomization,
- radical change in social structures,
- liberalization in many spheres of society and a decrease in the emphasis on morality (lower influence of religion in Europe),
- the process of individual independence – in the sphere of social macrostructures, as well as in meso- and microstructures.

Among the most important characteristics of 'post-industrial families' are (Tyszka, 2003):

- a significant increase in the employment of women, due to reasons such as a desire for a more interesting life and for self-realization, as well as for economic reasons,
- egalitarianism (equality) in marriages and families,
- parents placing a higher value on the material aspects of life than on having children,
- individual family members having differing norms and values,
- the expulsion of traditional values – including family values – by modern civilization
- the individualization of activities and interests within the family,
- the independence of family members,
- the weakening of cohesion within families leading to disintegration in some cases,
- an increase in marital conflict and a rapid growth in the divorce rate leading to a high rate of divorce,
- a decrease in the percentage of people living in formalized marital relationships and a growth in the percentage of cohabiting or single people.

The family, in a cultural sense, has ceased to be a natural and necessary institution. Starting a family is no longer a natural course of events, but a matter of choice. The post-modern human being is a *homo optionis.* This type of human being must make decisions about everything, even the most important issues connected with life, death, religion and his or her own identity. *Homo optionis* emerged as a result of the process of individualization occurring in postmodern societies. In traditional societies, individuals knew their place and had a defined set of norms and values.

In conjunction with the disintegration of traditional social norms, questions have arisen about which new ways of life to choose in place of the old ones. This issue is connected with another factor, the evolution of the *' "procreation climate", conditioning the decision to have children. Modern democratic systems favour and enhance individualization. This is visible in the labour market, which is clearly directed towards the individual, and is indicated by the need for mobility, training, individual pension schemes etc. Such demands force people to think about themselves as 'individuals, planning and designing their lives'* (Beck & Beck-Gernsheim, 2002).

Today, the individual is doomed to individualization – *'it is an obligation to (...) create and manage one's biography as well as ties and nets surrounding the individual, among changing preferences and at different stages of life, constantly adjusting to the labour market, educational system, state, wealth etc.'* (Beck & Beck-Gernsheim, 2002).

This sort of planning also has an impact on the sphere of procreation. Due to the commonplace availability of contraceptives, children can be planned. However, this decision is often postponed as the individual is more concerned about planning their own career path or self-development (Slany, 2002).

The economic reasons that force young women to postpone childbirth concern not only potential mothers, but also future fathers. The commonplace decision to conceive a child is more and more frequently postponed into the indefinite future: increasing numbers of newlyweds appear to be committed to remaining as an eternal *'boyfriend and girlfriend'*. The decision to have a child is analysed, according to American economist and empiricist Gary S. Becker, in terms of benefits and losses – not only material, but also emotional. According to this researcher, marriage as a free-will partner relationship, serving joint production and consumption needs, aims at maximizing its private profits under market discipline. Having a child can be a profitable experience – the family is a place in which children are conceived and brought up. The family can be effective in coordinating the expense of having children and bringing up children successfully. It should be emphasized that the role of the family changes according to market conditions and government policy. And here another important factor influencing the procreation sphere is evident – the interdependence between the reproductive needs of society, social policy and family fertility. Many countries with a low birth rate try to promote a pro-family policy or,

to be more specific, a prenatal policy. However, such countries do not, in fact, support the procreative tasks of the family and do not recompense the cost of bringing children up. This field of social policy is expensive and countries with a market economy remain largely within the sphere of individual rationalization. It is also worth pointing out the role of mass media in popularizing family patterns. The end of the 1990s and the beginning of the new millennium were, in the media, the age of 'singles' and a particular focus on entertainment and careers. However, over the last few years, a slow change in this trend has been observed. There is now a switch taking place towards traditional family values alongside the *'fashion for maternity',* which was started by famous Hollywood actresses and celebrities all over the world (Beck & Beck-Gernsheim, 2002).

As well as the previously discussed external factors, **internal** factors are also important with regard to family development. Internal factors include the effect of the number of children in the family, their age and the age of their parents. At the present time, the average planned family includes one or two children – having that number is a factor which tends to reduce further active participation in procreation. Another characteristic feature of modern life is the increasing age of the first-time mother, which can have a negative effect on the total fertility plan – the older the potential parents are, the greater their difficulties in conceiving a child (Koziński & Rychter, 2008).

The next group of factors influencing procreation are known as beyond-decision factors that condition fertility e.g. a long-lasting illness of one of the partners, isolation, death or physiological infertility. Another important factor is also the change in the perception of the role and value of a child in the family. The potential view of the parents is influenced by a whole range of factors, among which a crucial role is played by the previously mentioned, widely-understood social climate, which influences procreative decisions. This climate is defined not only by marriage and family life patterns promoted by different opinion-forming societies but also, perhaps even mainly, by the real possibilities of implementation, dictated by economics and living conditions as well as by the labour market situation.

The final internal factors that can affect procreation decisions are individual traits, resulting from the personalities of partners, their worldview, attitudes and accepted value systems (Kluzowa & Slany, 2004).

As has already been discussed, pro-family attitudes are influenced by many external and internal factors. As not all of these factors are relevant to a particular group, a basic set of determinants that influence procreation attitudes has been created: these are physiological, economic, cultural and socialization factors.

Physiological factors such as long-lasting illness, isolation, a partner's death or physiological infertility occur relatively rarely among young people. Even if one of these

factors appears (e.g. infertility), it is usually not realized at this stage of life and, consequently, is not significant.

Economic factors affect the living conditions of potential parents (such as having or not having their own home), fears of a reduction in their standard of living (caused, among other things, by the danger of losing their jobs – this is highly realistic in the case of a woman who is also looking after children), and the lack of aid from the state which does not recognize a pro-family policy. In a discussion about the influence of economic factors, another influence regarding the sexes should also be mentioned. Although the equal sharing of childcare responsibilities has been widely discussed, it is, nevertheless, mainly the woman who has the duty of looking after children and the role of a mother is, in her case, a central role which can make it impossible for her to fulfil other roles. A father does not usually have to forgo many roles that are not connected to parenthood; in the case of women, this probability is much higher. They are often forced to decide between choosing one role (that of a mother) at the cost of another (that of an employee).

Norms, value systems and most especially attitudes to religion are among the **cultural factors** that influence attitudes towards procreation. They undoubtedly have a significant importance in shaping procreative and anti-procreative attitudes among young professionals. A theory may be proposed that among religious people, whose value system is based on tradition, the frequency of anti-procreative attitudes will be lower than they are among more liberal people. An especially important phenomenon is the extent of the influence of the 'no-children fashion' among young people and a similar message imparted by the mass media. The people who follow this fashion are at liberty to choose roles in society that are different from the role of a father or a mother. Young, well-educated people have many life choices available to them, and scenarios that entail having offspring do not play a crucial part in these choices. Many of these people can fulfil themselves with other aspects of life such as their professional careers, through developing their own interests or in pro-social activities.

Socialization factors include, among other things, one's own childhood experiences, the atmosphere in the family home, and attitudes to adoption. It is assumed that people who did not have negative experiences connected with their family environment (divorce, a hostile atmosphere, financial and emotional deficiencies) will display anti-procreative attitudes with a lower frequency than those who have undergone negative family experiences.

In summing up the characteristics of the individual factors that influence change in the development of the family, it must be acknowledged that the essential role concerning the transformation of procreative attitudes has been adopted by young people. The way future families will look in the modern world depends on these people and their children (Owsiejczyk, 2009).

Table 2-1. Factors influencing the modern family

Direction of changes	Effects
1. Industrialization and globalization	Expansion of numerous industrial and service providing institutions Higher level of education and better access to culture Socioeconomic and social-cultural transformations Raised standard of living in both average and highly-developed countries Emigration from lower to better-developed countries Blends of cultures increase the risk of social and political tensions Development of strong international institutions, creating elements of global culture on a continental and intercontinental scale (e.g. pop culture, pop music)
2.Progress in science, technology and medicine	Automation and the robotization of production (the replacement of people with automated machinery) Development of information and communication technologies (ICT) Modernization of social media and the development of new forms of social media based on the Internet Progress in medical care and hygiene resulting in improved physical health and extended lifespans Popularization of modern contraceptives resulting in a decreasing birth rate and changes in demographic structure
3. Independence of the individual in a society	Increase in individual interests and personal aspirations at the expense of group interests Less communication with actual neighbours and more communication with 'virtual' friends through social media Increase in divorce and the number of 'singles' New role of work (in the preindustrial period – work was the basis for supporting the home and family, in the industrial period – the husband, then the wife and then the children went out to work; everyone had their own life) Tensions associated with the burden of consolidating roles within and outside the home

3. Abstract

The family has always been and will always be the most important institution for the development of human values. It is the basis of an individual's socialization and the foundation of personal development.

In a healthy family environment, all of the desired psycho-physical traits of a child are shaped. The family environment determines if the child will become a healthy individual, physically and mentally resistant, or if the child becomes weak, and both emotionally and socially immature. The family stimulates a child's intellectual development. The relationship between the parents has a huge influence on the atmosphere in the family home, and it also has an impact on the behaviour and functioning of the whole family, and on its intellectual and emotional development. An important element within the family are the various roles of the family members, which are concerned mainly with care, child rearing and fulfilling the family's needs.

In the family, in the process of growing up, the individual characteristics that are important for mental health are shaped by: a) the individual's personality, the ability to fulfil needs, b) emotional reactions and patterns, c) ways of dealing with difficult situations in life, d) value systems, setting goals in life and establishing ways of achieving these goals.

The family fulfils the need for close communication and emotional contact between its members. It creates the best conditions for confiding in another person, and for ameliorating feelings humiliation and other destructive aspects of everyday life. The harmonized family maintains an emotional balance and creates conditions for expressing the personality traits of family members.

From theoretical discussions and research into the modern family, it is clear that an important aspect of family life is the issue of family roles. The change in the scope of the tasks fulfilled by women and men is an important element of the changes experienced by the modern family. The main changes are the increased participation of men in family life and the increased participation of women in the production force.

The traditional ideal of the family has been damaged: marriage is no longer perceived by many people as a necessary condition for family life; lone parenthood is commonplace; homosexual relationships are habitually regarded as being socially acceptable. The modern family is still undergoing changes. Both the husband and wife, and even the children, are in full time employment. The modern family has less and less

control over the lives and functioning of its members. However, the transformation of the modern family has not changed the fact that it is still the basic environment for preparation for living in society.

The most frequently discussed hazards facing the modern family are: unemployment, poverty, homelessness, divorce/separation and addiction. All of them are negative factors which threaten the condition of the family and are the main reasons for its breakdown, at the same time they can negatively influence each of its members as individuals. The family has always been subject to stress, and many families cope with this as an ongoing process of change and development. However, some more vulnerable families require assistance in times of crisis and stress.

It is essential that healthcare providers develop an understanding of stress and how this impacts on families and individual family members. It is also crucial for them to identify those families who require more support, so that they can provide appropriate coping strategies, assistance and help to empower the family to deal with their situation.

There are various approaches to the concept of the family as a subject of healthcare and each has a different focus: the individual, the family and the family as a part of a larger society. In order to provide the most effective interventions, it is essential that the family is assessed effectively and a number of assessment models and tools exist to provide this. The provision of care often involves the participation of the whole family, and the family health nurse is in a position to observe and evaluate the care relationships within the family, with reference to the optimal care model, and aiming at a balance between excessive and deficient care. The family's nursing care efficiency is dependent on the structure of the family; the family's knowledge and skills; its physical, mental, social and emotional abilities and its living conditions. Various legal documents and acts have ensured that a focus is applied to the consistent provision of family policy, especially the rights of children, and provide underlying support for family-focused healthcare provision. Effective family health care requires good relationships between families and health care providers, as well as support and interventions based on a family-centred health care model.

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MODERN FAMILY – THREATS AND HEALTH CARE

OVERVIEW

Section 1 considers the problems and threats facing the modern family. It explores the nature of stress and crisis and how this can impact on families, identifies those families who would particularly benefit from intervention, and suggests various approaches and coping strategies.

Section 2 examines the concept of the family as a subject of care. Approaches to this concept and strategies for the assessment of the family are examined. Strategies with regard to care – and the level and quality of care – which is provided by the family are discussed. Examination of the legal provisions which cover the legislative area of the family, highlights the underlying social support in place for family-focused healthcare provision. Finally, the necessity for establishing good relationships between the healthcare provider and the family, in order to provide supportive and effective family health care, is highlighted.

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1. Problems and threats facing the modern family

1.1. Introduction

The modern day family is exposed to a wide range of stress-inducing factors – perhaps more varied than ever before. Families have always dealt with stressful situations and, indeed, a certain amount of stress is believed to be natural, expected and essential for healthy development. Stress and stressful situations can impair the ability of the family to function, and some families – especially multiproblem families and those experiencing chronic problems - may need help in order to cope. Vulnerable families, families who are faced with negative choices, and families who are living in poverty are particularly in need of help. Utilizing the resources of the family, and identifying the best strategies to help the family to cope can be effective approaches. These include the provision of information and support, assisting the family to identify and understand the causes of the situation, and the exploration of coping strategies.

1.2. Families experiencing crisis

The modern family is exposed to many extreme situations such as natural disasters, damaging fear, loss and terrorism. Even the most well-adjusted family can be placed in a crisis situation because of stress endured over a long period of time. A family crisis is a continuous disruption, disorganization or incapacitation of the family social system.

The fluidity of family structures require most families to deal with several family structural transitions during the course of the lives of its members (Price, McKenry, & Murphy, 2000), (Teachman, Polonko, & Scanzoni, 1999).

Families are increasingly experiencing a wide variety of stress-inducing factors associated with both positive and negative events: advances in technology, industrialization, urbanization and increased population density (including housing, traffic and demand on infrastructure).

Boss defines family stress as pressure or tension on the status quo; it is a disturbance of the family's steady state (Boss, 2002), (Boss, 2006).

Life transitions and events often provide the essential conditions for psychological development, and family stress is perceived as inevitable and normal - or even desirable - since people and therefore families must develop, mature and change over time. With change comes disturbance and pressure – this is referred to as stress (Boss, 2002).

According to the *Oxford English Dictionary,* the term *stress* can be traced back to the early 14th century when the word had several distinct meanings, including hardship, adversity and affliction (Rutter, 1988).

Even among researchers who study stress today, stress is variously defined as a stimulus, an inferred inner state and an observable response to a stimulus or situation; there is also a debate concerning the extent to which stress is chemical, environmental or psychological in nature (Frankenhaeuser, 1994), (Lazarus & Folkman, 1984), (Sarafino, 1990).

The study of family stress began at the University of Michigan and the University of Chicago during the 1930s and the upheavals caused by the Depression (Boss, 2002).

ABC-X Stress Model

This family stress framework can be explained as follows: A (the provoking or stressor event of sufficient magnitude to result in a change in the family)-interacting with B (the family's resources or strengths)-interacting with C (the definition or meaning attached to the event by the family)-produces X (stress or crisis). The main idea is that the X factor is influenced by several other moderating phenomena. Stress or crisis is not seen as inherent to the event itself, but conceptually as a function of the response of the disturbed family to the stressor (Hill, 1949), (Boss, 2002), (Burr, 1973).

Ten Dimensions of Family Stressor Events (Lipman-Blumen, 1975):

1. *Internality versus externality:* Refers to whether the source of the crisis was internal or external to the social system affected.
2. *Pervasiveness versus boundedness:* Refers to the degree to which the crisis affects the entire system or only a limited part of it.
3. *Sudden onset versus gradual onset:* Marks the degree of suddenness with which the crisis occurred, that is, without or with warning.
4. *Intensity versus mildness:* Involves the degree of severity of the crisis.
5. *Transitory versus chronic:* Refers to the degree to which the crisis represents a short- or long-term problem.
6. *Random versus expected:* Marks the degree to which the crisis could be expected or predicted.

7. *Natural generation versus artificial generation:* Indicates the distinction between crises that arise from natural conditions and those that come about through technological or other man-made effects.
8. *Scarcity versus surplus:* Refers to the degree to which the crisis represents a shortage or overabundance of vital commodities - human, material and non-material.
9. *Perceived solvability versus perceived insolvability:* Suggests the degree to which those individuals involved in the crisis believe the crisis to be open to reversal or some level of resolution.
10. *Substantive content:* This dimension differs from the previous nine in that it subsumes a set of subject areas, each of which may be regarded as a separate continuum graded from low to high. Using this dimension, the analyst can determine whether the substantive nature of the crisis is primarily in the political, economic, moral, social, religious, health, or sexual domain, or in any combination of these.

The terms *stress* and *crisis* have been used inconsistently in the literature. Boss makes a useful distinction as she defines a crisis as (a) a disturbance in the equilibrium that is so overwhelming, (b) pressure that is so severe, or (c) change that is so acute that the family system is blocked, immobilized and incapacitated (Boss, 2002), (Boss, 2006).

When a family is in a crisis state, at least for a time, it does not function adequately. Family boundaries are no longer maintained, customary roles and tasks are no longer performed and family members cease to function at optimal physical or psychological levels. The family has thus reached a state of acute disequilibrium and is immobilized (Price, Price, & McKenry, 2010).

Family stress, on the other hand, is merely a state of changed or disturbed equilibrium. Family stress, therefore, is a continuous variable (degree of stress), whereas family crisis is a dichotomous variable (either in crisis or not). A crisis may not necessarily permanently break up the family system. It may only temporarily immobilize the family system and then lead to a different level of functioning than that experienced before the stress level escalated to a point of crisis. In fact, many family systems become stronger after they have experienced and recovered from crisis (Boss, 1988).

Cognitive coping strategies refer to the ways in which individual family members alter their subjective perceptions of stressful events. Sociological theories of coping emphasize a wide variety of actions directed at either changing the stressful situation or alleviating distress by manipulating the social environment (McCubbin, Joy, Cauble, Comeau, Patterson, & Needle, 1980).

Thus, family coping has been conceptualized in terms of three types of responses (Boss, 1988), (Lazarus & Folkman, 1984), (Pearlin & Schooler, 1978):

1. Direct action (e.g. acquiring resources, learning new skills),
2. Intrapsychic (e.g. reframing the problem), or,
3. Controlling the emotions generated by the stressor (e.g. social support, use of alcohol).

These responses may be applied individually, consecutively or, more commonly, in various combinations. Specific strategies are not inherently adaptive or maladaptive; they are very much situation specific. Flexible access to a range of responses appears to be more effective than the use of any one response (Moos, 1986).

Because the family is a system, coping behaviour involves the management of various dimensions of family life simultaneously (McCubbin, Joy, Cauble, Comeau, Patterson, & Needle, 1980):

1. Maintaining satisfactory internal conditions for communication and family organization,
2. Promoting member independence and self-esteem,
3. Maintaining coherent and united family bonds,
4. Maintaining and developing social supports in transactions with the community,
5. Maintaining some efforts to control the impact of the stressor and the amount of change in the family unit.

Ever since family nursing in the community began, health professionals have encountered families that have chronic problems and many barriers to achieving optimum health. Some families have experienced generations of poverty, as well as a variety of problems - physical, psychological and social – that prevent the family from functioning effectively (Maurer & Smith, 2009).

Both the individual and the family have resources available to them, but some families experience several stressors simultaneously (multiproblem families). Many families with chronic problems have combinations of problems.

A family crisis is a continuous disruption, disorganization or incapacitation of the family social system (Burr, 1973).

According to ICNP® terminology, a Family Crisis is *'An imbalance in the mental, social or economic stability of the group, with alterations in its normal functions and difficulties with problem solving and communication. There may also be a failure to adapt to change, and to recognize and use internal and external resources. to acknowledge changing situations with regard to internal resources, external support networks, a tense environment and inefficient family communications.*' An Impaired Family Process occurs when the *'Family is unable to achieve family functions and tasks. Change in the role of the family,; lack of family objectives, indifference to change, an inability to*

recognize the need for help, the inability to handle tensions, stress and crisis, a neglected home, distrust in other people, a feeling of hopelessness' (International Council of Nurses – ICN, 2011).

A family in crisis may have serious disturbances in the organization of the family and may require basic changes in its patterns of functioning in order to restore stability. The family perception of the event responsible for the disturbance may be the most important mediating factor (Boss, 2002).

The key issue could be the family's resources, including inherent family strengths and specific ways of dealing with issues. Resources may include personal traits, such as innate intelligence or a sense of humour, also, family system resources include communication, problem-solving abilities and social support. The ongoing coping process could be a form of adaptation. This process occurs within the context of the community in which the family lives, which suggests pathways for intervention (Patterson, 1988).

Having chronic problems means that families suffer from a combination of stressors simultaneously. Some families are vulnerable, some are presented with only negative choices, some struggle with poverty and some have disturbances in the internal dynamics of the family.

Multiproblem Families have needs in several areas simultaneously: difficulty in achieving developmental tasks, illness or loss, inadequate resources and support, disturbances in internal family dynamics, or environmental stressors. Multiproblem families are families in which combinations of low functional levels, multiple stresses, multiple symptoms and a lack of support interact to threaten or destroy the family's ability to meet the physical and emotional needs of its members.

Vulnerable Families

Providers in the United Kingdom have defined three types of family groups (Barrett, 2008):

1. **The 'invisible'** - the overlooked or those unable to articulate their needs: this includes those caring for others, those with mental health problems, socially isolated parents, homeless families and families with needs below the officially determined threshold.
2. **The 'under-represented'** - traditionally, the marginalized, disadvantaged or socially excluded: this includes service users who fall into well-defined categories, often linked to population characteristics, such as minority ethnic groups, prisoners, parents of disabled children, parents with disabilities, homeless families, refugees and asylum seekers.
3. **The 'service resistant'** - those unwilling to engage with service providers, the suspicious, the over-targeted or disaffected: this group includes families 'known' to

agencies such as social services, who are wary of engaging with providers, or others who are distrustful and potentially hostile to service providers.

Another group includes those who do not access services at all. This may be because:
- They live in areas where services are either not available or not easily accessible.
- There are simply not enough services to meet their needs.
- They have not come to the attention of the service providers that typically provide onward referrals.
- They move from place to place, often because they are engaged in seasonal work or have high levels of debt.
- They do not have access to public transport or transport of their own, or the cost of petrol may limit their travel.
- They may have a family member in prison.

Families with Negative Choices

These are families who are offered the possibility of aid but cannot accept it because, for example, the patient may have become attached to the caregiver and there are difficulties in leaving him or her in the care of others. Although it is possible to support such families, this kind of situation makes assistance practically impossible.

Families in Poverty

The poor, both as individuals and as a group, are continually faced with multiple and chronic stressors, including frustration over their employment options, inadequate and unsafe housing conditions, repeated exposure to violence and crime, inadequate child care assistance, and the harsh attitudes and responses of health and social service agencies (Berne, Dato, Mason, & Rafferty, 1990).

Poverty cannot just be defined by statistics and reports, such as the poverty line, in order to identify if people are impoverished in their respective countries. The concept of social and cultural exclusion is a better way to convey poverty as a process that involves multiple agents (Skalli, 2001).

Many developing countries have social and cultural norms that prevent women from having access to formal employment. In particular, in parts of Asia, North Africa, and Latin America, the cultural and social norms do not allow women much opportunity to work outside the home or to have an economic bargaining position within the household (Sen, 1990). This social inequality deprives women of the opportunity to develop certain capabilities, particularly those connected with employment, which leads to women facing a higher risk of poverty (Sen, 2001). The increase in occupational gender segregation and a widening of the gender wage gap increases women's susceptibility to poverty (Bianchi, 1999). Fulmer describes the family life cycle of

poor families enmeshed in chronic unemployment and discrimination as a life of being vulnerable to problems (Fulmer, 1988).

Families consume eight basic resources. These are available in varying quantities and poverty may still exist if these are untapped as resources. Ruby Payne outlines the basic resources that families must manage and maximize in order to become self-sufficient. Briefly, these resources include (Payne, 2013):

1. **Financial:** Having the money to purchase goods and services.
2. **Emotional:** Being able to choose and control emotional responses, particularly to negative situations, without engaging in self-destructive behaviour (This is an internal resource and reveals itself through stamina, perseverance and choices.).
3. **Mental:** Having the mental abilities and acquired skills (reading, writing, computing) to deal with daily life.
4. **Spiritual:** Believing in divine purpose and guidance.
5. **Physical:** Having physical health and mobility.
6. **Support systems:** Having external resources, such as friends, family and backup resources, accessible in times of need.
7. **Relationships/role models:** Having frequent access to nurturing adult(s) who interact appropriately with children and who do not engage in self-destructive behaviour.
8. **Knowledge of hidden rules:** Knowing the unspoken cues and habits of a group.

Families with Disturbances in Internal Dynamics

Multiproblem families are often unable to provide for the security, physical survival, emotional and social functioning, sexual differentiation, training of children, and for the promotion of the growth of individual family members. These families are characterized by insufficient internal support, frequent or intense emotional conflict, an inability to conform to societal expectations and the acting out of family members.

Helping Families Cope with Crises: Best Practices

1. Start by recognizing the sources of family resilience and strength.
2. Offer hope.
3. Help the family to identify and describe the nature of the stressors.
4. Explore the family's appraisal of the situation, including its meaning to family members and their judgment of their ability to respond.
5. Provide information about the nature and demands of the stressor that may not be known to the family.
6. Help the family to divide the tasks required by the stressor into manageable parts.
7. Help the family to explore current and alternative coping mechanisms.

8. Validate and emphasize the use of internal family resources, including personal and family strengths.
9. Access external sources of social support.
10. Arrange for tangible sources of external support such as financial assistance, health care, home visitors, support groups, food assistance and transport.
11. Encourage a positive reappraisal of the situation as the family moves from adjustment to adaptation to their new state.

2. The family as a subject of care

2.1. Introduction

Four different approaches to care are inherent in family nursing (Kaakinen, Hanson, & Denham, 2010):

1. The family in the context of individual development.
2. The family as a client.
3. The family as a system.
4. The family as a component of society.

Each approach derived its foundations from different nursing specialties: maternal-child nursing, primary care nursing, psychiatric/mental health nursing, and community health nursing, respectively. All four approaches have legitimate implications for nursing assessment and intervention (Kaakinen, Hanson, & Denham, 2010).

2.2. The concept of the family as a client

Family nursing care centres on the assessment of all family members; the **family as a client** is the focus of care. Through this approach, every member of the family is in the foreground, and consideration of individuals is not mutually exclusive to the consideration of the family as a whole. The family is seen as the sum of the individual family members and the focus is on each individual. Each person is assessed and health care is provided for all family members. The family unit is not necessarily the primary consideration in the provision of care, however.

2.3. The concept of the family in the context of its impact on the health and health management of individuals

The conventional approach to family nursing care focuses on the assessment and care of an individual client in which the **family is the context**. This is the traditional nursing focus, in which the individual is in the foreground and the family is in the background. The family serves as the context for the individual, either as a resource or as a stress factor with regard to his or her health and illness.

The focus is on the family as a client and the family is viewed as an interactional

system in which the whole is more than the sum of its parts. In other words, the interactions between family members become the target for nursing interventions, which flow from the assessment of the family as a whole.

The Family as a Component of Society

This approach to care views the family as a component of society, in which the family is viewed as one of the many institutions in society, similar to health, educational, religious or economic institutions.

The family is a basic or primary unit of society and it is also a part of the larger system of society. The family, as a whole, interacts with other institutions to receive, exchange, or deliver communications and services. It was family social scientists who first used this approach in their study of families in society (Kaakinen, Hanson, & Denham, 2010).

2.4. Family Assessment

Family Assessment Models - The Family Assessment and Intervention Model (FAIM)

The FAIM model postulates that to maintain its stability over time, the family develops a range of responses to stressors, known as lines of defence and resistance. The family develops problems when stressors overwhelm the defence systems. The reaction of the family depends on how disturbing the stressor is and how capable the family is in mobilizing resistance to restore a sense of stability. The model addresses a) health promotion, activities for well-being b) problem identification and family factors at the lines of defence and resistance and c) family stability and functioning at the levels of prevention/intervention. The *Family Systems Stressor - Strength Inventory (FS3I)* is an assessment instrument based on this model (Hanson & Mischke, 1996).

The Friedman Family Assessment Model

This model draws on structural-functional systems and family developmental theories. Friedman's approach views the family as an open system interacting with other institutions in society such as those of health, education and religion, it focuses on the family structure and functions. This assessment tool, which was first developed in the 1970s, broadened its scope in recent versions to include family nursing diagnoses and interventions from a multicultural perspective (Friedman, 1998).

The Calgary Family Assessment Model (CFAM) and the Calgary Family Intervention Models (CFIM)

The CFAM and the CFIM blend nursing and family therapy concepts and are grounded in systems theory, cybernetics, communications theory, change theory and the biology of cognition. Assessment questions focus on collecting information concerning the family's structural, developmental and functional status. An emphasis is placed on identifying the strengths and resources of families. The CFAM is a map of family circumstances and assumes that the family is who it claims to be. The CFIM provides a means to decide on interventions consistent with the family assessment. Fundamental to this tool is the recognition that each family is unique and has specific strengths. Interventions are directed towards strengthening, promoting and/or sustaining effective family functioning in the cognitive, affective and behavioural domains. The goal is to assist family members to discover new solutions to help diminish and ease emotional, physical and spiritual suffering. Elements of the Calgary Family Assessment Tool are provided in the table below as an example (Wright & Leahey, 1994a).

Table 4-1. The Calgary Assessment Tool (Assessment Questions)

1. Structural Assessment.	**Internal:** family composition, gender, rank order, subsystems, boundaries **Context:** extended family, larger systems **External**: ethnicity, race, social class, religion, environment
2. Developmental Assessment	**Stages, tasks, attachments**
3. Functional Assessment	**Instrumental**: activities for daily living **Expressive**: emotional communication, verbal communication, nonverbal communication, circular communication, problem solving, roles, influences, beliefs, alliances/coalition

Source: Adapted from Wright and Leahey (Wright & Leahey, 1994b).

WHO/EURO Family Health Nursing Model

As a recent addition, the European Region of the WHO (EURO) family health nurse (FHN) model draws on several of the frameworks already mentioned. It combines aspects of systems theory (to analyse the complexities of health care), interaction theory (to consider relationships with family and individuals in nursing), and developmental theory (to stimulate awareness and an understanding of the developmental stages of individuals and family in order to define the families). In this context, FHNs are defined as nurses who will 'help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients' homes and with their families' (World Health Organization, 1999).

2.4.1. Care relationships in the family

Full family involvement is often observed in the implementation of care functions for the families of the chronically ill and disabled.

A family nurse who has direct contact with his or her charges is able to observe and evaluate the care relationships in the family.

The provision of care by carers can take different forms: from over-protectiveness (excessive care) to a complete deprivation of aid (nursing shortfall). Both lead to negative consequences for the sick or disabled person, and for his or her family. Between these two models of assistance, we find the optimal model (optimal care) that can provide the necessary help.

Excessive care (overprotection)

Excessive care is based on the higher care services, which are not necessary to meet the current needs of a sick or disabled person.

Excessive care makes a sick or disabled person dependent on the assistance of others, undermines their self-confidence and lowers their self-esteem. A sick or disabled person, who is totally dependent, becomes resourceless and they have no opportunity for their personal development.

Nursing shortfall (lack of necessary care)

This is a situation in which there is a lack of willingness to assist. It is a problem that can be considered from three perspectives:

1) A relationship between the family member (especially the main carer) and a sick or disabled person, with emphasis on the specificity of the relationship, e.g. due to the age of the man dependent on family care
2) The level of efficiency of the family in terms of securing adequate care, and the extent of the changes that are taking place in the family as a result of disease: the family has a requirement to deal with this, but requires help from the outside.
3) In this model, adverse effects may be observed for the disabled patient (neglect, loneliness, rejection by close family) and for the family (an increase in conflicts and misunderstandings that can lead to the disintegration of the family).

Optimal care

Optimal care means the balance between necessary care and nursing and actually getting that help. This type of relationship is usually based on the family fully accepting the condition of the sick person, and provides the sick person with the

greatest opportunity to develop and with equal opportunities for an independent and active life.

2.4.2. Efficiency of family nursing care

The assessment of the efficiency of family nursing care may be determined by analysing the factors which shape it. Each factor is relevant to the quality of care and may place restrictions on or cause withdrawal from the provision of assistance by family members/carers. Therefore, these factors should be the subject of a nursing diagnosis or the focus of other persons who are working with the family e.g. a social worker. Knowledge of family constraints with regard to the family's caring role allows the nurse to determine how the family should be supported and how the family can be helped to overcome the identified limitations. Figure 4-1 presents the factors that determine the efficiency of nursing care for the family (Kawczyńska-Butrym, 1995).

Whether the family will cope with the problems arising from the care of the disabled or chronically ill person depends, among other things, on the capabilities of the family, its potential and outside help. The potential of the family is characterized by such features as mutual emotional support of family members, participation in the performance of daily duties and a knowledge of the possible sources of assistance. The elements that provide the family with strength are: love, a sense of connection and kinship, concern about the fate of loved ones, the desire to live which is inherent in human beings, a sense of duty, a wish to improve their situation and faith in God.

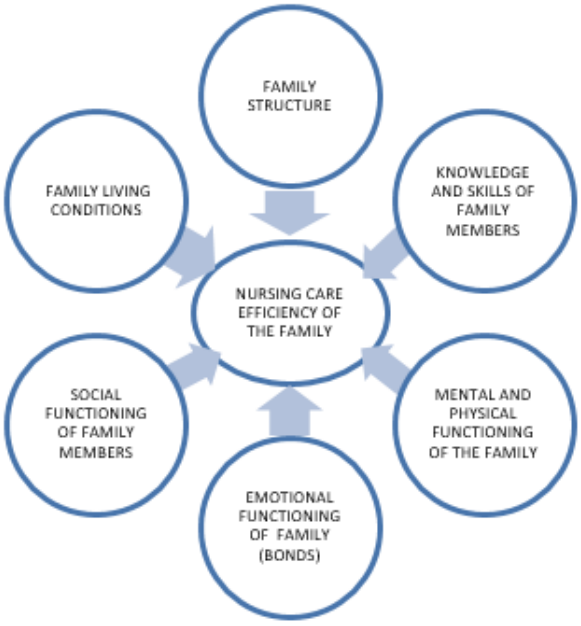

Figure 4-1 Efficiency of family nursing care according to Kawczyńska-Butrym.

2.5. The rights of families

Interest in family policy in Europe dates back to the beginning of the twentieth century. In the literature, it is stressed that the European Union's strategic objective should now be to improve conditions for the formation and functioning of families, and to raise birth rates. It cannot however, solely focus on increasing fertility rates, but should also concentrate on improving the quality of the functioning of the family in all its dimensions. Given the current demographic situation in European Union countries and the present socioeconomic factors, it must be assumed that the most important challenges concerning family policy in the EU include (Balcerzak-Paradowska, 2009):

- the aging of the population,
- changes in the form and structure of the family,
- changes in the labour market.

One of the basic principles of the EU is the principle of the free movement of people, which became the basis for the introduction of social security systems. A coordinated approach allows the citizens of one member state, who are staying in another member state, to be treated equally as citizens of the host country and to be entitled to the benefits of social welfare. Family benefits are provided for in the legislation of all member states and constitute a separate section of social security, also, the regulations concerning these benefits vary between the member states with regard to their scope, terms of purchase and funding rules. Among these benefits are family allowances which, in essence, are similar in all EU countries and take the form of cash benefits, which are paid out periodically and which are dependent on the number and age of the children. Disability benefits may also be an entitlement. Community provisions introduced separate principles for the coordination of family benefits depending on whether they are paid to people who are active professionals, including those temporarily out of work, those who are authorized or entitled to a pension or retirement, or orphans. It is worth highlighting the actions of *The European Observatory of National Family Policies* which operates at the Austrian Institute for Family Studies. The Observatory was created in 1989 to:

- monitor and compare the actions of the European Union which have an impact on children and family,
- analyse demographic changes and their impact on the structure and functioning of families,
- analyse the impact of socioeconomic changes on families.

Analytical and research activity carried out by the Observatory provides the information necessary for the application of the open method of coordination within the EU. In addition to the legislation in force in the European Union, it is also essential to have family policy documents issued by the United Nations.

Key acts of the United Nations in the field of family policy are as follows:

- The **Universal Declaration of Human Rights (UDHR)**, proclaimed on 10 December 1948 by the United Nations, as a UN General Assembly resolution, did not create a new international law. However, at the present time, the Declaration is considered to be customary law and provides the basis for human rights protection (United Nations, 2015).
- On the basis of the UDHR, the **International Covenants on Human Rights**, which bind all States – Parties, as international agreements from the outset, were adopted by The General Assembly in 1986 (United Nations, 1986).
- The **Convention on the Rights of the Child,** adopted on 20 November 1989 by the UN General Assembly (United Nations, 1989).

In terms of the complexity of the regulations concerning the family, the Convention on the Rights of the Child has priority.

The catalogue formulated was based on the following principles:

- Principle of child welfare.
- Principle of equality (all children are equal from the perspective of the law, regardless of origin, gender, or nationality).
- Principle of respect for the rights and responsibilities of both parents (the state respects the autonomy of the family and intervenes only in special cases and according to certain procedures).
- Principle of state aid (the state is obliged to take all legislative and administrative measures to ensure the implementation of the rights recognized in the Convention).

The Convention establishes the status of the child based on the following assumptions:

– The child is an independent entity but, due to his or her mental and physical immaturity, requires special care and legal protection.
– The child, as a human being, requires respect for his or her identity, dignity and privacy - the family is the best environment for the child's upbringing.
– The state has a responsibility to support the family, and not attempt to replace it with regard to its functions.

The analysis above provides evidence that the consistent provision of family policy, especially the rights of children, is one of the priority objectives of social policy, implemented in the framework of the European Social Model, and this is reflected in the documents issued by the Council of Europe and the UN. Thus, it sets out the direction and priorities for action for family policy and family law.

2.6. Working in partnership with families

Caring for families is a role intrinsic to nursing. The family setting provides the opportunity to address the health needs of the family unit and its individual members. Working in partnership with the caregiver in order to individualize interventions tends to be more successful in meeting specific needs as defined by the caregiver and care recipient (Archbold, 1995). Families contribute most of the care that is provided for older adults, regardless of the care setting. The ways in which families organize themselves and structure this care varies (e.g., primary caregiver vs. collective caregiving). Nursing care is most effective when it is provided in partnership with families and by using a family-centred care model.

Family-centred care has emerged in response to increased family responsibilities for health care.

The principles of family-centred care include (Lewandowski & Tesler, 2003):
1) recognizing families as 'the constants' in children's lives, while the personnel in the healthcare system vary,
2) openly sharing information about alternative treatments, ethical concerns and uncertainties about healthcare treatments,
3) forming partnerships between families and health professionals to establish what is important for families,
4) respecting the racial, ethnic, cultural and socioeconomic diversity of families and their ways of coping,
5) supporting and strengthening the ability of the family to grow and develop.

Ahmann describes family-centred care as a philosophy that calls for the formation of partnerships between parents and professionals that support parents in their central caring roles (Ahmann, 1994).

The importance of working in partnerships with families in the healthcare system seems so obvious, yet many healthcare providers view dealing with the families of patients as an extra burden and much too demanding.

Within a particular project, primary healthcare nursing practice focused on the individual within a community-orientated approach, in which the nurses worked in partnership with other disciplines. However, the process of learning from each other's expertise and experience was one of the most successful and enriching outcomes of the project. The underpinning argument in this case is that FHNs have the potential to reach many people through working in partnership with families and communities.

Increasingly, the process of partnership, in which the family is actively engaged in its healthcare provision, is replacing the traditional approach to health care, where physicians and nurses are viewed as experts who decide what is good for the family and its members. Families want to be involved, and informed consumers are demanding a greater degree of control over their care. In partnership with families, nurses can examine how the characteristics of families influence health.

Lazenbatt evaluates the contribution of nursing to the improvement in partnerships with families. He describes in detail the contribution that nurses, midwives and health visitors made in targeting their efforts to meet certain healthcare and social requirements. The aim of the study is to show an example of 'effective practice' involving nurses, midwives or health visitors (Lazenbatt, Orr, Bradley, & McWhirter, 1999).

Eight characteristics were identified which defined aspects of effective practice. These were:

1. A holistic view of health and social needs.
2. Health alliances and inter-agency cooperation.
3. Empowerment.
4. A research based approach.
5. Multi-disciplinary teamwork.
6. Needs assessment.
7. Community development.
8. Audit and evaluation in practice.

Flynn has demonstrated that community-oriented advanced practice nurses (APNs) have the skills and expertise required to support community leaders in their efforts to build healthier communities. She recommends that APNs draw on examples such as community leadership development, community assessment, nurse managed services, research and policy advocacy (Flynn, 1997).

Roth developed a model of a potentially long-lived partnership in which the partners do not know with certainty how 'good' the partnership will be relative to their outside opportunities. If the partnership were known with certainty to be a 'good one', the partners would understand that it will be long-lived and will both invest substantial resources in it. The partners learn about the quality of their partnership by observing current and past outcomes. The greater the amount of investment in the partnership, the more likely it is that the partners will realize that it is a good partnership.

The more often partners observe good indications about the partnership, the more likely the partners are to invest. In the model, as formulated by Roth, no matter how much is invested, 'bad' partnerships will eventually be discovered to be bad, but on the other hand, some 'good' partnerships are dissolved by rational decision-makers

because a run of bad luck has led the partners to think that the partnership will not last and hence the partners do not invest (Bergstrom, 2005).

Family nurses must begin to develop a partnership with families based on a model that recognizes strengths and avoid using a deficit model. Using the Family Nursing Process approach outlined in this chapter, nurses and families work together to identify the needs that are a priority for the family.

A partner, according to Webster's Dictionary, 'is one who shares; a partaker, a colleague; either member of a couple who dance together'. A partnership, according to the same source, is 'a relationship resembling a legal partnership and usually involves a close cooperation between parties having specific and joint rights and responsibilities'. The essential idea in these definitions is that of sharing and joint responsibility. Both parties, while approaching matters from a different context, share an interest that allows them to work together for their mutual benefit and, in the case of nursing, for the 'greater good'. The image of a couple dancing together is particularly apt in illustrating the point. In dance, both individuals have to be in tune with each other's moves, they must be synchronized and aware of each other's 'steps'. As a result of this co-operation, the dance itself transcends the individual partners, its beauty depends on how well the dancers move together and understand each other. In reality, in community–university partnerships, the dance is difficult to master (Bernal, Shellman, & Reid, 2004).

The Partners in Caring model has three major constructs:

1. Knowledge of the community.
2. The culture of caring.
3. An open communication system.

The central premise of the model is the creation of a partnership whose commitment to the population being served is paramount. The starting point for the model was Anderson and McFarlane's Community as Partner Framework.

According to Anderson and McFarlane, there is a reciprocal relationship between the people in a given community and eight-community subsystems. These subsystems are the physical environment, economics, education, safety and transportation, politics and government, health and social services, communication and recreation. The subsystems are influenced by the residents of the community and, in turn, they affect the people in the community. The second component of the framework, the nursing process, involves the analysis of the assessment data of the eight subsystems, leading to a community health diagnosis with subsequent planning for appropriate interventions. The authors evolved their model from viewing the community as a client to viewing the community as a partner. This was an important leap in our conceptual thinking and one that we adhere to and support with enthusiasm (Anderson & McFarlane, 2011).

The **Care Model** includes healthcare organization, community resources and policies, decision support, delivery system support, clinical information systems and self-management support. The Care Model has the potential to outline the work necessary to address the complex problem of working in partnership with families because it includes the need to form community partnerships to support self-management.

The Nurse-Family Partnership has produced consistent evidence, based upon replicated, random, controlled trials with different populations living in different contexts that it can (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004), (Karoly, Kilburn, & Cannon, 2005), (Olds, 2002), (Olds, et al., 2004a), (Olds, et al., 2004b):

- improve prenatal health,
- reduce childhood injuries,
- reduce the rates of subsequent pregnancies and births,
- increase the intervals between first and second pregnancies and births,
- increase maternal employment,
- reduce women's use of welfare,
- reduce children's mental health problems,
- increase children's school readiness and academic achievement,
- reduce costs to government and society,
- be most effective for those most susceptible to the problems examined.

A pattern seems to be emerging concerning the centrality of such concepts as open communication, the sharing of power, and commitment to and trust in the development of partnerships that work and are sustainable. Our Partners in Caring model adds one important component - the creation of a culture of caring that permeates all aspects of the partnership. It is our belief that nursing education is most relevant when commitment to care and ownership of that care is not simply the responsibility of the practice setting but a shared responsibility between education and service. Nursing educators need to be creative and design experiences that best model our most cherished nursing values. Therefore, nursing instructors should be active players in creating patient care environments/experiences that promote and sustain our beliefs in the centrality of patient care.

When patients and family members are empowered by the information they require, the result is a more effective partnership with professionals. Nurses are in a key position to liaise between professional team members and the family. Patients and families should be encouraged to ask questions, and these questions should be answered with full explanations and support. Nurses are an important source of information about a wide range of issues as patients and their families cope with the end-of-life experience.

Nurses, therefore, must foster good communication to ensure that both the patient's and family's needs and wishes are understood and supported within a caring

relationship that is built on a partnership between professionals and families. It is commonplace for healthcare providers to block families from participating because they are convinced that they know what is best for the families concerned or because they are trying to protect the families in their charge. However, effective end-of-life care is not possible unless open and mutual communication occurs between families and professionals, and unless families participate in shared decision making to the extent that they desire.

3. Abstract

The most frequently discussed hazards facing the modern family are: unemployment, poverty, homelessness, divorce/separation and addiction. They are all negative factors which threaten the condition of the family and are major reasons for its breakdown, but at the same time they can negatively influence each of its members. The family has always been subject to stress, and many families cope with this as an ongoing process of change and development. However, some more vulnerable families require assistance in times of crisis and stress.

It is essential that healthcare providers develop an understanding of stress and how this impacts on families and individual family members. It is also crucial for them to identify those families who require more support, and to provide appropriate coping strategies and assistance to help to empower the family to deal with the situation.

There are various approaches to the concept of the family as a subject of care and each has a different focus: the individual, the family and the family as a part of the larger society. In order to provide the most effective interventions, it is essential that the family is assessed affectively and therefore a number of assessment models and tools exist to provide this service. The provision of care often involves the participation of the whole family, and the family health nurse is in a position to observe and evaluate the care relationships within the family, with reference to the optimal care model, and with the aim of achieving a balance between excessive and deficient care. The family's nursing care efficiency is dependent on the structure of the family and the family's knowledge and skills as well as its physical, mental, social and emotional abilities and its living conditions. Various legal documents and acts have ensured a focus on the consistent provision of family policy, especially the rights of children, and provide underlying support for family-focused healthcare provision. Effective family health care requires good relationships between families and healthcare providers along with support and interventions based on a family-centred healthcare model.

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HEALTH EDUCATION IN THE FAMILY AND LOCAL COMMUNITY

OVERVIEW

The patient's/client's education is a process that includes the teaching of the client, and the educational impact on the client and his or her environment. Its objective is to shape (change or strengthen) health-oriented attitudes according to the socially acceptable objectives of health intervention, prevention and health education.

The most important tasks realized within the educational function of the FHN is a deliberate influence on the client's mind-set, a shaping of health-oriented behaviours and an encouragement of the client to take individual responsibility for their own health, as well as preparing to undertake health-oriented activities for themselves, for their family and the local community.

Self-care is the maintenance of one's personal health. It is any activity of an individual, family or community, with the intention of improving or restoring health, or treating or preventing disease. Self-care includes all the health decisions people (as individuals or consumers) make for themselves and their families in order to become and stay physically and mentally fit. Self-care incorporates exercise undertaken to maintain physical fitness and good mental health. It also involves eating well, self-treatment, practising good hygiene and avoiding health risks, such as smoking and drinking, in order to prevent ill health. In addition, self-care incorporates taking care of minor ailments, long-term conditions, and one's own health after discharge from secondary and tertiary health care.

Individuals carry out self-care, and experts and professionals support that process to enable individuals to achieve the highest level of self-care.

Self-care support is extremely valuable in terms of empowering the individual and has considerable scope in developing countries, which have an already overburdened healthcare system. However, it also has an essential role to play in affluent countries where people are becoming more conscious about their health and want to have a greater role in taking care of themselves.

To enable people to carry out enhanced self-care, support can be provided in various ways and by different service providers, in particular, by nurses, who are at the forefront and can prepare people to take care of themselves. The ability to carry out self-care is the essential issue for all clients in primary health care, and nurses could play a crucial role in this respect. Therefore, they must be well trained and well prepared.

This chapter integrates both management of self-care and teaching the client/patient.

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1. Introduction

Health education, as an inseparable element of health promotion, is an important factor in shaping health-oriented attitudes and in raising a healthy generation. It should focus on creating a positive attitude towards health and health problems.

Health education is the key tool in health promotion. Achieving success in the process of health promotion depends on the active engagement of competent people equipped with proper knowledge and skills.

2. Health education and health promotion

Health education is the conscious, planned creation of learning opportunities and choices that can make a specific change to health related behaviours.

T. Williams et al. defined health education as a 'process in which people learn to take care of their health – both their own and other people's from their community' (Williams, Wetton, & Moon, 1989).

Health education is the conscious creation of learning opportunities in order to achieve a previously planned and defined behavioural change. It aims to improve and protect health through stimulating, by the process of learning, voluntary changes in the individual's behaviour. It is achieved through the direct education of an individual and through the use of the mass media.

Activities aimed at the education and development of individuals are as follows:
- Upgrading the level of health knowledge.
- Counselling with regard to health risks.
- Creating a high degree of self-esteem and independence.

Education through the mass media is impersonal by nature and includes the process of increasing the level of social awareness and creating an effective advisory climate with regard to health problems and health risks. Mass media education may take the form of advertisements, marketing, news bulletins and use radio, television, the press and other forms of publication to disseminate information.

Traditional health education has a close relationship with disease prevention, but is highly deficient as far as the needs of health promotion are concerned. Aimed only at rousing individuals, it may give rise to accusations of 'blaming the victims' as the possibility of changing one's own behaviour is often totally beyond the individual's reach, this results from broadly understood environmental factors.

A traditional understanding of the role of health education places limitations on its efficacy to a significant extent. At the present time, it is obvious that if education is to be effective, it cannot restrict its influence only to individuals and their behaviours.

Modern education should have three levels:

- Upgrading the general level of knowledge and skills connected with the disease, as to the specifics regarding individual cases, highlight prevention and how to deal with difficult situations.
- Upgrading the general level of knowledge and skills connected with using health-care systems and with understanding the rules of how such systems function.
- Increasing the general level of awareness concerning the social, political and environmental factors that influence health. In order to increase the efficacy of educational influence, it is necessary to apply different forms of health education, including those aimed at groups, organizations and whole societies.

Health education should be regarded as a powerful means to apply all of the available social forces to achieve broadly understood health-serving changes, including the implementation of changes in environmental conditions.

The advantage of 'education for change' over a traditional model of education:

- Accounts for the multiple-causality of diseases and takes into consideration not only the behavioural, but also the social, economic and political determinants of health, and highlights the necessity of designing and implementing educational programmes on three levels: individual, community and society.
- Uses a variety of strategies, also, intervention programmes are planned in such a way that one activity increases the influence of another.
- Is directed at the fundamental problems of people who demand solutions for their own use.
- Is rooted in popular movements for social justice – movements like the women's health movement or environmental protection, which have been fighting for some time for the implementation of change in the politics of healthcare and in institutions connected with health.

The most important aim of 'education for change' is to create a more humanitarian, democratic, healthy and just society.

Education that meets the challenges connected with health promotion should:

- Use the term 'positive health'.
- Apply innovative attitudes and educational technologies.
- Adjust to the intervention and participation of non-professional health care.
- Apply multi-sector and multi-disciplinary approaches.
- Develop new strategies connected with different levels of activity (government, legislation, professional, social).
- Take into consideration the social and environmental factors that influence health-connected decisions.

Health Education Models

A model is a pattern, according to which our recipient is to be educated. We can differentiate between three health education models according to their usefulness in the area of health promotion.

The first model – **disease-oriented health education** – is the furthest removed from the idea of the education model. The main aim is to prevent specific diseases. The activities undertaken, based on this model, are aimed at risk factor groups who are associated with particular diseases.

According to this plan, the 'diagnosed population' determines the 'prescription' which defines how recommendations are realized. Activities are aimed at preventing diseases and the avoidance of diseases is their intended result.

The positive aspect of the influence of strengthening and improving the health potential of individuals is not a consideration.

The second model – **education oriented to risk factors –** is based on similar assumptions, but the difference with this model is that it concentrates on the elimination of particular risk factors designed to prevent not one, but several diseases simultaneously. The advantage of this model is the assumption that, in education, the interdisciplinary cooperation of specialists, e.g. cardiologists, is required.

The opportunity to spread information concerning the same topic, e.g. tobacco smoking, by several specialists, increases the likelihood that it will have a beneficial influence on people's behaviour. The basic flaw concerning this and the previous model is that they do not promote the positive aspects of health.

The third model – **health-oriented life education** – has theoretical assumptions which are rooted in the socio-ecological concept of health. The main emphasis is not on diseases and risk factors, but on people and places (home, work, educational and leisure environments).

The most important principle is that people from particular environments and social groups should actively participate in determining their own state of health, and that they should take part in identifying the factors that influence their own health and health behaviours, and help to shape and implement activities aimed at improving the health of the community. People and places are priorities. The main effort is focused on creating and implementing complex health education programmes aimed at the social environments that are crucial for shaping the health of a given community.

The educational activities undertaken are, according to the assumptions of this model, intended to influence the factors shaping health in such a way that health potential in all its aspects, physical, mental and social, is increased.

The factor that differentiates this model from the other two is the complexity of the activities addressing healthy people. It involves designing and implementing health education programmes aimed at the needs of a specific community (e.g. school environment, workplace, home) and also key groups (e.g. the young, the elderly). Thus, we may observe a shift away from the notion of treating people like objects in health education. The activities undertaken, according to this model, are connected with the assumption that individuals can and should have a higher level of responsibility than before for their lives.

Health Education - Setting Approach

According to the Ottawa Charter *'Good health is a major resource for social, economic and personal development and an important dimension in the quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it.*' (World Health Organization, 1986).

The setting, according to WHO, is a place in which people use and shape the environment and where they may create problems connected with their health. The objects of intervention within the setting approach are social systems, not individuals. The key aim is to stimulate, shape and strengthen the mindset widely known as the participating attitude ('What can they do for themselves and how can we help them?'). The activities which are undertaken enable people to identify with their own setting and participate in common problem-solving. Examples of such programmes are: community projects (healthy city projects, school initiatives that promote health, health promotion in the workplace etc.) and healthcare system enterprises (hospitals promoting health). Settings which play a vital part in health education are: the family, nursery, school and health-care institutions as well as local communities, the workplace and army units.

A health-oriented setting is an environment that is changed in order to promote health, not a place where activities connected with health promotion are undertaken. The setting is a dynamic system and, according to the modern theory of management, it may be called a 'learning organization'.

Health-oriented activity should be stimulated in a setting using the existing structures and functions of a given organization in order to undertake health-oriented initiatives. Thus, environments that are conducive to health promotion (the family, school, district, hospital, workplace, city) are created. WHO documented and promoted several health-oriented activity projects based on the setting approach (e.g. Health City, Health Promoting Schools, Health Promoting Hospitals and Health Promotion in the Workplace).

Setting approach - selected examples

Family

The skills within a family that create conditions conducive to good mental health include:

- Effective communication.
- The ability to inform other family members about one's own emotional states, needs and desires.
- Setting common aims and establishing ways of realizing them.
- Dealing with difficult situations.

School

In conjunction with the family, school teaches acceptable patterns of behaviour.

- At school, the child should learn how to solve commonplace life problems.
- Teachers should present a model behaviour pattern for difficult situations, they should teach methods for dealing with emotions, and they should also teach children how to express their views in an appropriate way.

Mental health promotion in the workplace

Levi calls for the following rules of mental health promotion:

- Work should be varied and should require effort.
- Workers should have the opportunity to learn and continue the training and education process throughout their careers.
- The employee must be able to make their own decisions in one area of their job.
- The employee should have social support.
- There should be some connection between the employee's activities and their social life.
- A job should give the employee a positive sense of their future prospects.

Mental Health promotion among the elderly

In 1982, the United Nations postulated the following:

- Increasing the level of economic help is important for mental health.
- More money should be allocated to research the aging process.
- Scientific research concerning the prevention of mental disorders should be undertaken, and the unnecessary institutionalization of old people should be targeted by enlarging family reserves and streamlining social care systems.

Due to the growing challenges of aging for European societies, the member countries of the EU commenced work on a research project - Healthy Ageing. The age group of the project was defined as people over 50. On account of this project, a definition of healthy aging was applied:

Healthy ageing is 'the process of optimizing opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life' (Agren & Berensson, 2007).

The issue of healthy ageing, which results from systematic activities for the benefit of health, appeared in 1998 as an element (fifth objective) of WHO policy (World Health Organization, 1999).

The synonym for healthy ageing is active ageing which, according to the European Commission's definition, involves:

- Participation in life-long learning.
- A longer period of vocational work.
- Later and gradual retirement
- Engagement in forms of activities that help to maintain health and a good physical condition

Early Psychological Help as an Element of Mental Health Promotion

This approach deals primarily with children and youngsters from unsound or harmful environments, families suffering from poverty, families beset by alcohol abuse problems, people living in environments with high rates of crime, the disabled, people suffering developmental crises, people undergoing difficult experiences resulting from traumas and difficult life situations, victims of violence, disaster victims, lonely people and the chronically terminally ill. Specialist help takes the form of psychological counselling and what are commonly known as crisis interventions.

3. Applying the PRECEDE – PROCEED model

The PRECEDE–PROCEED model is a cost–benefit evaluation framework proposed in 1974 by Lawrence W. Green that can help health programme planners, policy makers and other evaluators, analyse situations and design health programmes efficiently (Green L., 1974). It provides a comprehensive structure for assessing health and quality of life needs, and also for designing, implementing and evaluating health promotion and other public health programmes to meet those needs (Green & Kreuter, 2005), (Gielen, McDonald, Gary, & Bone, 2008).

The basic premise of the PRECEDE-PROCEED model is a thorough diagnosis of the situation, as a result of which the programme of active education will be effective. The authors differentiated five types of the diagnosis mentioned above: social, epidemiological, behavioural and environmental, educational, organizational and administrative. These identified diagnosis types are phases of planning in the procedure of this model (PRECEDE). They determine the stage of implementation and the effectiveness of the programme (PROCEED).

Phase 1 - Social diagnosis – concerns a process of gauging the quality of life; techniques of estimating needs are used in order to describe the quality of life within the context of social problems: unemployment, violence, family functioning disorders and social results of diseases.

Phase 2 - Epidemiological diagnosis – concerns the description of health problems (which contribute to the problems of the first phase). Epidemiological indicators concerning mortality, incidence, disability and range (spread, intensity, duration) are used.

Phase 3 - Behavioural and environmental diagnosis – concentrates on the identification of those health behaviours which are connected with the most important health problems defined in the epidemiological diagnosis. This diagnosis encompasses five stages: distinguishing behaviour from other factors, creating an inventory of behaviours, establishing their hierarchy and their changeability and targeting those behaviours as the focus of influence.

Phase 4 - Educational diagnosis - relates to the fourth and fifth phases. In the fourth phase, three categories of elements that shape behaviours and influence health behaviours are distinguished: predisposing factors (personal attitudes, views), strengthening factors (support or pressure from the environment) and facilitating factors (the availability of health care).

Phase 5 - Administrative diagnosis – Pertaining to phase five, this diagnosis deals with the tactical choices resulting from the possibilities and means for drawing up and implementing the programme.

Between phases five and six, the diagnostic part of the model (PRECEDE) ends and implementation and evaluation (PROCEED) begins. The sixth phase is the implementation of the programme. The seventh, eighth and ninth phases concentrate on evaluation.

In the American 'Role Description Project', we find seven sections describing the role of the health promoter/educator. Four of them are connected with the planning and realization of health programmes.

The seven sections can be described as follows:

1) Knowledge and skills in estimating individual and group needs within the scope of health education.
2) Knowledge and skills in planning effective health education programmes.
3) Knowledge and skills in implementing health education programmes.
4) Knowledge and skills in evaluating the effectiveness of health education programmes.
5) Skills in identifying, organizing and coordinating the actions of individual people and institutions within the parameters of the realized educational programmes.
6) Skill in acting as the originator or key figure in health education promotion.
7) Skill in identifying the broadly understood communication, educational needs and social problems of individuals and of determining the possibility of satisfying those needs.

4. Supporting parenthood and the early years of life

Parenthood is a unique event in the life of a man and woman, from planning the first pregnancy to having children. Responsible parenthood involves the parents setting their priorities for the future and is associated with parents preparing themselves properly and taking care of their own health, which is at the same time an indicator of parental care with regard to the child's welfare. The physical and mental development of their offspring depends greatly on the health behaviours of the parents.

Health education, the prevention of ill health and the promotion of effective healthy behaviours should be areas of concern for the man and woman at pre-conception, pre-natal, antepartum and postpartum stages.

The creation of awareness of responsible parenthood in a society has an effect on the health of the global population – the health of future generations depends on the health of their parents.

The report 'Mental Health Promotion and Mental Disorders Prevention – Policy for Europe' was compiled within the network IMPHA Mental Health Promotion Action – Implementing Actions for Mental Health Promotion, in which representatives of twelve European countries participated. It points out the ten most important spheres of influence of mental health promotion and the prevention of mental health disorders:

1) Supporting parenthood and the early years of life.
2) Promoting mental health at school.
3) Promoting mental health in the workplace.
4) Supporting mental health ageing.
5) Dealing with groups at risk of mental disorders.
6) Preventing depression and suicides.
7) Preventing violence and psychoactive substance abuse.
8) Engaging basic and specialist healthcare.
9) Reducing social disability and preventing stigmatization.
10) Implementing cooperation with other sectors.

Among these ten spheres of influence of mental health promotion and the prevention of mental health disorders, supporting parenthood and the early years of life was emphasized as being the most important.

The most important objectives are:
- Supporting parents and their skills, especially in families in at-risk groups.
- Reducing alcohol, drug and tobacco consumption during pregnancy.
- Increasing nursery availability for children from at-risk groups.

Home interventions for pregnant women, encompassing education concerning health behaviours, parental skills and mother-child interactions, should be conducted in high-risk groups within the population.

Investing in a healthy start in life has an effect on development in childhood, in adolescence and when the child matures. During pregnancy and the first years of the child's life, parents, especially those from poor environments or suffering from mental health disorders, can experience more mental health issues, and there is a higher probability that they will fail to provide their children with a healthy start in life. This, in turn, can lead to an increase in mental health problems and mental disorders in their children. These problems can persist in adolescence and into maturity, with the effects passing from generation to generation. Using addictive substances during pregnancy can be harmful to the foetus and the newborn child, doubling the risk of low birth weight and its associated consequences. A delay in the development of speech and the resulting difficulties this can cause with primary school learning can hamper the child's feeling of adequacy, leading to less effective learning and increasing the risk of psychiatric symptoms in adolescence and other mental health disorders in later life.

Positive proactive parenthood can increase children's self-esteem, and can also protect them from later destructive behaviours and disorders connected with using psychoactive drugs. Pre-school education helps the cognitive, linguistic and social-emotional development of children, this leads to social and economic benefits on a large scale (for example, an increase in employment, improved reading and writing skills, enhanced social responsibility, as well as a decrease in the number of unwanted pregnancies among teenagers, a reduction in crimes and arrests, and economic profit equal to seven times the amount of invested resources).

The most important interventions for supporting parenthood and the first years of life:
- Defining and identifying high-risk groups within the population - for example, parents from socially and economically deprived environments, parents with mental disorders, single mothers on low incomes, and single, underage mothers.
- Compiling sets of training materials based on scientific proof with regard to the intervention of trained healthcare professionals and social and welfare workers in order to help establish parental roles.
- Implementing home interventions, based on scientific proof, for use during the antepartum period and targeted at pregnant women and their partners from at-risk groups – interventions should include education with regard to health behaviours, parental skills and mother-infant interaction.

- Implementing screening programmes and short-term intervention for pregnant women, these should be run by properly trained healthcare workers, in order to reduce or stop alcohol, drug and cigarette consumption.
- Implementing early diagnosis and treatment for postnatal depression, used in combination with interventions dealing with the fulfilment of parental roles in order to help depressed mothers gain parental skills.
- Providing parents, after the birth of their first child, with parental skills education which includes focusing on the relationship and interactions between the child and parent, as well as an element of pre-school preparation through stimulation of the child's reading skills.
- Cooperating with family planning services in order to implement early pregnancy prevention programmes and contraceptive distribution.
- Cooperating with the educational sector in order to increase the availability of pre-school education, especially for children from high-risk groups.
- Cooperating with the financial sector in supporting a tax policy that would protect children from poverty e.g. using tax loans or benefits.

The family, in its formation phase or during the period of active parenthood, must contend,, among other matters, with the following problems:

- Marital choice.
- Making subsequent procreative decisions.
- Establishing a physical location for the family.
- Establishing an employment base.
- Mutual realization of the roles of the other partner.
- Combining one's own interests with other people's interests (those of one's children in particular).
- The ability to use the benefits of family life in order to lessen the difficulty of combining one's own aspirations with the rights of one's children.

Additional, important aspects concerning the health of a developing family:

- It is beneficial to know if an individual has Rh-, and if there is a history of diabetes, epilepsy, mental health issues, or a tendency towards haemophilia, in a partner's family.
- It is necessary to inform the doctor supervising a pregnancy and labour about the possibility of any genetic predispositions and family irregularities (alcoholism), as well as the incidence of tobacco smoking by the mother or other toxic factors that may affect the foetus.
- Family planning should not only be associated with contraception. A thorough examination of the fertility cycle, and the regulation of its course, is also needed in order to plan the period of conception optimally. This activity should be supported by a period of rest and the cessation of smoking, it should also be preceded by general medical examinations.

5. Teaching and shaping health-oriented behaviours in the client's environment

All modern concepts of bringing children up in a healthy manner are based on the principle of making people aware, as early as possible, that the natural and social environment, as well as one's own health behaviours and lifestyle, are the main determinants of human life. The process of raising awareness should start at an appropriately early stage in the family home. Health education has a vital role to play in the process of young people's socialization. The process of education is initiated by giving children knowledge about health, and by shaping their attitudes, skills and habits.

Health education includes a set of processes such as: shaping, nurture, and the self-direction of one's development in order to influence the development of one's personality. Because this development is ongoing throughout one's life, we should view health education as a continuous process that contributes to the broadly understood process of human nurture.

Health education achieves its purpose when it does not end at the level of knowledge but extends to dealing with the mental structures which regulate human behaviour, i.e. attitudes, habits, value systems.

The power of the influence of the family in promoting a healthy lifestyle depends on its health culture and its way of thinking and acting.

A personal attitude and willingness to act are very important in education.

If a person states that smoking cigarettes has a harmful effect on health, it means that that person is displaying a cognitive attitude.

If this person smokes, it means that their attitude is not complete: there is a lack of cohesion of the attitude's particular components which should be internally integrated.

Example:
- Cognitive component – knowledge (the harmfulness of smoking, beliefs).
- Affective component – emotional engagement (aversion, disgust towards smoking).
- Behavioural component – activity (the will to quit smoking).

A person's behaviour, under the influence of an attitude, is treated as a final effect of the mental processes caused by that attitude.

The person decides to undertake a certain activity because they have become aware of their health problems.

The family as a setting for health education

The family is the basic and most important setting (environment) for health education. Family members live within defined material, cultural and social conditions, which determine the family's lifestyle, attitudes towards health, health problems and ways to deal with them. The health education of the family is a process which is:

- Concerned with all family members.
- Connected with all family functions (procreative, caring, socializing, emotional, recreational and economical).
- Influenced by socioeconomic and cultural factors (the influences of other environments (e.g. school) on its members).

The activities of the nurse, within the scope of health education, are primarily concerned with health counselling and advising.

The nurse who fulfils the role of health consultant should be:

- A health leader – they should live according to health-oriented lifestyle rules.
- A good informer – they should provide the family with information according to their needs.
- A supporter – they should enhance the family's feeling of effectiveness.
- A social marketing expert – they should be able to implement a health education programme adjusted to the family's needs.
- A good politician – they should mediate between the family and local leaders who have an influence over the availability of products or services concerning health.

Key features of a good health educator: empathy, kindness, respect, authenticity and frankness.

The choice of effective models and methods for the family's health education depends on the diagnosis of the needs and problems of the whole family.

The exemplary pattern of family health education:

- Phase 1 – CHOICE – encouraging the whole family or its individual members to decide to change and providing the motivation required to change a certain element of their lifestyle.
- Phase 2 – CHANGE - helping the family to implement and maintain this change.
- Phase 3 - ADVOCATE – a continuation of the previous stage, this includes the provision of support for the family with their altered lifestyle.

Health education in a family with a difficult situation is challenging and requires proper preparation and the creation of conditions that will allow for cooperation with other institutions in the social community.

When acting to promote health, the family should be treated subjectively, and the focus should be on promoting health 'WITH the family' and not just 'TOWARDS the family'. Involving all family members and encouraging a sense of personal responsibility for healthcare should prevent the often observed and demanding attitude that healthcare workers alone are responsible for the health condition of the individual. The provision of effective healthcare requires the family to cooperate with state institutions, this ongoing process should invite collaboration, education, advice and activity in cooperation with the family. Education and advice on how to live a healthy life and how to take responsibility for our own health are important.

The family should be perceived as a 'learning organization', and entry points in the educational activities of this system should be identified by the factors which influence it. The key entry points in the family, with regard to health promotion, are economic and education levels, housing conditions, employment, genetic conditions, and inherited behaviours.

Modern families fulfil the task ascribed to the creation of a health-oriented setting to varying degrees. Therefore, where educational activities are concerned, the individual situation of the family should be taken into consideration as well as its characteristic mutual socialization influences. The important condition of the effectiveness of health education should also be acknowledged – positive feedback between the individual, their family and the social environment. Activities should concern not only the patient, but the whole family.

Each family member should be encouraged to become an active participant in the education process, and not only the passive object of its influences. Active methods of learning and teaching should be used so that the individual can make conscious decisions concerning their health and the health of other persons in their health-oriented setting.

Implement the idea: 'family health in family hands'.

Selected key issues in family health education

Health and mental welfare – establishing an appropriate mental condition (with regard to general mental ability) allows for the maintenance of mental stability in difficult situations.

Emotions and stress – when strong emotions or stress reactions emerge, the biochemical intracorporeal balance is upset, which results in the function of particular

organs being affected by hormones. Five such major emotions are: fear, anger, disgust, sadness, happiness.

Positive stress (eustress) facilitates the process of overcoming obstacles and negative stress (distress).

Optimism – an essential element of mental health. Shaping a positive attitude towards the world results in very real benefits: it influences one's physical and mental state and mood, it makes it easier to overcome obstacles, and produces a sense of perspective in the face of life's challenges. Seligman (1993) claims that being an optimist is advantageous as optimists succumb to illnesses less often, have healthier lifestyles and live longer.

One's sense of identity and value - an important element of one's identity is a sense of autonomy: an individual's awareness of what they can do, their responsibilities and what they can influence. Shaping identity is a life-long process and requires reflection and self-awareness.

Life skills - developing life skills is an important element of health education and mental health promotion. It appears that a successful life is not only the result of education and a general level of intelligence, but is also linked to an aptitude for dealing with emotions and building motivation (emotional intelligence), as well as the ability to understand other people and oneself (personal intelligence).

Body care – 'Respect, attitudes and behaviours in relation to one's body are connected to health; the awareness of health is based on body awareness.' (Woynarowska, 2012).

Examples: self-examination of breasts and testicles, appropriate sun protection

Healthy diet and physical activity – are basic elements of a healthy lifestyle, they are also a way of preventing diseases and are an important element during periods of treatment.

Safety – injury prevention – The need for safety (in a very broad sense), according to A. Maslow's hierarchy of needs (Maslow A.D., 1997), is one of the basic (primal) human needs in every stage of life.

Sexuality – sexual education is a branch of interdisciplinary education concerning human sexuality within the biological, health, social, cultural, historical, philosophical and even political spheres.

6. A sense of coherence as a health-oriented factor

The idea of modern health perception (health promotion) is to make people aware of their personal responsibility for maintaining the care of their health.

Current ideas in health promotion, are in accordance with the slogan 'my health in my own hands - I am responsible for my own health', and aim for the establishment of responsibility for the health of one's own family and one's community. Such a pro-active attitude should be developed in other areas of life and work.

Aaron Antonovsky points out that one of the key health-oriented factors is the so-called sense of coherence (SOC). According to Antonovsky, this is a belief that the external world is sensible and predictable and means that events and processes unfold according to our expectations (Antonovsky, 1984).

A SENSE OF COHERENCE is the most important construct of the salutogenesis concept, defined by Antonovsky as the 'global orientation of a human being, expressing the degree to which this human being has an intense, persistent but dynamic sense of confidence that (Antonovsky, 1984):

a) Stimuli which originate from the internal and external environment in the course of life have a structured, predictable and explainable character.
b) Sources are available that will allow them to meet the demands created by the stimuli.
c) For this person these requirements are challenges worth the effort and engagement'.

The basic components of SOC:

(1) **A sense of comprehensibility –** the ability to comprehend events, allowing the individual to see them as less stressful and cognitively sensible – clear, explainable, coherent.
(2) **A sense of manageability –** the perception that the available resources are sufficient to meet the requirements created by the stimuli.
(3) **A sense of meaningfulness** – the belief that 'something' makes sense, and is worth the effort and engagement (one's life is worth creating).

According to the author, a high level of coherence in a human being makes them more resistant to disease, less likely to succumb to illness, and more likely to recover quickly (Antonovsky, 1984).

SOC positively affects health and stress management. The ability to deal with stress and other issues depends on a set of attitudes which create a sense of coherence. People with a high sense of coherence continuously look for potential methods of prevention and instruments of support, and are also more effective in learning strategies for dealing with stress.

The influence of SOC on human health

A strong sense of coherence enables an individual to:

1) Avoid risks and dangers and engage in health-oriented activity.
2) Perceive omnipresent stimuli as opportunities for challenges and as situations that are easy to manipulate.
3) Regard resistance to disease as being within one's potential.

7. Counselling and consultancy in health promotion

Family health nursing is based primarily on health promotion and disease prevention. Important components in this process are: care, consultancy, counselling, development counselling, support (sustaining) counselling, protective counselling and curing counselling.

Caring functions that may be performed by a nurse in relation to the subject of their care:
- diagnostic,
- therapeutic,
- providing rehabilitation,
- educational,
- health-promoting,
- preventive.

Below is a definition of 'care' which also takes into account selected and particularly important care functions of a nurse. Care is an activity aimed at comprehensive support, with regard to sickness and health, and through activities preventing diseases, and promoting health.

CARE

Caring is probably one of the oldest forms of interpersonal activity, from which the trends in care activities in professional nursing undoubtedly originate.

The dictionary-based, common understanding of the term 'care' means (Macmillan Dictionary, 2020):
- noun (care): 'the activity, skill, or profession of looking after someone who needs help or protection'.
- the verb (to care for someone): 'to do the necessary things for someone who needs help or protection'.
- adjective (caring): 'kind, helpful, and sympathetic towards other people'.

When considering the concept of care in nursing, one may observe an element of the common understanding of this term. This care means: looking after someone, satisfying the needs of the person in care in a persistent and selfless way.

Dąbrowski (2000) defines the concept of 'care' as one which is based on compensatory responsibility, the satisfaction of the needs of the subject of care by the

caregiver in a persistent and selfless way within the established caring relationship (Dąbrowski, 2000).

The foundation of care, as understood in this way is the assumption that its determinant and strictly understood object are the supra-individual needs of people, which they are not able to satisfy on their own. Their implementation takes place in an asymmetric care relationship, in which the mentee is in a position that requires help, resulting either from a lack of motivation to undertake self-care activities, or from a lack of knowledge and skills, or from a lack of vitality and opportunities caused by the disease process or stage of the developmental process. The role of the carer is a selfless and persistent compensation for the existing deficiencies (Ślusarska, 2008).

CONSULTANCY

Consultancy – professional action aimed at helping family members to make choices, adjust and solve problems that are connected with the development and preservation of health.

COUNSELLING

Counselling is one of the educational methods most frequently used in health education to help individuals and families. During counselling, a person with a need (the client) and a person who provides support and encouragement (the counsellor) meet and discuss certain issues in such a way that the client gains confidence in their ability to find solutions to their problems. Counselling is for the most part one to one communication, which is a process of assistance where one person explicitly and purposefully gives his or her time to assist people to explore their own situation, and act on a possible solution. The process includes several steps in which the counsellor first asks questions in order to understand the problem and then helps the client to understand their problem for themselves. After this, the counsellor needs to work together with the person to find solutions that are appropriate to their situation. Counselling involves helping people to make decisions and give them the confidence to put their decisions into practice.

Counselling is aimed at the optimization of activities in different spheres of life, by implementing defined ways of behaving and supportive activities that complement other professional activities carried out by the nurse, in order to improve the situation. Counselling has several areas:

- Development counselling.
- Support (sustaining) counselling.
- Protective counselling.
- Curing counselling.

Development counselling is aimed at those who are healthy and do not have limited abilities, this group seeks new and better solutions for health and development, they have alternative ideas but do not know which options to choose. The main emphasis is on health promotion.

Support (sustaining) counselling aims to maintain health and welfare, and provides aid in situations in which the appearance of a difficulty can be predicted (conflicts, crises in the initial phase).

Protective counselling aims to protect individuals from the negative results of illnesses and life problems.

Curing counselling (intervention) means organizing first aid, providing explanations, and directing individuals to competent people e.g. during terminal illness, mental disorders, developmental crises and adaptation problems.

8. Telenursing

According to the American Telemedicine Association Telehealth Nursing Special Interest Group, **Telehealth Nursing** is the removal of time and distance barriers for the delivery of some or all of the required healthcare services or related healthcare activities. Some of the telecommunications technologies employed in telehealth include telephones, computers, video transmissions, direct connections to instrumentation and image transmission (Millholland, 1997 cited in American Telemedicine Association Telehealth Nursing Special Interest Group, n.d.).

Telenursing – is the delivery, management and coordination of care and services provided via telecommunications technology within the domain of nursing (American Association of Ambulatory Care Nursing (AAACN), 2004 cited in the American Telemedicine Association Telehealth Nursing Special Interest Group, n.d.).

Telenursing - is the use of telemedicine/telehealth technology to deliver nursing care and conduct nursing practice (Fitzpatrick, 1999).

Telenursing - refers to the use of telecommunications technology in nursing to enhance patient care. It involves the use of electromagnetic channels (e.g. wires, radio and optical) to transmit voice, data and video communication signals. It may also be defined as distance communications, using electrical or optical transmissions between humans and/or computers (International Council of Nurses (ICN), 2001 cited in the American Telemedicine Association Telehealth Nursing Special Interest Group, n.d.; Skiba & Barton, 2000).

Telenursing – may be defined as the practice distance nursing using telecommunications technology (National Council of State Board of Nursing (NCSBN), 1997).

Telenursing – may be defined as the use of telemedicine technology to deliver nursing care and conduct nursing practice (Schachta & Sparks, 1998).

Telenursing - is the use of telecommunications technology to provide nursing practice at a distance (MeetingsNet, n.d. cited in American Telemedicine Association Telehealth Nursing Special Interest Group, n.d.).

Telenursing – refers to the use of telecommunications and information technology for the provision of nursing services in health care whenever a large physical distance exists between patient and nurse, or between any number of nurses. As a field, it is

a part of the practice of telehealth, and has many points of contact with other medical and non-medical applications, such as, telediagnosis, teleconsultation, telemonitoring, etc. (Wikipedia, n.d. cited in the American Telemedicine Association Telehealth Nursing Special Interest Group, n.d.).

Leveraging technology for primary health care

By means of telenursing, people are able to remain in their homes or remote communities — and communicate vital signs, test results and concerns to nurses working across town, or hundreds of kilometres away. Nurse-led 24-hour health information telephone services provide telephone triage, advice and information about illnesses and conditions, including support and self-help groups, local healthcare facilities and on-call services. This service is both supportive to the community and cost-effective for the health system, as it dramatically reduces the number of people seeking help in hospital emergency departments (International Council for Nurses, 2008).

Telenursing is not a panacea for every problem related to treatment and demographic change, but, with certainty, if it is appropriately and reasonably used, it can be used to improve the position of vulnerable people, and the elderly in particular. Direct contact with the patient/client is a very important element in a nurse's job, and, therefore, telenursing is a solution that helps to support the work of a nurse.

9. Abstract

Health education is about making the intended impact on the patient's mindset by shaping his or her health behaviour, by encouraging the patient to adopt a sense of responsibility for his or her own health, by preparing the patient for cooperation and collaboration in the nursing and treatment processes, as well as by promoting self-treatment and non-professional care. Health education gives the client/patient knowledge and develops the skills necessary for them to take action. When working with patients, it is desirable that the effects of treatment should be intended, deliberate and well thought out. The nurse acts as an educator and a teacher, and he or she should at least have a basic level of knowledge and skills in pedagogy concerning the process of bringing up and teaching children.

Healthcare requires cooperation between the family and state institutions, and the latter should invite the family to collaborate, and also teach, advise and work with the family. It is important to educate and advise people on how to live a healthy life and to develop their sense of responsibility for their own health and the health of their loved ones.

Therefore, the process of creating a change in awareness about health requires not only numerous central, social, political and educational activities, but also an effective reference to the working and living environment of the client (setting). Acting in accordance with the concept of the setting approach to health, we do not limit ourselves to current health problems, but also take into account the social impact of setting on human opportunities, risks, habits and attitudes. The local system of values, habits, customs and behaviour are the basic factors determining health behaviour. It is important to establish health-promoting settings. In order to achieve this we require the commitment, cooperation and collaboration of all entities present in a particular community. According to the setting approach, the family plays a special role due to the processes of primary and secondary socialization.

The International Classification for Nursing Practice organizes the work of nurses. It does not just plan patient/client education in accordance with an international standard, but also allows it to continue when the unit moves to another location. Developing a plan of care means planning educational interventions based on diagnosis. The nurse is given confidence because they are able to use all possible tools in order to improve their knowledge and skills to meet the expected level of care.

ICNP® provides the opportunity to form a nursing practice which is based on scientific evidence and which allows for the pursuit of the best possible quality of service.

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WORKING METHOD OF THE NURSING PROCESS

OVERVIEW

The nursing process is a specific aspect of the nurse's work, and involves providing the client with professional care, which is based on assistance, support and motivation, in order to undertake nursing activities aimed at improving or maintaining the health of individuals, families and/or their environments.

The primary task of the PHC nurse is to prepare the client/patient, and those taking care of them (families, guardians), to independently carry out the tasks necessary for maintaining and improving health, and for functioning at the highest level in health as well as in sickness and disability (Kilańska, 2008).

The nurse, working in an interdisciplinary team, sets goals, defines priorities and establishes the method and means of care.

The nursing process constitutes a method of complete nursing care directed at an actively involved and participating subject (individual, family, social group). This method allows for the provision of continuous, planned and individual care for the client/patient, and gives the nurse the opportunity to act independently. The use of this method makes it possible to undertake scientific research, and to carry out an assessment of the quality of care as a result of the documentation required for particular stages of the process (Kózka & Płaszewska-Żywko, 2008).

Table of Contents

1. Nursing process

1.1. Introduction

This module is a review of the nursing process and its application to nursing practice. It focuses on how to make a nursing diagnosis and how to plan nursing care.

The nursing process is an organizing framework for professional nursing practice. Critical thinking is a part of that process. The nursing process begins by establishing a relationship with the patient and their family, and by collecting the necessary data in order to make a nursing diagnosis and care plan.

1.2. Defining the nursing process

According to the WHO, the nursing process is a term referring to a characteristic system of intervention nursing, which is significant in terms of the health of individuals, families and/or their communities. The nursing process requires the application of scientific methods in order to identify the health needs of individuals, families and/or their communities, and for the identification of the best possible ways of satisfying these needs.

The nursing process, as a basic method in the nurse's work, is the most important element of nursing practice and can be a useful tool for improving the quality of care.

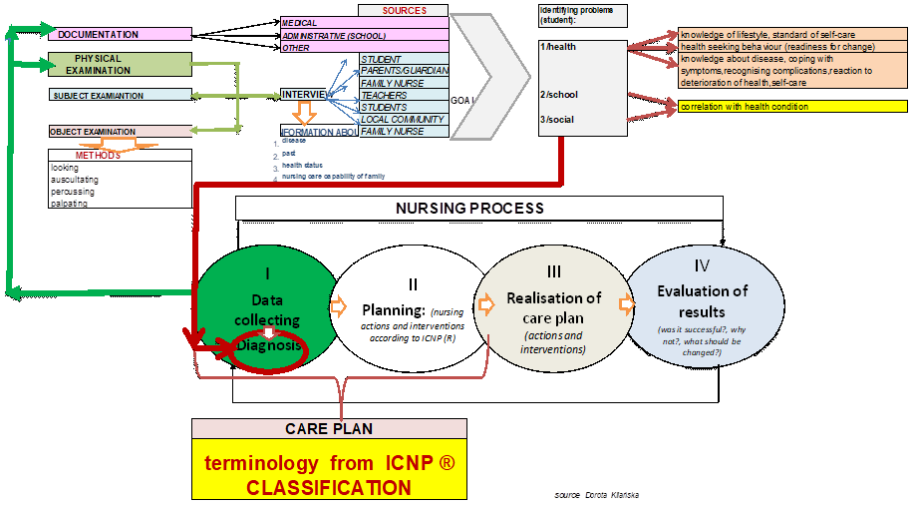

Fig.1. Nursing process based on data collection
Source: Kilańska, 2008

1.3. Stages of the nursing process

The nursing process is systematic and organized into specific components:
1) Assessment: assessment of data and nursing diagnosis - analysis of the assessment data to determine the client's actual and potential health problems.
2) Planning: the development of a plan of action to reduce, resolve or prevent potential problems, establish priorities, and to formulate the goals and outcomes expected by the nurse while documenting the nursing care plan.
3) Implementation: the delivery of nursing care, and the execution of the planned nursing interventions while collecting data about the client.
4) Evaluation: determining the effectiveness of the plan of care.

1.4. Data collection and analysis

Assessment is a step that requires data collection. It involves performing a thorough holistic nursing appraisal of the client, it is the first step required to make an appropriate nursing diagnosis. The data should contain objective and subjective information about the biological, mental, physical, socioeconomic and spiritual conditions of the patient and/or the patient's family: this is useful for drawing up further stages of the nursing process.

The family nursing process includes an assessment of the family history. The nurse gathers data from a variety of sources in order to obtain an overview of the family situation. In all cases, the family assessment begins from the first moment that the family is referred to the nurse.

The family nurse uses their visits to collect information about the patient's environment.
1. Comprehensive data concerning the patient, family and environment includes:
   - The family health situation.
   - An in-depth analysis of the conditions of particular family members that takes into account specific nursing problems or specific threats.
   - Existing health risks – e.g. addictions.
   - Untreated and worrying symptoms, and an accumulation of risk factors in the health conditions of particular family members which have not yet been diagnosed by a doctor.
   - Identification of major functional limitations, independence and activities of family members.
   - The level of physical fitness of particular persons, which indicates the possibility of a lack of self-care and the reasons for this.
   - The potential limits of the family when dealing with and treating health problems.
   - The availability of support for loneliness, and the individual's or family's lack of available help.

- Local community provision that supports health promotion and protection, or health care.
- A self-assessment of health conditions, existing risks, health aspirations, planned lifestyle changes and health behaviours by the family and its individual members.

2. The data should be properly documented. Health professionals in the area should be able to use and update the data.

1.4.1. Data sources

The most important data sources include:

- The patient.
- The patient's family.
- Others who are aware of the situation (relatives, friends, community leaders, school teachers, persons working for the family's benefit e.g. charity groups).
- Members of the healthcare team who are involved in the treatment, and social workers.
- Direct examinations.
- Documentation (medical, social worker's, statistical).
- The knowledge and experience of the nurse.

The range of sources is indicated in Fig.1.

1.4.2. Methods and techniques of data collection

The key methods and techniques of data collection are:

- Interview with the client.
- Interview with persons participating in the care process.
- Assessment of the client's knowledge concerning their health condition and activities required to maintain health, improve the health condition, slow down the progression of disease, adjust the patient to permanent disability and prepare them for death.
- Physical examination.
- Disease/health analysis, including information about lifestyle and diet.
- Family history.
- Local community history, focusing on cultural values, emerging behaviours, lifespan and health behaviours.
- Analysis of reports dealing with the condition of the natural environment.
- Analysis of diagnostic examination results.
- Analysis of survey results.
- Analysis of applied scales of health, as well as physical, mental and social efficiency assessments.
- Monitoring.

1.4.3. Range of collected data

Collecting data may include the general assessment of the whole of the family's health situation, which is essential for planning and organizing nursing care for the patient in a specific family, or group of families in a particular area or local community. Full documentation is required.

From the beginning, data collection may be targeted at an identified health problem (e.g. prevention and early diagnosis of cardiovascular system diseases or types of cancer) or it may focus on other issues (the health of the mother and child). Subsequently, data collection can be based on narrower and more specialist documentation: attachments may provide further information.

1.4.4. Nature of data

The nature of the data is concerned with the human and material resources of the person, family or environment:

- The limits of the patient's (or family's) opportunities concerning health, the optimal level of functioning, and an independent and active life is a negative aspect which requires improvement, alteration and help.
- The development of potential which can be used for promoting and protecting health, self-care, health recovery, achieving an optimal level of function and the maintenance of an independent and active life is a positive aspect of each case.

1.4.5. Genogram

A genogram is a way of drawing a family tree which allows us to obtain information about family members and their mutual relationships, at least within the range of the last three generations. It enables the nurse to obtain information about the causes of death and genetic diseases in previous generations and thus, helps to identify the health risks for clients. It defines the most important characteristics of the functioning of the family and the health problems of its members thereby indicating the possibility of using nursing intervention in the course of the nursing process.

As a result of the indicators on the diagram (Fig.3), information concerning: family structure, emotional bonds and the family occurrence of diseases, addictions, obesity, mortality and their incidence may be recorded.

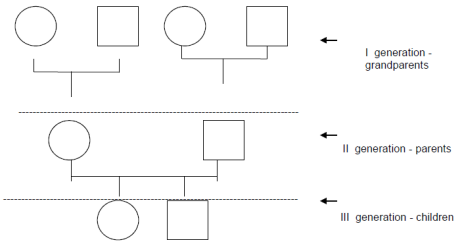

Fig. 2 Basic Genogram format
Source: Kawczyńska-Butrym, 2001

Family interview to enable data collection for the genogram

1) Identify who is in the immediate family.
2) Identify the person who has the health problem.
3) Identify all of the people in the immediate family.
4) Determine how all the family members are related to each other.
5) Gather the following information concerning each family member:
   - Age.
   - Sex.
   - Correct spelling of name.
   - Health problems.
   - Occupation.
   - Dates of relationships: marriage, separation, divorce, living together, living together/committed.
   - Dates and ages of death.
6) Seek the same information for the family members at the same generational level, and for those in the preceding generational level.
7) Add any additional information that is relevant to the situation, such as geographic location and interaction patterns.

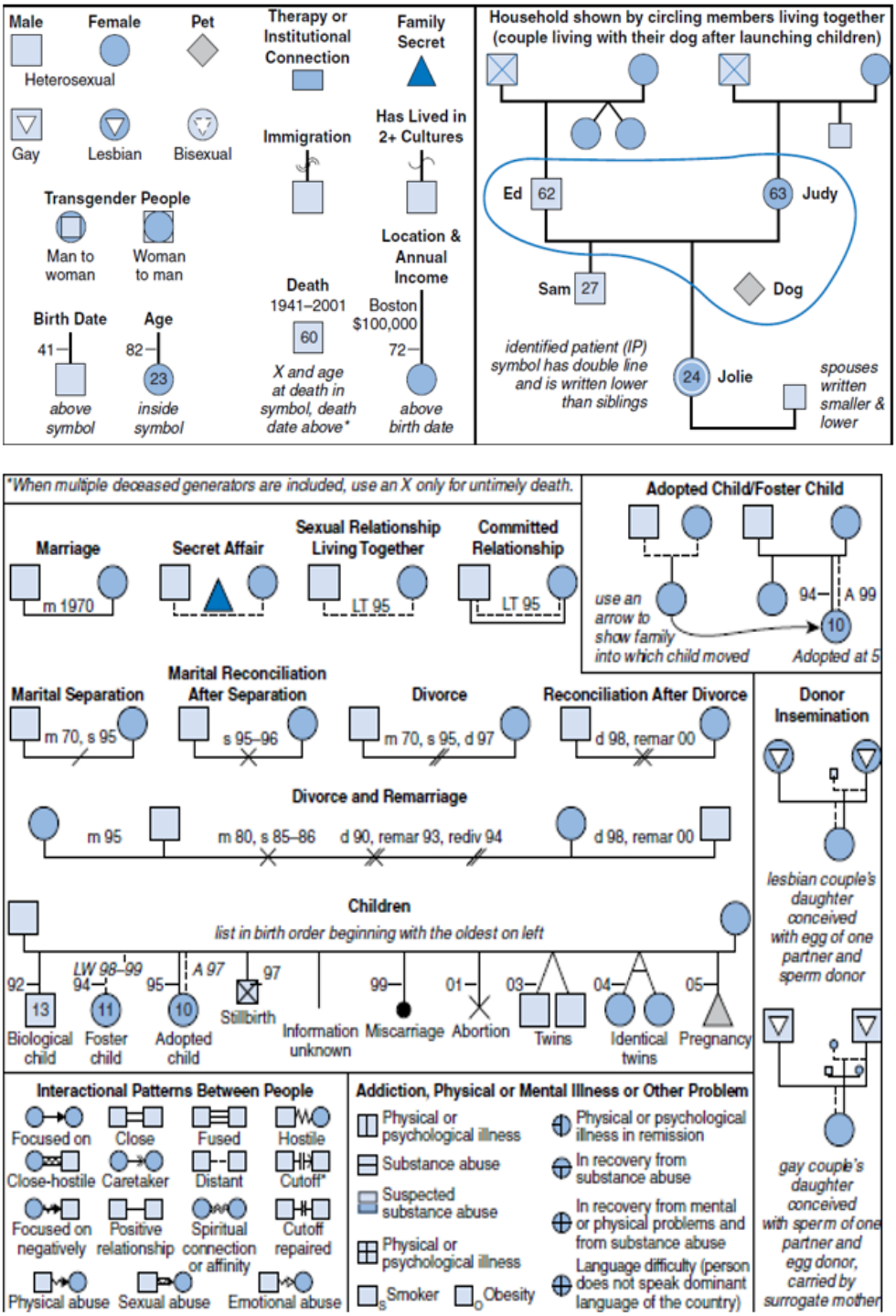

Fig. 3 Visual representation of family characteristics – symbols
Source: Kaakinen, Gedaly-Duff, Coehlo, & Hanson, 2010

1.4.6. Ecomap

An ecomap is a family assessment tool consisting of a graphic representation of a family relationship with its environment. The different aspects of the social environment are shown by circles, and the nature of the relationship to each aspect is indicated by the type of line joining the family to it (Fig. 4). All of the significant involvements that family members have are included - work, school, extended family, recreation, social groups, friends, church, health treatment etc. (Government, 2009):

1. Each family member can be represented by a colour that they have chosen.
2. Activities that the family engages in together can be depicted by another colour that will extend from the centre of the circle to the activity outside the circle.

Through the various processes of data collection, patterns of health problems may appear, and further education of the family could be beneficial with regard to these. By creating a visual depiction of the system in which the family exists, families are better able to envision alternative solutions and possible social support networks.

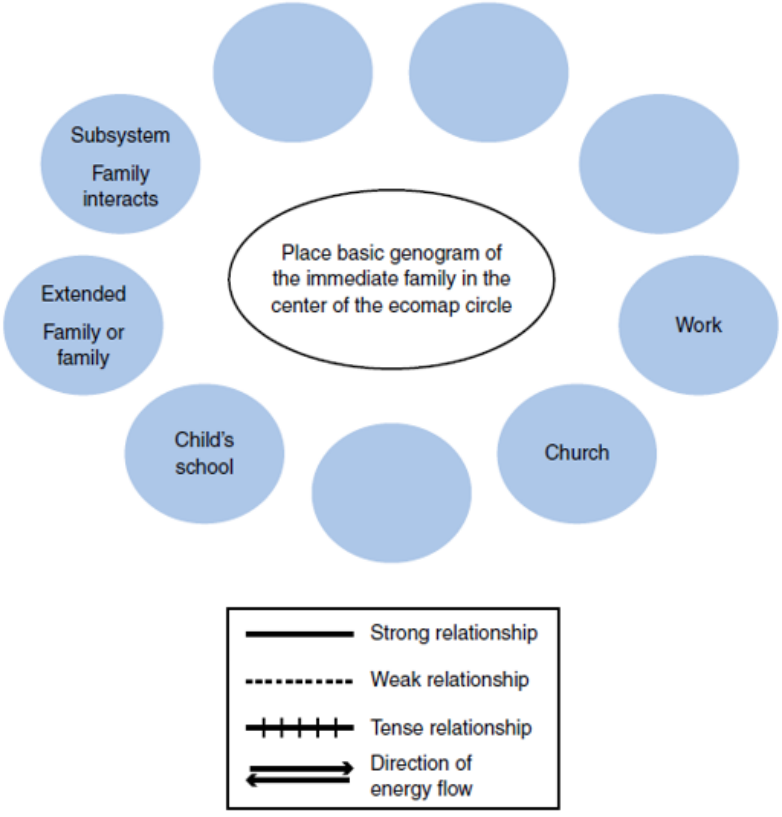

Fig. 4 Ecomap
Source: Kaakinen, Gedaly-Duff, Coehlo, & Hanson, 2010

The genogram and ecomap are instruments used to assess the composition and relationships of the family in the context of family members' lives, and are powerful and important tools used to assist in the organization of healthcare and nursing, and to identify a family health strategy.

1.5. Nursing diagnosis

According to the North American Nursing Diagnosis Association, a nursing diagnosis is a statement of the client's current health status and concerns, which can be helped by nursing intervention. These concerns are actual or potential problems, which the client is experiencing or may experience, and that may be prevented, resolved or reduced through nursing intervention (Carpenito-Moyet, 2004).

A nursing diagnosis in family nursing should (Kawczyńska-Butrym, 2001):
- Define the current condition of the patient, family and/or local community.
- Present potential possibilities for the maintenance of health, and highlight factors that create risks for the client's health.
- Define the stage of disease that require the implementation of nursing intervention.

The characteristics of diagnosis in community nursing (Kilańska, 2008):
1. Oriented towards the individual, family and/or local community.
2. Describes the possibility of prevention – stages I, II and III.
3. Requires data from different sources.
4. Collected data depends on the type of diagnosis.
5. Influences the data collected and the choice of the most appropriate nursing model.
6. Results in nursing activities which are oriented towards preparing a patient/family to care for themselves and also take care of loved ones without the direct intervention of a nurse.

1.6. Planning care

After making an accurate diagnosis, the nurse, together with the patient/family, set care goals, which take into account any previous problems. As a result of the goals set, the nurse is aware of what they need to achieve during the period of care and what activities they should undertake. The goals should be clear, explicitly defined, take account of the time factor, and be realistic in relation to the patient's capabilities and nursing options. When planning, it is important to correlate activities to the goals set, and to identify clients who will realize those activities for a particular patient/family. The goals should be documented.

Formulating a care plan entails setting nursing goals, which are linked to the particular situations of the family and its individual members, and which are met with the cooperation and acceptance of all family members.

Nursing goals are determined by diagnosis and may include the following:
1) Family health promotion and education, and also improving the conditions which support health.
2) The limitation and elimination of health risks occurring in the family.
3) Disease prevention (nonspecific and specific) in relation to identified family members.
4) Referring persons with observed worrying symptoms to a doctor, in order to diagnose risks and early symptoms of disease.
5) Supporting the beneficial activities of the doctor conducting the treatment (reinforcing motivation, education, running errands).
6) Identifying a specific nursing care plan in a terminal situation.
7) Preparing the person in need of nursing for self-care, preparing other family members to nurse the sick person, and preparing the patient, to the best of his or her ability, to live an independent and active life to ameliorate the effects of their disease, and to deal with disability and the problems resulting from their situation.
8) Increasing and supporting the efficiency of nursing care, if anything to weaken or limit its efficiency has occurred.
9) Enabling the patient to identify types of stress and to deal with stress.
10) Providing the family with effective and appropriate support when dealing with a crisis and/or a family member's disability.

1.7. Realization of a care plan

The nurse is responsible for supporting the family in the realization of their care plan. The nurse and family work together to implement the plan of care, incorporating the most family-focused, cost-effective and efficient interventions that will assist the family in achieving the best possible outcomes.

Nurses can help families to realize their care plan through:
1. The provision of direct care.
2. Teaching family members knowledge and skills connected with self-care and self-nursing, in particular:
   - Teaching them about health, how to maintain it, and risk factors.
   - Teaching them about how to take control of their own health.
   - Teaching them about the self-assessment of symptoms.
   - Teaching them about specific nursing tasks (rehabilitation).
   - Identifying sources of outside help and enabling families to receive that help in the desired form.

3. Helping families to deal with problems:
   - Everyday activities.
   - Stress - eliminating the causes of it, and also reducing and dealing with stress.
   - Critical situations – providing social support from available sources.
4. Helping to maintain physical and social activity:
   - Motivating families to increase, maintain or re-establish social activity.
   - Protecting families from social isolation by providing help in eliminating barriers, extending social contacts and increasing individual development.
   - Increasing or encouraging social integration with self-help groups, support systems and the community.

1.8. Evaluation of the nursing process

The nurse and the family work together to assess if the results of the care plan are in agreement with the goals set and if the goals have been completely achieved. Is the care plan working well? Does a new care plan need to be put in place or does the nurse/family relationship need to end? In the case of a partial realization of the goals, the factors which made the aims impossible to achieve should be analysed. An evaluation allows for the further consideration of the patient, his or her family and the environment, which allows for the establishment of new goals that correspond to the current and reviewed diagnosis of the nurse.

Reasons for failing to achieve goals may include the following factors (Kaakinen, Gedaly-Duff, Coehlo, & Hanson, 2010):

- Family apathy.
- Family indecision about outcome or activities.
- Nurse-imposed ideas.
- Negative labelling.
- Overlooking family strengths.
- Neglecting cultural or gender implications.
- Family perception of hopelessness.
- Fear of failure.
- Limited access to resources and support.
- Limited finances.
- Fear and distrust of the healthcare system.

1.9. Documenting the nursing process

Documenting the nursing process is a very important aspect of a nurse's work. A nurse should carry out her duties in accordance with the principle that an activity which is not documented is an activity which was never completed. In order to document nursing activities, which are the result of a nursing diagnosis, standardized dictionaries, which include the terminology of many areas of nursing, are used. The manner in which data is documented is usually determined by national standards, or the standards of conduct that regulate the use of the documentation, which makes the process more straightforward for its participants.

1.9.1. Rules for documenting according to Penny Prophit

Guidelines for documenting are clear and simple (Prophit, 1976):

1) Be concise, precise and give complete descriptions.
2) Always write legibly with a pen.
3) Do not rush – review the data before writing anything down, and contact the patient/client again for further explanation or to check information which seems to be incomplete.
4) Be sure that facts remain separate from your interpretation.
5) Always document an observation of the following:
   - a change in condition or the appearance of new problems,
   - no change in condition,
   - the patient's/client's reaction to treatment,
   - the patient's/client's reaction to instruction,
6) Always document the initial assessment and, if possible, do this immediately after conducting the interview, however, observe the patient/client before the interview and do try to cooperate with them.
7) Always, if possible, quote the exact words that the patient/client or family member has used.
8) Always read what any colleagues, who are also involved in the care of the patient/client, have written before writing down your own comments.
9) Sign your name under each of your entries.
10) Never make changes in the documentation to cover up for your mistakes.
11) Avoid sophisticated terminology.
12) Do not allow long periods to pass without an entry.
13) Do not standardize – no problem can be exactly the same with regard to every patient/client because every human being is individual and unique.
14) Before starting to document your findings, ask yourself the following questions:
   – What did you hear?
   – What did you see?
   – What do you think about it?
   – What will you do?

- What did you do?
- How did the client/patient react to your idea?

15) Imagine that the documentation is a camera taking a photo of the client/patient. Give as many details as you can, so that everyone who reads your notes is able to observe the person through your eyes.
16) Regard the documentation as a means of communicating the information necessary for the care of the patient/client.

1.9.2. Electronic patient record

The electronic patient record is slowly replacing paper documentation containing information about the health of the patient and his or her care. The implementation of the electronic patient record (EHR - electronic health record) will ensure the free movement of the medical records of patients between providers, with guaranteed continuity of the collected personal data and sensitive data (e.g. information concerning treatment, test results, care plan, etc.). An added benefit is also the possibility of implementing life-saving treatment, regardless of client location. The utilization of the electronic patient record will provide an insight into the actual history of the disease and patient care, thereby reducing the risk of misdiagnosis and prevent the repetition of medical examinations which have already taken place. It will also eliminate the duplication of information. The use of electronic patient records will translate directly into the rationalization of the cost of treatment and will improve the quality of medical services. In addition, according to a study (Sansoni & Giustini, 2006) it will reduce the amount of time required to document the information necessary for the therapeutic process. Within the patient's data, which can be found in the EHR, it will be possible to document nursing practice (planned care, including planned activities) based on the International Nursing Minimum Data Set (I-NMDS), in which nursing diagnoses and interventions constitute basic nursing data.

The **International Nursing Minimum Data Set - I-NMDS** is the basic, minimum set of information needed in order to describe the field of nursing and nursing practice itself, and which is collected during the provision of nursing care. The aim of I-NMDS is to gather information in order to describe and study nursing, healthcare resources and selected issues within nursing care, including the effectiveness of planned care. Support for the collection and use of data about nursing is necessary due to the immense contribution of nursing to improving the health of patients undergoing care. Therefore, this activity should be supported by local, national and international healthcare structures. The requirements of I-NMDS include:

- Describing the health condition of the patient.
- Describing nursing (activities, results, care, use of material and human resources).
- Enhancing the quality of services provided by nurses and midwives in practice.

- Solving problems in human resource management within nursing (staff shortages, inadequate working conditions, uneven geographical location of staff).
- Focusing on the challenges facing nursing (technological innovations).
- Improving practice through research and its reliance on scientific evidence (Evidence Based Nursing - EBN).
- Increasing the efficiency of healthcare systems.
- Contributing to the improvement of public health.

Categories of data elements that should be included in the I-NMDS:

- Place (location, payment systems, nursing staff) - indicated by the care provider.
- Demographic data (residence, status, year of birth, gender, reason for application, type of clinical services for the client/patient) - collected at the client's first contact with the healthcare provider.
- Nursing care (diagnoses, activities, level of care provided) - classification will enable ease of data collection; the data will be included in an area documented by the nurse.

Hence, the International Classification for Nursing Practice (ICNP®) has been introduced to I-NMDS. It aims to adopt the common terminology used for describing the elements of nursing practice, the activities performed by nurses in relation to the specific needs of a client and the patient's condition. Common terminology allows one to define nursing practice in a way that enables a comparison to be made between clinical centres, patient populations and geographical areas. Moreover, it allows one to identify the specific contribution of nurses to the work of a multidisciplinary healthcare team, and it also allows one to acknowledge nursing practice and other professionals who provide care services.

The creation of the Minimum Nursing Database is a project which was conducted under the auspices of the International Council of Nurses (ICN) and the International Medical Informatics Association of Nursing Informatics Special Interest Group (MIA NI-SIG). This project was developed and initiated by Werley and Lang in 1988. The work on I-NMDS is currently being coordinated by the Centre for Nursing Minimum Data Set Knowledge Discovery, which was established in 2007, and located at the University of Minnesota - School of Nursing in Minneapolis, Minnesota.

It is clearly necessary to base I-NMDS on a dictionary which may be used internationally and without risk of failing to understand the terminology used by nurses. I-NMDS can be used for the international coordination of data collection and analysis, in order to obtain relevant information to support the description of nursing in the analysis and improvement of nursing practice. ICNP® provides information for building the I-NMDS.

1.10. Summary

The nursing process is the primary method of a nurse's work, and the various stages of the process form an important tool for improving the quality of nursing care.

Only systematic and planned nursing interventions, as defined by the process of nursing, make it possible to shorten the hospital stay of the patient, and serve as a good preparation for self-care and the provision of guidelines for care. The nursing process also gives patients the opportunity to influence their care.

The nursing process can be used to ensure the continuity of care, and provides a guarantee that ensures the rights of patients in accordance with EU Directive 24/2011 on patients' rights in cross-border healthcare.

2. ICNP® in the nursing process

The International Classification for Nursing Practice (ICNP®) is an international standard for describing all areas of nursing, it was selected by nurses for widespread use around the world. It ensures continuity of care and allows for communication between nurses and midwives. In 2003, the ICNP® was awarded ISO 18104:2003, which governs the use of classification in creating a plan of care - that is, providing nursing diagnoses and interventions. Moreover, in the era of information technology and with the need to ensure the interoperability of data, it is necessary to use standardized terminology to make this possible.

2.1. Introduction

The ICNP® constitutes the basic source of information that is necessary for supplying patients with continuous care. In order to provide continuity of care, it is important to implement solutions which will allow for the interoperability of the terminology in use. This occurs when, in order to communicate across language barriers, we use unified nursing terminology dictionaries. In this case, it will be possible to create a care plan, as shown in Fig.5 and Tab. 1, using ICNP®.

In nursing practice, many dictionaries and classifications are used, which allow nurses to create a database for basic nursing diagnoses and interventions, thus allowing for the achievement of a high quality of care.

Classifications are as follows:
1. NMDS (Nursing Minimum Data Set).
2. NMMDS (Nursing Management Minimum Data Set).
3. NANDA-I (North American Nursing Diagnosis Association International).
4. NIC (Nursing Interventions Classification).
5. NOC (Nursing Outcomes Classification).
6. ENP (European Nursing Pathways).
7. Omaha System.
8. CCC (Clinical Care Classification).
9. ICNP (International Classification for Nursing Practice).
10. PCDS (Patient Care Data Set).
11. ABC Codes.
12. SNOMED CT (Systematic Nomenclature of Medicine Clinical Terms), on which the ICNP ® dictionary is based.

In order to create a care plan for a client/patient that can be implemented worldwide, the International Classification for Nursing Practice (ICNP®) is recommended.

In recent years, however, significant advances have been made towards the development of concept-oriented reference terminologies that support the domain concepts of nursing. Among the remaining major challenges are the development of a reference terminology model that supports the representation of nursing concepts, and the integration of the reference terminology model with other models within the healthcare domain. A number of efforts have focused on addressing these challenges. Prominent among these is the work within the European Standardization Committee (CEN TC 251) that brought together the efforts of the International Classification of Nursing Practice (ICNP®) programme, Telenurse ID, and other European efforts (e.g. nursing activities within the Galen Projects) into a Prestandard – CEN prENV 14032. Also, of relevance to this International Standard are activities related to the International Medical Informatics Association Nursing Informatics Special Interest Group, Nursing Terminology Summits, Systematized Nomenclature of Medicine (SNOMED) Convergent Terminology Group for Nursing, Health Level 7, and Clinical Logical Observation Identifiers, Names, and Codes (LOINC).

2.2. Reference terminology model for making diagnoses using ICNP®

There are seven axes in the Classification as shown in Fig. 5, *Focus* refers to the **nurse's area of attention and is important from the point of view of nursing** (e.g. pain, accessibility, attitude, comfort, nutrition, sleep, management).

1. *Judgement* contains terms which allow one to judge the focus, i.e. the condition, symptoms (real, disturbed, interrupted condition, expected, mild, proper, absolute level, prescription state, total, independence, potential risk). According to ICNP®, **JUDGEMENT is a clinical opinion or statement concerning the subject of nursing practice.**
2. *Client* contains information about the subject of the nurse's activities (an adult, a child, an elderly person).
3. *Localization* according to ICNP® means the **anatomic or special orientation of the diagnosis or activities** (rear, blood vessel – vein, body area - abdomen).
4. *Time* refers to information about the **point, period, break or duration of an event** (reception, birth, chronic).
5. *Actions* includes terms showing **intentional activities undertaken towards** (done by) **the client** (e.g. washing, consultation, examination, assistance, parameter control).
6. *Means* contains terms allowing for a definition of the means through which the nurse undertakes activities/nurse interventions.

The electronic version also contains highlighted nurse diagnoses (DC).

Constructing the care plan requires the nurse to act in accordance with a nursing process creation pattern - i.e. gathering data during the medical interview and physical examination, establishing the patient's problems, and constructing a diagnosis using readymade diagnoses from the Classification or acting according to the pattern shown in Fig. 5 and Fig. 6.

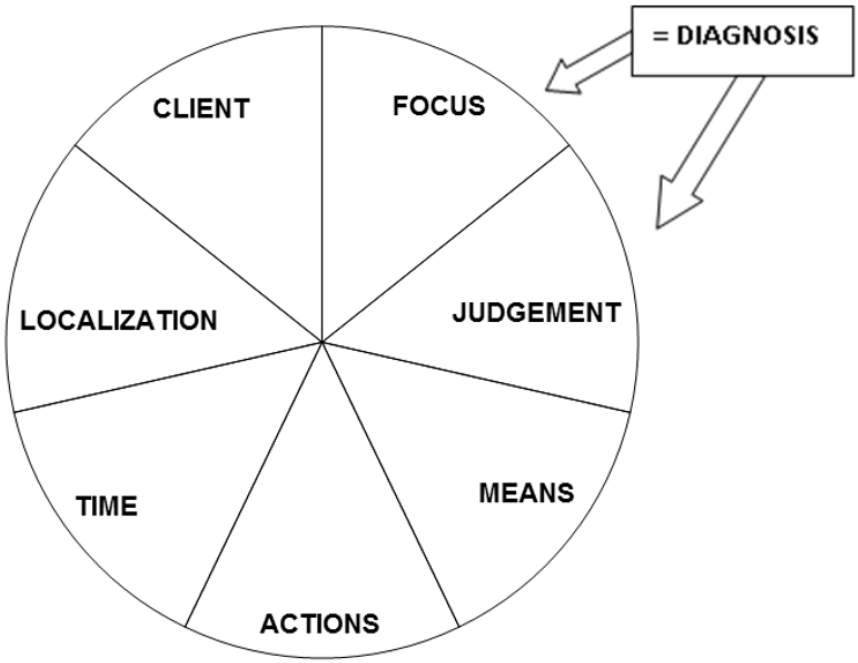

Fig. 5. Model for creating diagnoses using ICNP ®axis1 Creation diagnoses using ICNP ® axis model

Source: own elaboration D. Kilańska „International Clasification for Nursing Practice®. Version 1.0. ICN 2006/Polish Nurses Association & MAKmed 2009, Lublin: p. 147

According to Fig. 2 the phrase describing the nursing diagnosis are the mandatory terms of the axis: 'Focus – F' and 'Judgment – J'; acceptable terms from the other axis; BASIC STANDARD ISO 18104:2011.

[1] Health informatics – Integration of a reference terminology model for nursing, 2003, http://www.iso.org/iso/catalogue_detail.htm?csnumber=33309, p. 3 [Access 12.05.2012]

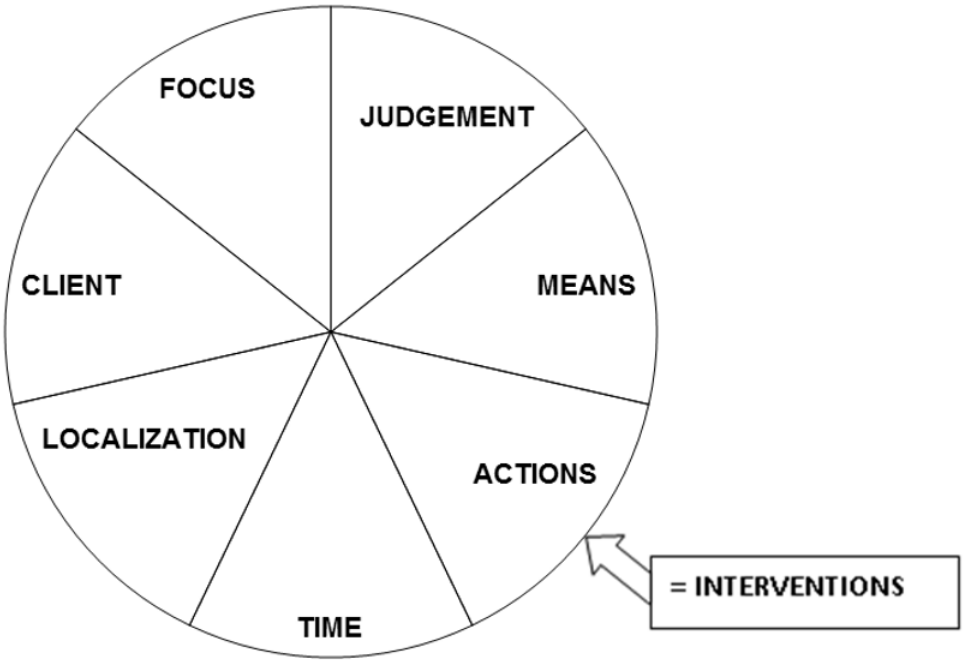

Fig. 6 Creation Interventions using the ICNP ® axis model

According to Fig. 3 the phrase describing the nursing Interventions is the mandatory term of the axis: 'Action – A'; BASIC STANDARD ISO 18104:2011.

For the purpose of this module, let us focus on a problem identified, during an interview, that concerns a lack of bowel movement, as described in Tab. 1.

Tab. 1 ICNP® Care Plan for constipation

Care plan/AXIS	Focus	Judgement	Action	Client	Localisation	Means	Time
Diagnosis	constipation (10000567)						chronic (10004395)
interventions	defaecation pattern (10005637)		**identifying (10009631):** establishing the identity of somebody or something systematically				
	pain (10013950)		**assessing (10002673)** :estimating the size,quality or significance			abdomen (10000023)	
	dietary need (10005946)		**teaching (10019502):** giving systematic information to somebody			**health promotion (10008776)**	
	medication's side effect (10022626)		**teaching about medication (10019470)**			**instruction material (10010395)**	
			Performing (10014291): doing a technical task			**enema (10006881)**	
Outcome		normality state (10013305)					

Source: PTP 2009, 35

The nurse diagnosis, according to ICNP®, described in Tab. 1, is: *constipation, chronic, real condition (actual) of an individual (patient).*

After establishing the diagnosis, it is necessary to plan nursing interventions which we can choose from the 'Actions' axis. **According to ICNP®, action is an intentional activity undertaken towards** (done by) **the client** (washing, consultation, examination, assistance, parameter control).

For the intervention, it may be necessary to identify the means we choose from the 'Means' axis.

The nurse who plans nursing interventions uses terms from the 'Actions' axis. In Tab. 1, the nurse planned interventions oriented at co-existing symptoms – 'pain'/causes – 'dietary need'/potential complications – 'medication's side effect'. Planning the intervention, the nurse establishes ('identifies') the patient's 'defaecation pattern'. For the planned interventions, the nurse will also use 'Means' of various kinds, which will allow her to complete the task. In the care plan presented in Tab. 1, the nurse realizing

the intervention uses 'Means' - 'abdomen', 'Focus' - *'defaecation pattern', 'health promotion'* in the case of 'teaching' or 'instruction material' in the case of 'teaching about medicine', and 'enema' for the intervention 'performing'.

In order to construct a diagnosis, it is necessary to choose a term from the 'Focus' axis, which is the nurse's subject of interest, and a term from the 'Judgement' axis. These two basic axes are the source of establishing a proper nursing diagnosis, which we can complete with terms from other axes when the focus of the record requires elaboration.

In order to plan the care, we can use diagnoses already existing in ICNP® or we can create them with the help of the international standard - ISO 18104:2003 – which shows how to combine terms from different axes in order to establish a nursing diagnosis – Fig.7.

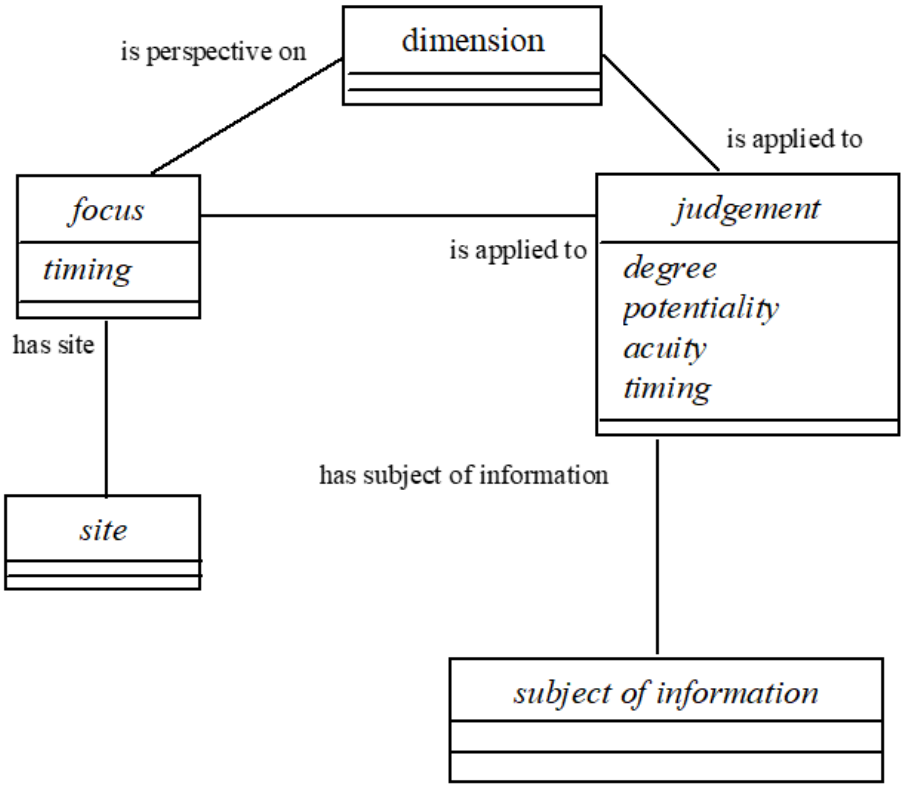

Fig. 7 Reference terminology model for nursing diagnoses
Source: International Organization for Standardization, 2003

According to the ICNP ® project instructions, the term which we can find in the Classification ICNP ®, refers to the 'Actions' axis, which contains subterms, thereby making it easier to use the Classification.

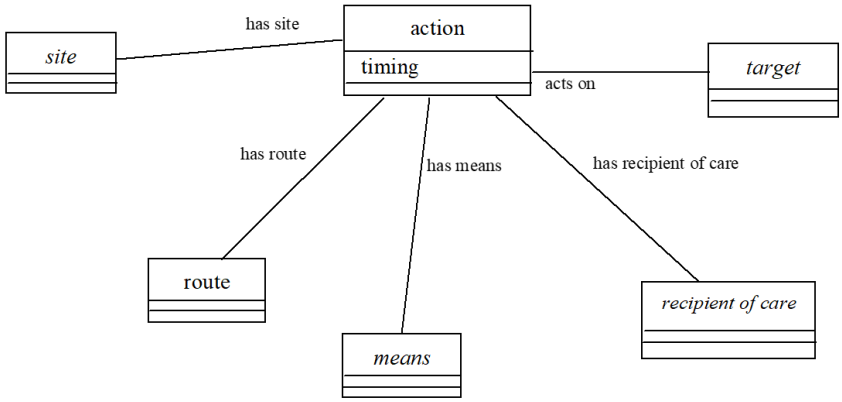

Fig. 8 Reference terminology model for nursing actions
Source: International Organization for Standardization, 2003

2.3 Care plan according to ICNP®

Below are some examples of nursing diagnoses and interventions for the purpose of creating a care plan.

DIAGNOSIS ('DC')1.: ***acceptance (F), partial (J)***

code	axis	Term in English	Definition in English
10000329	**F**	Acceptance	Coping: Reducing or eliminating barriers, apprehensions or tensions.
10014081	**J**	Partial	Extent

Depending on the cause, the nurse chooses interventions from the list which she is going to use in practice and which are interventions in line with her level of competence. Below are some suggested interventions.

MODEL INTERVENTIONS ('IC') FOR DIAGNOSIS 1.:

code	axis	Term in English	Definition in English
10024515	**IC**	Providing Reality Orientation	Providing
10027046	**IC**	Providing Social Support	Providing
10027051	**IC**	Providing Emotional Support	Providing

code	axis	Term in English	Definition in English
10032068	**IC**	Monitoring For Impaired Family Coping	Monitoring
10030589	**IC**	Assessing Emotional Support	Assessing
10024192	**IC**	Assessing Attitude Toward Disease	Assessing
10002723	**IC**	Assessing Coping	Assessing
10030639	**IC**	Assessing Knowledge of Disease	Assessing
10006173	**A**	**Documenting**	Describing: Accumulating and recording information.
10006945	**A**	**Enhancing**	Promoting: Heightening, intensifying, or improving something already of good quality.
10024589	**IC**	Supporting Decision Making Process	Supporting
10026427	**IC**	Reinforcing Achievements	Reinforcing

OUTCOME: Acceptance (F), Total (J)

code	**axis**	Term in English	Definition in English
10000329	**F**	Acceptance	Coping: Reducing or eliminating barriers, apprehensions or tensions.
10019876	**J**	Total	Extent

DIAGNOSIS ('DC') 2. *Impaired Sleep Pattern ('DC')*

code	**axis**	Term in English	**Definition in English**
10001300	**DC**	Impaired Sleep Pattern	Sleep Pattern

MODEL INTERVENTIONS ('IC') FOR DIAGNOSIS 2.:

code	**axis**	Term in English	**Definition in English**
10001938	**A**	Patient Advocating	Advocating: Facilitating a plea on behalf of the patient.
10002171	**A**	Alleviating	Treating: Making something easier to bear.

code	axis	Term in English	Definition in English
10033040	**IC**	Teaching About Sleep Pattern	Teaching
10024185	**IC**	Assessing Adherence	Assessing
10026055	**IC**	Assessing Depression	Assessing
10030589	**IC**	Assessing Emotional Support	Assessing
10030602	**IC**	Assessing Family Process	Assessing
10026086	**IC**	Assessing Fatigue	Assessing
10033882	**IC**	Assessing Knowledge	Assessing
10002781	**IC**	Assessing Readiness To Learn	Assessing
10027079	**IC**	Assessing Self Esteem	Assessing
10027080	**IC**	Assessing Self Image	Assessing
10024280	**IC**	Assessing Self-efficacy	Assessing
10006173	**A**	Documenting	Describing: Accumulating and recording information.
10012242	**A**	Motivating	Promoting: Causing somebody to act in a particular way or to stimulate the interest of somebody in an activity.
10001917	**A**	Advising	Guiding: Suggesting that the course of action being promoted should be followed.
10002401	**A**	Anticipatory Guidance	Guiding: Directing persons on health related subjects in advance of an event.
10005254	**A**	Counselling	Guiding: Enabling somebody to come to their own decision through dialogue.
10012154	**A**	Monitoring	Determining: Scrutiny of somebody or something on repeated or regular occasions.

OUTCOME

code	axis	Term in English	Definition in English
10014956	J	Effective	Positive Or Negative Judgement: Positively judged state.

DIAGNOSIS ('DC') 3.: ***Adherence To Diagnostic Test***

code	axis	Term in English	Definition in English
10030144	**DC**	Adherence To Diagnostic Test	Adherence To Diagnostic Test

MODEL INTERVENTIONS ('IC') FOR DIAGNOSIS 3.:

code	axis	Term in English	Definition in English
10006173	**A**	Documenting	Describing: Accumulating and recording information.
10012242	**A**	Motivating	Promoting: Causing somebody to act in a particular way or to stimulate the interest of somebody in an activity.
10012154	**A**	Monitoring	Determining: Scrutiny of somebody or something on repeated or regular occasions.

OUTCOME

code	axis	Term in English	Definition in English
10014956	J	Effective	Positive Or Negative Judgement: Positively judged state.

DIAGNOSIS 4.: ***Adherence To Immunization Regime***

code	axis	Term in English	Definition in English
10030185	**DC**	Adherence To Immunization Regime	Adherence To Immunization Regime

MODEL INTERVENTIONS ('IC') FOR DIAGNOSIS:

code	axis	Term in English	Definition in English
10006173	**A**	Documenting	Describing: Accumulating and recording information.
10012242	**A**	Motivating	Promoting: Causing somebody to act in a particular way or to stimulate the interest of somebody in an activity.
10012154	**A**	Monitoring	Determining: Scrutiny of somebody or something on repeated or regular occasions.

OUTCOME

code	axis	Term in English	Definition in English
10014956	**J**	Effective	Positive Or Negative Judgement: Positively judged state.

DIAGNOSIS 5.: ***Altered Blood Pressure***

code	axis	Term in English	Definition in English
10022954	**DC**	***Altered Blood Pressure***	Blood Pressure

MODEL INTERVENTIONS FOR DIAGNOSIS:

code	axis	Term in English	Definition in English
10020727	**A**	***Verifying***	Evaluating: Establishing the truth or correctness of something.
10019502	**A**	***Teaching***	Informing: Giving systematic information to somebody about health related subjects.
10032052	**IC**	Monitoring Blood Pressure	Monitoring
10019462	**IC**	Teaching About Dietary Need	Teaching
10021719	**IC**	Teaching Family About Disease	Teaching
10024625	**IC**	Teaching About Treatment Regime	Teaching
10026525	**IC**	Teaching The Family About Dietary Regime	Teaching
10032902	**IC**	Teaching About Device	Teaching
10032918	**IC**	Teaching About Eating Pattern	Teaching
10032956	**IC**	Teaching About Health Seeking Behaviour	Teaching

code	axis	Term in English	Definition in English
10032960	**IC**	Teaching About House Safety	Teaching
10033040	**IC**	Teaching About Sleep Pattern	Teaching
10019470	**IC**	Teaching About Medication	Teaching
10019489	**IC**	Teaching About Managing Pain	Teaching
10006564	**A**	Educating	Teaching: Giving knowledge of something to somebody.
10004189	**A**	Checking	Observing: Establishing the accuracy, quality or condition of something.
10024185	**IC**	Assessing Adherence	Assessing
10030543	**IC**	Assessing Arterial Blood Flow Using Ultrasound	Assessing
10024279	**IC**	Assessing Response To Teaching	Assessing
10027079	**IC**	Assessing Self Esteem	Assessing
10027080	**IC**	Assessing Self Image	Assessing
10024280	**IC**	Assessing Self-efficacy	Assessing
10022912	**IC**	Assessing Medication Supply	Assessing
10030641	**IC**	Assessing Mobility Pattern	Assessing

code	axis	Term in English	Definition in English
10033368	**IC**	Assessing Need	Assessing
10033882	**IC**	Assessing Knowledge	Assessing
10030639	**IC**	Assessing Knowledge of Disease	Assessing
10026600	**IC**	Assessing Family Coping	Assessing
10030591	**IC**	Assessing Family Knowledge of Disease	Assessing
10002747	**IC**	Assessing Eating Or Drinking Behaviour	Assessing
10030589	**IC**	Assessing Emotional Support	Assessing
10026064	**IC**	Assessing Environment	Assessing
10024251	**IC**	Assessing Exercise Pattern	Assessing
10006173	**A**	Documenting	Describing: Accumulating and recording information.
10031996	**IC**	Measuring Blood Pressure	Measuring
10031036	**IC**	Counselling About Alcohol Use	Counselling
10031043	**IC**	Counselling About Drug Use	Counselling
10031058	**IC**	Counselling About Tobacco Use	Counselling

code	axis	Term in English	Definition in English
10026208	**IC**	Counselling About Fears	Counselling
10005017	**A**	***Consulting***	Relating: Seeking advice, obtaining information, sharing ideas and considering jointly.
10005254	**A**	***Counselling***	Guiding: Enabling somebody to come to their own decision through dialogue.

OUTCOME

code	axis	Term in English	Definition in English
10014956	J	Effective	Positive Or Negative Judgement: Positively judged state.

2.6. Summary

The International Classification for Nursing Practice (ICNP®) organizes nurses' work and allows it to be maintained in situations where the patient/client moves to another location or moves abroad.

The International Classification for Nursing Practice is an important source of information that is necessary for ensuring the patients'/clients' continuity of care.

By collecting data concerning nursing practice under the guidance of IMNDS and by using the international standard of nursing, the ICNP®, the nursing process will also be clear in terms of international community care.

The systematization of nursing will provide the opportunity for professional cross-border consultation with such Centres of Reference set out in Directive 24/2011/UE. Data interoperability is the ability to plan nursing services and form health policies, not only in one country, but in the EU as a whole.

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Source: own elaboration by D. Kilańska based on„ International Classification for Nursing Practice', Polish Nurses Association/ MAKMed 2009, p. 35.

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COOPERATION IN AN INTERDISCIPLINARY TEAM

OVERVIEW

The family health nurse can act as an independent healthcare services provider as well as a member of a healthcare team. Irrespective of the form of the delivery of the healthcare service, their basic focus is to work with clients, members of the primary healthcare team, other health service providers according to the needs of the client/patient and representatives of organizations and institutions, to act to improve the health of an individual/family.

No professional group within the area of medical care can work independently, considering the bio-psycho-social human sphere (Kapała, 2007). A prerequisite of professional care is cooperation and mutual trust within a therapeutic team. According to Jankowiak and Bartoszewicz (Jankowiak & Bartoszewicz, 2003) the characteristics of the team are: 'a common aim, shared activity and responsibility for its implementation, mutual agreement on the scope of activities and individual obligations and rights, and also the efficient flow of communication'. A family health nurse can work with others in the community, not only to protect and improve health, but also to be supported in their actions in caring for the sick client/patient.

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1. Cooperation in an interdisciplinary team

1.1. Introduction

The multidisciplinary nature of teams caring for the patient/client provides a better quality of care than that possible by health professionals working in isolation. However, although some interdisciplinary teams achieve excellent cooperation, the lack of proper communication between disciplines often creates barriers.

Poor communication can lead to conflicts and an inability to cooperate, both between individuals and between teams, and this may be detrimental to the patient/client.

Effective teams often have special attributes that allow them to cooperate efficiently. The characteristics of good cooperation between interdisciplinary teams are: effective communication, mutual respect between the disciplines, recognition of the scope of activities, an appreciation of teams' own limitations, a willingness to work within a team, and setting a common goal.

1.2. The essence and competences of effective interdisciplinary teams

The team is regarded as a specific social group of two or more persons, among whom there are direct interactions. Team members have a common purpose, and accept and implement some acknowledged values and norms. The group has its own internal structure with an identifiable leader.

An interdisciplinary team is a task force: a group of people and professionals from different fields who deal with specific problems by using the resources at the disposal of each team member.

In the healthcare professions in particular, where people are the subjects of interactions, nobody works alone, individual actions are always associated with the activities of other employees. Therefore, the functioning of the team is often accompanied by a feeling of membership, and the perception of oneself as a part of a social unit.

The necessary competencies in interdisciplinary teamwork include:
1) Knowledge – skilful collaboration in various aspects of care of the patient/client.
2) Attitudes - the ability to empathize, modify attitudes and cope with a routine that limits flexibility of actions.
3) Interpersonal competences:
   - Ability to determine objectives and tasks based on the efficient use of the resources of the team (management by objectives, task management).
   - Ability to organize team work (determining roles, ways of making decisions).
   - Ability to draw on the resources of one's own experiences, both personal and professional.
   - Ability to deal with the dynamics of the group (difference of opinion, the conflict of responsibility).

To ensure effective interdisciplinary team work, one should:
- Appoint a leader.
- Determine the time and place of meetings.
- Ensure that all members of the team get to know each other.
- Establish priorities for discussion.
- Set a goal which defines the work of the team.
- Plan the necessary steps to achieve the goal.
- Identify and delegate tasks, and set deadlines for their implementation, in accordance with the qualifications and competences of the members of the team.
- Establish rules and clarify ways of sharing information and communicating between members of the team.

1.3. Fundamentals of communication

Communication is the process of exchanging information. It may be concluded that:

It is the basis of interaction.

It is based on the mutual exchange of information by interacting partners, which is termed feedback.

It is a process, which means that it is determined at one time and has a certain degree of continuity.

The aims of the communication process:
1. The exchange of pieces of information and agreeing on the individual views of the interlocutor. In this case, it is important to accurately represent our position, what we say and how we express ourselves are both important. It seems necessary to take into account the capabilities of the interlocutor.
2. Giving instructions, common tasks. The main task in this case is the transfer of content to bring about a change in the behaviour of others.

3. Determining one's own position:
    - Symmetrical relationships - each person rules in part.
    - Complementary relationships - one person is in charge, the other is subordinate.
4. Expressing one's own thoughts, desires and emotions.
5. Shaping one's own 'I'.

Concepts and models of communication

Deaux and Wrightsman claimed that one might present at least four aspects of the communication process:

- Communication is the basis for the establishment of social systems, for example, groups, nations, peoples.
- Communication is still an operating, dynamic process.
- Verbal and non-verbal communication is part of the same process of communication. Verbal communication makes up about 38% of messages. Paralinguistic communication which is closely related to verbal communication accounts for 7% of messages.
- The relational component of information is important- it is not only what is communicated that is important but also how it is communicated.

Adler's and Rodman's model - the authors drew attention to the human needs satisfied in the communication process (Adler & Rodman, 1997):

- Physical needs - satisfactory communication with other people is the basis of physical health.
- Ego needs - communication with other people is a way to find out who we are.
- Social needs - through communication we establish contacts with other people.
- Practical needs - communication provides the information necessary for efficient functioning.

Shannon's and Weaver's model - the authors draw attention to the following aspects of the communication process (Shannon & Weaver, 1949):

- Bidirectional course of communication and their interrelationships. The sender becomes the receiver and the receiver becomes the sender. Therefore, the messages are not only bidirectional but also interdependent.
- In the communication process, the environment plays an important role, this may be understood as the physical surroundings and psychological environment which includes the personal experience and communication skills of the participants.
- The communication process is sometimes disturbed by so-called 'noise':
    - Physical noise, or loud noises, poor visibility.
    - Psychological noise, the factors inherent in the sender or receiver, which make people less able to communicate.

Discussion of elements of the communication model:

1. The intentions of the sender (thoughts, feelings, purpose). Every act of communication precedes the appearance of any intent (purpose of communication).
2. Message - to realize the intentions, the sender selects the content to be transmitted. This choice may be more or less accurate, which can, to a greater or lesser extent, serve the intentions for which it was created.
3. Encoding - the search for a form in which a message can be sent, for example, by means of words or non-verbal behaviour. A set of behaviours and the meanings assigned to them are called code.
4. Transmitting signals - the signal is transmitted by means of one of the communication channels, or all at once (verbal, non-verbal).
5. Receiving signals - a signal transmitted by the sender must be received by the receiver. The receiver does not operate like a mirror that reflects the submitted information. He/she makes a selection of the signals sent, and pays attention to some signals, others are discarded. The result is that the message may be received as it was given, or it may be distorted.
6. Decoding – the translation of the received signals into comprehensible content, and the validation of the received content.
7. Interpretation - knowing the message the receiver can try to interpret the intentions of the sender who sent the message.

Factors influencing communication:

1. Situational factors:
   - The place where the act of communication takes place. We have to take into account those factors that distract and hinder the concentration of interlocutors such as noise, a ringing phone, ringtones, other people.
   - The presence of third parties.
   - A limited time – haste makes received information inaccurate and a long-lasting conversation causes tiredness and fatigue.
2. Factors attributable to the sender:
   a) Positive:
      - Knows what they are talking about – involved.
      - Has clear and pure intentions.
      - Inspires confidence.
      - Knows how to argue.
      - Clear and concise messages.
      - Has intuition.
      - Takes care of the tempo, volume, tone.
      - Takes into account the possibility of the message being misunderstood by the interlocutor.

b) Negative:
- Opposite to the above.
- Non-verbal behaviour of the sender denying the content of the message.
- Deliberately fails to disclose certain content or deliberately misleads others.

3. Factors inherent with the receiver. An ideal receiver:
- Knows how to listen and be attentive.
- Is open and interested.
- Has a positive attitude towards the sender (tolerant, accepting).
- Has knowledge, can explain ambiguities.
- Does not interrupt.
- Does not judge, does not make allusions, does not mock, or ridicule.
- Is discreet and tactful.
- Is patient.
- Responds to what is said to them, has no 'poker face'.

1.4. Communication in an interdisciplinary team

Communication is a process that forms the basis of all actions and interactions in an interdisciplinary team, and can affect their execution. The creation, development and duration of any human interaction is fully dependent on communication. Communication, when taking place effectively, is an exchange of verbal and non-verbal signals in order to achieve an effective level of cooperation between communication partners. The main purpose of communication is the 'coordination of the instrumental and interpersonal behaviour of the people initiating the communication activity' and 'it is not only about a direct coordination of observable behaviour, but it is also about agreeing on beliefs, opinions and attitudes towards reality' (Nęcki, 2000).

The process of effective communication is the transmission of information for the benefit and understanding of all participants. Effective communication helps one to be more proactive and to act more effectively. Good communication is also very important in order to avoid conventional and unchanging attitudes and, in addition, to develop group skills.

<u>The benefits of effective and efficient communication:</u>
- Efficiency and effectiveness in the implementation of tasks.
- Increase in the flow of information.
- Improvement in day-to-day operations.
- Facilitation of the group decision-making processes.
- Stimulation of creative problem-solving.
- The creation of an atmosphere of teamwork and the development of bonds between the members of an interdisciplinary team.
- Improvement in human relations, and the development of mutual trust and loyalty.

The effectiveness of the communication process depends on several factors, including: the elements involved in the communication process (i.e. message sender, channel of communication, receivers, feedback, and the effect which a message has on the receiver), and their mutual compatibility.

Barriers to effective communication:

1) Associated with the sender of the message:
   - Conflicting or inconsistent signals.
   - Lack of credibility.
   - Unwillingness to communicate.
2) Associated with the receiver of the message:
   - Tendency not to listen.
   - Prejudices.
3) Resulting from interpersonal relationships between the sender and the receiver:
   - Semantics – linguistic differences.
   - Differences in status or actual authority.
   - Differences in perception.
4) The impact of the environment:
   - Noise.
   - Information overload.

1.5. Interdisciplinary cooperation in medical care

The changing priorities, organization and financing of healthcare systems creates a new dimension for cooperation between interdisciplinary teams. The well-coordinated cooperation of professionals can help to facilitate complete, shared and economically advantageous care for the patient/client, and can have an impact on today's health challenges such as health promotion and disease prevention.

The advantages of interdisciplinary health care:

1) Patients:
   - An improvement in health due to an increase in cooperation regarding the provision of services and the solving of complex problems.
   - Integration of medical care in dealing with the patient/client's problems and satisfying their needs.
   - Recognition of the patient/client as an active partner in the process of care, and the provision of assistance for patients with significant cultural diversity.
2) Healthcare workers:
   - Increased job satisfaction and innovation in the course of their activities.
   - Change in patient care from treating sudden and acute clinical conditions to long-term preventive care.

- Acquisition of practical skills and competences.
- Focus on specific areas of knowledge.

3) Healthcare systems:
   - Increased effectiveness of healthcare provision.
   - Maximization of resources.
   - Improvement in the quality of medical services.

An interdisciplinary team consists of practitioners from various fields who care for a patient/client. They define common goals of care, delegate tasks and take responsibility for ongoing activities. Integrated and comprehensive care (which takes into account various aspects of patients' needs) is conducted through active and continuous communication, both between members of an interdisciplinary team, and between team members and patients and their families.

With regard to the interdisciplinary approach to patient care, healthcare workers work independently, but simultaneously, and each of them is responsible for a different range of patient care. According to the needs of the patient, there is communication and consultation between team members in order to ensure the highest quality of care.

Key specialists within interdisciplinary care teams include nurses, midwives, doctors, pharmacists, nutritionists, social workers, physiotherapists, occupational therapists, speech therapists, psychologists and dentists. One should also mention those involved in the management of care such as directors of healthcare institutions and social care centres, receptionists and others.

The basic tasks of an interdisciplinary medical team involve coordination, effective communication and shared responsibility. The first step, with regard to coordination, is to allocate tasks; in other words, to decide which team members will take responsibility for the specific needs/problems of the patient. It is important to realize that the patient and their family are the main members of the team.

Effective communication is necessary in order to facilitate coordinated care. The ideal communication system, which is essential to the delivery of coordinated care, includes a well-functioning recording system, regular team meetings to discuss issues of patient care, and the development of efficient mechanisms for communication with external systems.

Leadership and decision-making in an interdisciplinary team are dependent on the nature and problems of patient care. Although, in the past, doctors were the leaders and key decision-makers in health care, there is now a trend to diversify these roles.

Tasks of an interdisciplinary team with regard to health care:
- Defining the problem and setting objectives.
- Gathering comprehensive information about the problem.
- Consulting specific team members about the problem.
- Discussing the problem from the perspective of a professional in the field.
- Developing potential solutions, exchanging opinions, facilitating discussion and selecting the best solution.
- Summarizing planned activities and delegating tasks to team members.

1.6. Elementary rules of cooperation in a therapeutic team

The therapeutic team consists of a group of people who are involved in the treatment process. The basic characteristics of the therapeutic team are: a common goal of action, combined responsibility for achieving the goal, joint agreement concerning the scope of activities, joint determination of specific duties and powers, efficient communication, and exchange of information.

Effective collaboration in a therapeutic team can lead to the most effective activities because each member of the team is a source of information about the symptoms, requirements and progress of the therapeutic process.

The primary members of the therapeutic team are a doctor and a nurse. Other team members are experts in psychology, nutrition and rehabilitation, a social worker, the patient and their family.

The activities of individual members of the therapeutic team should be innovative and team members should take responsibility for their decisions.

Basic rules of cooperation within the therapeutic team:
- The therapeutic team should have a functional structure, created for a specific purpose such as taking care of a demographic group of developmental age.
- Team members have clearly defined roles and powers.
- The team has a defined internal communication system (between team members), and a set schedule of meetings.
- The coordinator of the team is chosen in order to achieve a specific therapeutic purpose. They should be the person who has the most direct contact with the patient or a specific group of services, such as a midwife coordinating care for pregnant women, or a therapist coordinating the work of a team which deals with addiction therapy.
- Members of the therapeutic team should develop a communication system for providing information about the patient in order to avoid the duplication of activities and to ensure a higher quality and efficiency of work.

Working in a therapeutic team is a great opportunity to build positive relationships between the professionals involved in the provision of services for patients in primary health care.

Appropriate changes to the current model of training medical staff, both at under- and postgraduate level, are being introduced to prepare the necessary conditions for the functioning of therapeutic teams. These activities include the introduction of thematic blocks, which are realized in an interdisciplinary way (combining students from different faculties), and training in team work, incorporated in various forms of postgraduate education.

1.7. Cooperation in primary health care

Primary health care is the part of the healthcare system which provides essential health services to both sick and healthy people by offering outpatient or home services.

Primary health care is centred on the family doctor. It is an essential form of health care based on practice and learning, and provides universal access to individuals and families in the community. It forms an integral part of the national health system of any country. The scope of its activities includes all services that affect health, not only with regard to income, socioeconomic conditions and education, but also in terms of diagnosis, treatment of diseases, health promotion and prevention.

It constitutes the patient's first contact with healthcare workers, and provides a location where specific preventive and therapeutic interventions are initiated. The overall objective of primary care is to improve and maintain the health of individuals and families. The partial objectives include: identification of the health needs of the local population, detection of health-risk factors, prevention of disease, detection of early signs of disease, diagnosis and treatment, rehabilitation and care, and health promotion.

The purpose of primary health care is to provide individual preventive, therapeutic and rehabilitation services in healthcare institutions, at the scene of an accident or sudden illness, or in the patient's home. The tasks of primary care also include the education and motivation of patients and the entire community with regard to caring for their own health and the health of their families. The fulfilment of these obligations, in terms of primary care, will be conditioned by the scope and types of services available and the responsibilities of doctors, nurses and other staff, who will provide these services in addition to the existing routine health services. These services should take into account issues of health promotion, which include health education and the prevention of various health-risk factors that might lead to disease.

Primary health care relies on four principles:
1) Equal and universal access to health care.
2) The active participation of social groups in the formulation and implementation of health programmes.
3) An interdisciplinary approach to health.
4) Methods of care based on the needs of patients/clients.

Primary care is constantly changing. As the range of primary care tasks increases, so do the demands on it. Teams which were initially dominated by doctors are now being led by other professionals, including community and family nurses, long-term care nurses, social workers and others.

A necessary prerequisite for professional care in primary care is a willingness to co-operate and a mutual trust between team members.

1.8. Communication in primary health care

In modern health care, it is desirable to work out a defined interaction model. At the present time, nurse and doctor interaction, which directly influences the interactions with the patient, functions as an **autocratic-paternalistic** model – this is a strictly formal model that focuses on setting and realizing goals. However, devising a second type of model, which may be defined as a **partnership model**, works on the assumption that it must be patient-oriented. It focuses on establishing an individual process of treatment that takes into consideration the patient's needs. According to this model, the nurse has their own role. They are an indirect link between the doctor and the patient. By implementing the treatment process that has been chosen by the doctor, the nurse is able to address the needs reported by the patient. During the treatment process, patients' needs can be identified at once and an effort can be made to meet them.

This model is based on **nursing-therapeutic-healing activity** - within these three dimensions, healing activity improves the patient's quality of life and has a positive impact on the process of treatment itself.

In the partnership model, the patient's role is crucial – they are a central link and the interaction subjects are the doctor and the nurse. Communication between the doctor, the nurse and the patient has the character of a triangular interaction. Such a relationship has an additional positive aspect – it allows for the medical therapeutic team to be viewed by the patient in a more social and familiar way.

Apart from delivering prescribed nursing treatment, the patient expects the nurse to be able to recognize their mental and emotional state. The patient also assumes that the nurse will display an attitude that will enable the patient to build a relationship with

him or her. However, a mere open attitude is not sufficient: the nurse has to be able to respond to the patient's attempt to establish the relationship, and to skilfully allow it to develop and encompass a positive attitude towards the disease being treated.

1.9. Summary

Working in a healthcare team, within an ethos of mutual cooperation and professional responsibility, has a number of positive effects on the patient and his family. Currently, no healthcare group is able to work alone, this is the case due to the bio-psycho-social sphere of human beings.

2. Communication in FHN practice

2.1. Introduction

The nurse, in the course of their professional duties, comes into direct contact with the subject of health care, their family and friends, the nurse's own professional team, and other members of the treatment team. This is due to the need to have effective and continuously improving communication.

Types of communication:
- Communication between staff.
- Communication between the nurse and the patient/client.

Effective and suitable communication is a condition of a successful process of care that is satisfactory to both parties (both the person who is cared for and the person delivering the care). Communication must be based on knowledge. All planes of communication can be divided into two groups:
- Verbal communication (verbal).
- Non-verbal communication (body language).

Both forms of communication are common in a relationship - verbal communication is supplemented by non-verbal communication. The relationship is generally dominated by verbal communication, but non-verbal communication is the predominant form for the patient.

2.2. Nurse – Patient Communication and its Conditions

The process of communication is important in everyone's life because the exchange of information between people is one of the basic activities that make it possible for us to function.

Communication should be of a therapeutic character due to which the nurse is able to help the patient to control their feelings of helplessness, fear, stress as well as showing them respect and manifesting a willingness to help. The nurse should be aware that mistakes made by them in the process of communication can cause a deterioration in the patient's condition (iatrogenic error).

The contact between nurse and patient is the contact between two people, one of which (the patient) is usually in a state of suffering, feels bad, has fears and doubts and expects a degree of understanding and help from the nurse.

The nurse – patient relationship is asymmetrical, it is the nurse who regulates the contact between them. The nurse has to apply their knowledge, abilities and skills which can make the contact either easier or more difficult:

- Empathy.
- Kindness.
- Openness.
- Acceptance.

The nurse should:

- Have a certain degree of knowledge about human beings and their behaviour in health and sickness, developmental regularities.
- Have certain skills of observation, active listening, understanding, asking questions, giving health information, interpreting non-verbal messages.
- Be willing to help and provide what is most needed by the patient.
- Be sensitive to the needs and suffering of others.
- Respect the patient, their dignity and individuality.
- Have the necessary skill to make an individual approach to the patient.
- Constantly develop and perfect their skills.

<u>The patient's characteristics influencing communication</u>

1. Patient's personality:
   a) Type of emotional reaction:
      - Aggressive type – having grudges towards others, rebellion.
      - Depressive type – a feeling of guilt, becoming withdrawn.
      - Fearful type – panic, fear, fright.
      - Levelled emotions – adjusted to the situation.

   b) Emotional maturity.
2. Resistance to difficult situations and the style of dealing with stress:
      - Focusing on the problem.
      - Focusing on emotions.
3. The level of intelligence.
4. The need for contact with others.
5. The ability to communicate.
6. Sickness – changes in the patient's manner of reacting to specific situations.

<u>Communication can be hampered especially by diseases such as:</u>

- Mental disorders.
- The diseases of the central nervous system.
- Diseases connected with severe or continuous suffering.

- Diseases evoking strong and negative emotions.
- Different ailments.

Developing a skill in therapeutic communication between the nurse and the patient requires the nurse to be aware of the possibility of making mistakes.

Among the possible mistakes the ones most often mentioned are as follows:

1. Defensive – verbal or nonverbal aggression towards the patient, not listening to them, not answering their questions or answering them as if being attacked. This type of behaviour may occur when a nurse is overworked, tired, irritated, or has personal problems. The best solution in such a situation is not to engage in conversation with the patient.
2. Comforting and falsely assuring – telling the patient something which is not true or platitudinous, such as; 'everything will be ok' when the patient shows concern. In such a situation the patient should be encouraged to speak.
3. Not giving information.
4. Reproving the patient – this happens when their behaviour is not correct – when they get up while they should be lying down etc, phrases such as 'you always...,' or 'never' are often used. The proper phrase should be: 'You shouldn't get up. Please lie down'. A reproachful attitude is often expressed in a nonverbal way – facial expression, look. Reproaching the patient can cause anger, a sense of guilt, lower self-esteem.
5. Not making sure that the message is understood.
6. Deaf silence – when neither the nurse nor the patient maintains the conversation. In such a situation it is recommended to summarize the previous talk or ask the patient if they want to add anything.
7. Indifference and a degree of reluctance to make contact with the patient.
8. 'Wrong questions' (asking questions that are unhelpful):
   - Questions the patient does not wish to answer.
   - Rhetorical questions.
   - The 'why?' type of questions.
   - Leading questions: It doesn't hurt, does it?
   - Asking too many questions at once.
   - Overly complex questions: "Could you tell me about your family, your career, if anyone has chronic diseases?
   - Too many closed questions.
9. Moralizing – this is a way of assessing the patient. It occurs when the patient's behaviour is not in agreement with what the nurse considers to be right from a moral point of view.
10. Patronizing – revealing signs of a tendency to look down on the patient – treating them with leniency and not as a partner. This type of communication is signalled by the use of terms like 'we' instead of 'you' and referring to elderly patients as 'grandma' or 'grandpa'.

11. Blaming.
12. Assessing – both verbal and nonverbal (gesture, look, facial expression). The patient who is assessed to be 'bad' does not form a positive relationship with the nurse. It is also unprofitable to agree with the patient too often when they are providing information as it may lead to the patient lying in order to please the nurse.
13. Advising the patient - giving the patient pieces of advice concerning decision making is a matter routine for a nurse. However, it is not proper to advise too often or to categorically state 'do this' or 'don't do that'. In such a situation the patient should be given the possibility of a choice due to their understanding of the pros and cons of the situation.
14. Suggesting answers 'Do you have a headache?'
15. Changing the topic.
16. Guessing – we guess what the patient is talking about but we do not confirm our guesses.
17. Entering the patient's personal problems too deeply.
18. Fraternizing with the patient.

Types of patients:

1. Children – the age of the patient is a factor which should be used to determine the process of communication. In the case of a child, the immaturity of their responses and their low resistance to stress should be taken into account. The quality of contact with the child depends on the degree to which these factors are taken into consideration and if the patient's right to participate in interaction is respected.
   The following factors make communication with a child difficult:
   - They cannot express what they feel.
   - They react with deep fear to a situation of sickness and hospitalization.
   - They are less resistant to pain and suffering.
   - They cannot deal with difficult situations.
2. Elderly patients – communication with the patient is dominated by many factors, the most important of which is the aging of the nervous system, this demands a stronger stimulus and also necessitates a more gradual type of reaction. A deterioration in hearing, sight, taste and touch perception occurs, the course of thought and the ability to register changes is slowed down. Elderly people also have disorders of a more emotional kind which, when combined with the changes in the nervous system lead to so called 'elderly eccentricities' which, in turn, form a barrier to nurse – patient communication. Possible eccentricities include:
   - Collecting things.
   - Living in the past.

   Other characteristics of elderly people which hamper the communication process:
   - A mentor's attitude; criticizing, distrustful, suspicious.
   - Altered sensitivity of the senses.
   - Hypochondriacal attitude.
   - Euphoric attitude.

- Some questions/activities evoke shame.
- Stupor and dementia.

Another factor which hampers the communication process is also the tendency to shape and apply stereotypes connected with older age: 'elderly people usually complain about something so why should I listen to them?', 'they are people for whom there is no hope,' 'older people are asexual' and so on. Old age is associated with negative traits, a deterioration in physical and mental strengths, the necessity of constant help and care.

Ways to improve communication with an elderly person:

- Empathic attitude.
- Avoiding stereotypical thinking.
- Taking the dysfunction of their sense organs into consideration.
- Accepting the fact that only 15% of elderly patients have organic nervous system disorder.
- Elderly people have intimate and sexual needs as well.

3. A mentally ill patient:
   - Lives in their own disturbed world which is difficult to reach and understand.
   - Often lives in a state of deep fear, is afraid of people who want to help them.
4. A patient with a mental disability:
   - Has difficulties expressing thoughts and feelings.
   - Cannot comprehend the person trying to communicate with them.
   - Has a lot of behaviours that are not socially acceptable.
5. A dying patient:
   - More and more unbearable symptoms.
   - Severe pains.
   - Tiredness with life and suffering.
   - Anger and rebellion.
   - Insomnia.
   - Despair.
   - Fear of death.
   - Helplessness.
   - The sense of being a burden on one's family.
   - Worrying about family.
   - A sense of isolation and rejection.
   - Spiritual crisis.

A Dying Patient as an Element of the Communication Process

Dying may be analysed in 3 aspects: mental, biological and social-cultural. All types of dying are processes that have their own rhythm and duration and end with the person's death.

From the point of view of the awareness of dying, four psychological models of dying can be distinguished:

1. A closed awareness model – this is a model of communication in which the sick person is not aware of their approaching death but the people surrounding them are fully aware of it and do everything they can to maintain the patient in a state of ignorance.
2. Suspicion model – the patient suspects that they are incurably ill and dying. They either try to prove their suspicion right or reject the idea.
3. Mutual pretending model – the dying person, despite their expressions of denial is aware of their condition but does not discuss their approaching death, just like the people around them.
4. Open awareness model – both the dying person and the people surrounding them are fully aware of their approaching death and their efforts are limited to adapting the patient to a state of acceptance and making the process of dying easier.

The role of the therapeutic team is to recognize whether the patient wants to know the truth about their unavoidable death or if they would prefer to live in a state of unawareness. At the present time, it is thought that the patient should know the truth. A full disclosure of the relevant information allows them to prepare for death, say goodbye to their relatives, conclude all of their life affairs and spend their remaining time as well as possible.

According to E. Kübler-Ross, when facing death as a result of a bad disease prognosis the patient goes through the following stages of so-called death consciousness (Kübler-Ross, 1969):

I. Denial and isolation.
II. Anger.
III. Negotiation – a deal with fate or God.
IV. Depression.
V. Acceptance.

All of these models of dying and the stages of death consciousness demand a separate way of communicating with the patient and adjusting to the appropriate model and phase of the process of dying. Engaging with the family is essential. Communication with a dying person may be improved through reducing their fear, this may be accomplished through the experience of knowing the most common reactions to an awareness of an impending death. The atmosphere around a dying person should be characterized by kindness, understanding and hope. This may be expressed in words but what is most important is the role of nonverbal communication – touch, smile, facial expression, look.

The problem with death is that the nurse – patient relationship is often a taboo. This inability of the dying person to make contact with their environment has

been called a 'glass wall' by L. LeShan. Interaction with a dying person is often accompanied by communication fear, which is determined by the frequency and length of contacts, the degree of the saturation of conversations with the topic of death and funerals and the quality of oblique statements concerning the health condition and prognosis.

2.3. Therapeutic communication in nursing care

Therapeutic Communication

Effective nursing cannot be carried out without efficient communication and the establishment of a good relationship with the patient. The art of conversing with those who are sick is professionally referred to as therapeutic communication.

The therapeutic relationship is central to all nursing practice. It is grounded in an interpersonal process that occurs between the nurse and the client(s). The therapeutic relationship is a purposeful, goal directed relationship that is directed at advancing the best interests and outcomes of the client.

According to the definition, therapeutic communication is 'supportive treatment, nursing and rehabilitation with psychological measures'. (Motyka, 2003) The psychological measures are understood to be the words directed towards the patient. However, in reality, it is not the actual words that matter, but their psychological meaning, as well as the meaning of the gestures, facial expressions and other non-verbal behaviours of the nurse, including the conditions in which the treatment and nursing are conducted.

Important psychological measures that support both the nurse and the treatment should, above all, include engaging with the patient's inner mental resources, such as their knowledge and skills, self-esteem and inner support, hope, the feeling that certain goals have been achieved and significant experiences have been undergone, the motivation to recover, and the ability to release emotional tensions.

In order to conduct effective communication, the application of certain rules is important. Every interpersonal relationship should be:

a) Intentional – we want to use communication to achieve a previously set goal.
b) Effective – before establishing contact with another person, think about what kind of impression you will make.
c) Therapeutic – this has a positive influence on the subject of care.

The objectives of therapeutic communication:

- To ease the patient's negative emotions, such as: fear, depression, anger, feelings of injustice, guilt or powerlessness, that are often experienced in illness.
- To enhance the patient's inner mental strength, by using the previously mentioned resources (such as the patient's self-esteem and sense of hope) that will allow the patient to deal more effectively with the stress of their illness.
- To enhance cooperation with the patient and prevent iatrogenic mistakes.

The therapeutic relationship should be treated as a psychological catalyst for all activities that are therapeutic in nature, such as giving explanations, encouraging the required behaviours and the following of instructions, reassuring, giving support etc.

The therapeutic relationship includes two essential elements. The first one is the **emotional aspect** which refers to the important features of the emotional element of the relationship, such as: the feeling of safety and trust from one side (patient) and acceptance, respect, care, empathy, honesty and reliability from the other (nurse). The second aspect of the therapeutic relationship is **the task aspect** which is concerned with acquiring the best nursing-therapeutic results, and with easing the patient's emotional problems which are connected with the illness and the accompanying situation.

Communication with the patient always has (although, according to the situation, the proportions differ) two essential planes. One of them is the **objective-object** plane which is concerned with the character of the disease and the methods of treatment. Another, no less important, is the **subjective-subject** plane which is more connected with the expectations, thoughts and feelings of the patient, and the thoughts and feelings of the doctor and nurse. It must also be noted that good communication is an interactive process, which means that it engages both sides of the relationship.

Medicine incorporates many methods of communicating with a patient, the most common of which is communicating through **asking questions**.

We can distinguish three types of questions: open, closed and focused.

Open questions give us freedom of speech. This is important as it compels the patient to take part in a conversation and the nurse has the opportunity to observe and gather information about the patient, i.e. to interview the patient in order to plan nursing care.

An interview is a method of gathering information and is used, not only in nursing as a medical science, but also in the liberal arts (psychology) and in social areas (social studies). Questions should not be addressed to people whose condition is very serious or whose emotional state or intellectual abilities do not allow them to give answers.

Closed questions are those which do not require complex answers: only short ones such as 'yes', 'no' or specific answers to precise questions such as 'where do you feel pain?' are enough. These questions are addressed to persons who have difficulties or limitations in giving an answer.

Focused questions are aimed at acquiring information on a specific topic.

Another method of communication is used when **the patient's statement or behaviour expresses inconsistency.** The nurse, when talking to a patient, has a role akin to that of a doctor. Thus, a form of verbalization is applied in which it is acceptable to draw attention to the emotions evoked by the patient, especially if the emotions are negative. However, this must be done gently in order not to offend the patient, but to explain their mistake.

There is also the **explanation method**. This is used when the nurse does not understand the sense of the patient's statement.

For every person, an effective method of communication should be chosen. It should have a supportive-healing character which will provide the patient with the specific help which is most needed. Talk/contact with the patient should afford help which in turn restores hope, and helps to combat feelings of powerlessness by stimulating useful activity and encouraging the patient to make an effort to take responsibility for the maintenance of their health. In order to meet such goals, a person needs someone close to them who can be trusted. The nurse, in order to be that key person, should be willing to give the patient everything they need in their particular situation.

One of the methods of establishing positive communication with the patient is by gaining their trust. Trust means being able to rely on a person without reservation or doubt. This state of mind and attitude includes the patient's acknowledgement of their dependence on the nurse, and at the same time it means the acknowledgement of hope.

In shaping the nurse-patient relationship, it is often stressed that it is the patient and their affairs that are at its centre, and the goal is to provide the best help available. With such an approach, there is no space in the relationship for the nurse's affairs, even if the patient asks about private matters. The nurse should refuse to discuss these matters and should change the topic of conversation, unless a discussion about the nurse's life experience could possibly help or support the patient.

In order to effectively create a relationship, four stages of communication may be distinguished: initial orientation (through interaction), identification (undertaking efforts to establish the relationship), active intervention, conclusion.

General aims of the nurse's communication with a patient:
- Maintaining and supporting verbal and nonverbal contacts.
- Exchanging information.

We can distinguish two levels of communication; the level of the relationship and the level of content. The LEVEL OF RELATIONSHIP defines the way in which the nurse establishes verbal and nonverbal contact with the patient, and relates to the time, the place and the circumstances of communication. The LEVEL OF CONTENT defines the range and character of the messages received and transmitted by the nurse and patient. The levels of the relationship and content dictate the character of the communication between the nurse and the patient, which in turn relates to the emotional and cognitive aspects of the relationship.

Specific aims of a nurse's communication with a patient:
- To make a nurse diagnosis.
- To plan individual care for the patient and their family (informing).
- To realize the planned nursing actions (counselling, encouraging, helping, supporting).
- To assess the realized nursing goals.

In individualized nursing, communication between the nurse and the patient and their family is crucial. This communication allows for:
- The patient's trust in the nurse.
- The nurse's collection of the broadest range of data about the biological, mental, social, spiritual and cultural aspects of the patient.
- The patient's cooperation in gathering information, planning, realizing and assessing the achieved nursing goals.

The rules regarding a nurse's communication with a patient:
1) The rule of treating the patient as a person.
   The patient is a person who participates in making decisions concerning their diagnosis, in planning nursing goals, and in realizing and assessing the achieved goals.
2) The rule of partnership in communication.
   The nurse and patient, while communicating as partners, mutually accept the importance of each other's problems, needs and expectations.
   Basic assumptions of the partnership in communication:
   - Defined nursing responsibilities of the nurse and the patient.
   - Freedom to communicate.
   - Mutual willingness to negotiate.
   - Benefits from communication for both the nurse and the patient.
3) The rule of cooperation, including communication, in reaching the nursing goals. Observing this rule allows for the patient and nurse to make decisions concerning the nursing diagnosis, care plan, care realization and assessment of the achieved goals.

4) The rule of open communication.
   This rule allows for the satisfaction of important needs in a situation where the patient's assistance and communication are essential. It permits the setting of limits to the nurse's advantage that results from their role or situation and which is keenly felt by the patient (expressing their opinion, beliefs, feelings, honest answers to the patient's questions, openness in body language – e.g. leaning forward).
5) The rule of two directions of communication.
   The notion of two directions of communication refers to the role change of the participant from speaker to receiver and vice versa. It means that the information transmitted to the patient by the nurse is in accordance with the nurse's intentions. The patient receives information at the same level as the nurse and this provides the nurse with useful feedback. In this situation, the patient becomes a speaker and the nurse becomes a receiver.
6) The rule of empathy in communication.
   An empathic attitude is a willingness to understand the thoughts and feelings of the patient by putting oneself in their position (cognitive empathy) and involves the ability to feel the patient's reactions in accordance with one's own feelings (emotional empathy). In nursing the patient, a crucial role is played by cognitive empathy.
7) The rule of competent informing.
   The nurse has a responsibility to:
   - Inform the patient about their rights.
   - Provide information about their health condition.
   - Keep information about the patient confidential.
   - Provide the patient's family, who is involved in nursing care, with the necessary information.
8) The rule of directed observation.
   During communication, the nurse pays attention to elements of nonverbal communication such as:
   - Body language, facial expressions, gestures, posture.
   - Physical appearance.
   - Physical contact during greetings and while performing nursing activities.
   - Paralingual behaviours – voice timbre, articulation, volume, pace of speaking.
   - Physical distance.
   - The impact of nonverbal behaviours on continuing speech.
9) The rule of active listening.
   Active listening is the ability to react in a verbal or nonverbal way to the speaker's statement and implies attentive listening by the receiver. A repetition of the sense of the statement by the listener leads the speaker to believe that they have been listened to and understood.
10) The rule of using verbal and nonverbal forms of communication.
11) The rule of maintaining a physical distance.
    The optimal distance, during a conversation between a nurse and a patient, is about 1.5m. Such a distance makes it possible to establish contact, and to create

an atmosphere of trust and a sense of safety; at the same time, it prevents the violation of the personal space of both the nurse and the patient.

12) The rule of maintaining eye contact.
Eye contact should last for about five seconds each time we look at the interlocutor. This is especially important while transmitting information, explaining, during active listening and when answering questions.

Maintaining eye contact:
- Shows active listening.
- Confirms the authenticity of the statement.
- Enables us to observe nonverbal reactions.

The characteristics of a therapeutic relationship

Health professional's characteristics:
- Respect and a genuine interest in the patient as a person.
- Emotional warmth.
- Tolerance and non-judgmental acceptance.
- Openness towards the patient, including empathy (i.e. the ability to temporarily enter the world of the patient's experiences and to view the situation from their perspective).
- A realistic trust in one's own strength and abilities while understanding one's limitations.
- Observing ethical values.

Patient's characteristics:
- Trust in the health professional.
- Some, even a minimal, understanding of the goal and method of treatment.
- Willingness to cooperate during treatment.
- Motivation to change, i.e. the will to be cured.

Characteristics of the therapeutic relationship:
- Boundaries of therapeutic contact – the awareness of where the therapeutic relationship ends and another type of relationship begins e.g. social or formal-professional.
- Contract - the awareness of a mutual, although usually not written, agreement defining the character and demands of both sides of the relationship; sometimes, especially when the patient crosses the boundaries that have been established to enable the achievement of goals, it is necessary to remind him or her of important aspects of the agreement, e.g. what they should and should not expect or what their obligations are as the person being treated and nursed.

The responsibility for creating the psychological conditions necessary for providing help lie mainly with the person who provides that help - in this case the nurse. The

ability to create these conditions depends on their interpersonal skills, especially the abilities of active listening and assertiveness, as well as on the characteristics of the nurse's attitude towards the patient such as warmth, empathy or authenticity.

Such characteristics of attitude are strongly connected with the stage of personality development and emotional maturity of the nurse; however, they can be shaped and developed through the appropriate training courses and through one's own conscious effort. The elements which create the desired character of a therapeutic relationship are described in brief below:

Acceptance — connected with both the warmth, care and respect with which the nurse treats the patient, as well as with the trust which the nurse has in the value, strength and abilities of the patient. It is worth mentioning the two crucial psychological elements. The first deals with the fact that acceptance towards other people is closely connected with self-acceptance, the other relates to the idea that acceptance refers not only to the patient's behaviour, but also to their inner reactions – to put it in the simplest way, to their thoughts, beliefs, feelings and needs. The nurse has the right not to accept behaviours which are disagreeable or dangerous or which constitute a significant obstacle to the patient's recovery. At the same time, the nurse should be able to accept the patient's feelings, regardless of how unjustified or irrational they seem to be, and should be able to admit the patient's right to have their own opinion.

Empathy means the ability to experience the patient's situation; to identify and view the situation from the patient's perspective. It is not a form of total identification with the patient. Rather, it is the ability to take the patient's beliefs and feelings and also the needs underlying these feelings into consideration. Empathy shown towards the patient enables them to feel understood and accepted. As a result of empathy, the patient no longer feels alone with their worries, and finds it easier to share their problems in a way that makes them seem less serious. Empathy is a very important element of the therapeutic relationship. Because of empathy, an atmosphere of closeness and trust is established, which gives the patient a sense of emotional security and support, and creates the opportunity to safely release negative feelings evoked by illness and invasive treatment methods.

Authenticity (genuineness and openness of the nurse) is the ability to openly present things as they are seen and experienced. This is a behaviour connected with the freedom of expression of thoughts and feelings, honesty and frankness. Authenticity breeds trust; it does not, however, mean eliminating self-control and freely voicing whatever is on one's mind. It entails the necessity of choosing what can be freely discussed with the patient and what emotions can be revealed to the patient without hurting their feelings. The nurse also has to be aware of how to inform the patient about the facts that they should be aware of, and to be able to determine what will be a mental burden to them. That is why authenticity appears to be the most

controversial characteristic. Let us remember though, that authenticity, which is necessary in a therapeutic sense, should not be in conflict with the equally necessary therapeutic control over one's behaviour and feelings. The therapeutic relationship is a professional relationship connected with the conscious aim of reaching a therapeutic goal. Consequently, being oneself in this type of relationship does not imply a lack of control over one's words, feelings and behaviour.

As has been briefly described in this chapter, the attitudes of the nurse – acceptance, empathy, authenticity – stimulate the patient's positive feelings in establishing the secure atmosphere of the therapeutic relationship. Creating this atmosphere can be a difficult task and, in most cases, it can pose a serious challenge for the nurse.

2.4. Active listening – building therapeutic relationships

Confirming message reception

This is a reaction to the patient's behaviour and statements which is a simple confirmation of having received the message: we are interested in the patient as a person and in the content of their message.

1. **Examples of statements confirming message reception:**
   Yes.
   Yep.
   Uh-huh.
   That's interesting.
   These statements may be used as well as more complex expressions in the form of open questions that refer to what the patient is talking about.
2. **Nonverbal reactions are also helpful:**
   - Nodding.
   - Revealing with a look, gesture or facial expression that we are listening to the patient's words and that what the patient has said is interesting to us.

   Showing a selective interest in certain topics which are connected, for example, with the patient's health problem, can be an indirect and very gentle means of steering the direction and course of the conversation.
3. **Qualifying statements used by the patient.**
   The aim of this technique is to highlight the precise nature of the importance of the discussed topic to the patient. It must be remembered that, from the perspective of human psychology, it is not only the outward facts that matter, but also the importance attached to them by a specific person.

Examples of the qualifying technique:

- What do you understand by this?
- What do you mean?
- How important is it for you?
- How does it work?
- Can you tell me more about it?

It should be noted that these sorts of questions do not necessarily prompt any particular answer, but can serve to qualify a patient's statement, which makes it much easier to identify what is really on their mind and what their problem is. It must be emphasized that, in order for a conversation to be of a therapeutic character, it should be conducted in a precise and, at the same time, personal way. That is why, in trying to reach the patient's innermost thoughts and feelings, it is better to avoid unclear expressions and generalizations.

Qualifying a patient's statements, especially those that refer to their thoughts and feelings, is a very important technique which allows the patient's innermost problems to be identified and dealt with. In some cases, it is possible that, by using this technique skilfully and without giving any subsequent advice or recommendations, we can enable the patient to find a solution to their problem by himself or herself. For example, when using the qualifying technique, we will not react directly to the patient's statement that they are nervous with a response such as 'yep'. Rather, we will ask: 'Nervous? What exactly do you mean?' or 'Could you tell me how this nervousness manifests itself?'.

4. **Paraphrasing.**

This is a technique which directly communicates how we have understood the interlocutor and what parts of their message have reached us. It reflects in words what – as we understand it – the patient thinks or feels, and only means that we have understood them, and does not indicate, in the slightest degree, our attitude towards the matter. However, this technique is not about us. By means of this technique, we repeat, as accurately as possible, in our own words, what the interlocutor has just told us, in such a way that we get some sense of their utterances and can pinpoint what the patient considers to be the most important issue. If it turns out that we have misunderstood something, then the mistake will be corrected by our interlocutor.

Advantages of paraphrasing:

- Easier to understand the content of a conversation.
- Easier to avoid misunderstandings.
- Easier to eliminate barriers.
- Misunderstandings can be cleared up on the spot.
- Shows a willingness to accept the right to a way of thinking different from our own - we communicate to the patient that, although we may not share their views, we acknowledge the patient's right to hold different views.

Examples of paraphrasing:
- I understand that...
- If I get you right…
- You think that...
- So, according to you…

Irritated patient:
- The nurses in this hospital prefer to sit in the staffroom drinking coffee rather than taking an interest in the patients.

Nurse:
- I understand why you think that nurses do not devote enough time to patients.
- I believe that something has upset you deeply. Can we talk about it?

When using the technique of paraphrasing, we do not avoid the possibility of discussion with the patient and the assertive presentation of our own views, but we refrain from it as much as possible. We take our lead from the patient, thus giving them support and learning about their problems. Using this style of communication at this stage in the relationship, we can learn a lot about the problems, attitudes and expectations of the patient. We will never learn that by rushing to attack the patient's views or by defending our own. Allowing the patient to take the lead in conversation evokes their trust and simultaneously provides us with precious information that can be used later in discussions or in providing essential explanations or recommendations.

Paraphrasing or reflecting the patient's feelings is definitely the most advanced technique of active listening. However, the application of this technique requires caution.

General rules of professional communication

In the process of communication, it is important not only to transmit and receive the message, but also to interpret it correctly. A lack of accurate communication makes the patient feel alienated, which in turn breeds fear. That is why the professional nurse and care giver:
- Listens with understanding, shows warmth and sympathy, and smiles in a friendly manner.
- Remains calm while discussing difficult problems with the patient, and presents a facial expression that manifests a willingness to support the patient, while solving the problems discussed.
- Avoids extreme and blunt statements which may evoke a feeling of fear.
- In situations of conflict and under stressful conditions, analyses both their own feelings and the patient's feelings, and tries to interpret their intentions objectively.
- Is assertive.

The nurse and care giver should look professional, which means:
- A neat appearance – while carrying out their professional duties, the nurse should avoid provocative clothing and hairstyles, make-up and jewellery. Nails should be clipped short and unpainted, and shoes should be comfortable, safe and not have high heels.
- Projecting an attitude manifesting inner calm and professional confidence (the nurse knows what her professional duties are, she knows what she should do and how to do it).

2.5. The role and form of non-verbal communication in health care

Verbal communication only constitutes around 35% of the message; the rest is transmitted nonverbally through silence, facial expressions, body movements and tone of voice. Studies of nonverbal communication reveal that only 20% of general knowledge is obtained through verbal messages; the remaining 80% is acquired through nonverbal messages. Mehrabian (Mehrabian, 2007) ascribes an even greater role to nonverbal communication. He claims that only 7% of information is included in a verbal message, 38% in the tone of voice and 55% by nonverbal means.

Nonverbal communication is often referred to as body language. This term refers to the transmission of information without the use of words through facial expressions, gestures or the position of hands, posture, tone of voice, eye contact etc. Every single person, without even saying anything, sends some kind of a message to their immediate environment. It is impossible not to communicate: even a mute and unmoving person communicates something to their immediate environment. A refusal to communicate also constitutes a message.

<u>The characteristics of nonverbal communication:</u>
- The spontaneity of the interlocutor and, consequently, more honesty in the expression of feelings.
- Multi-channel character – the simultaneous transmission of the information using different elements (gestures, facial expression, tone of voice etc.) at the same time.
- A lack of explicitness in the interpretation of the message because there is a possibility that different people will interpret the body language of the same person in different ways.

The literature on the subject distinguishes ten types of phenomena constituting the general phenomenon of nonverbal communication. These are:
- Gestures – movements of the hands, palms, fingers, legs, feet, torso.
- Very rich and explicit facial expressions which can communicate both emotional states and objective information.
- Touch and physical contact convey many signals.

- Physical appearance (clothes, hairstyle, jewellery, makeup, tattoos, the visual presentation of men and women).
- Paralinguistic sounds such as sighs, growls, wails, panting, moans, laughter, giggling, hums (hmmm, uh-huh, mhm) which do not form words.
- Vocal canal (operating voice) – intonation, acceptance, timbre, rhythm of speaking.
- Looks and the exchange of glances – eye contact in which the quality and length of the look is a crucial element of communication.
- Physical distance between the interlocutors – the distance between them during a conversation reveals significant information, e.g. about mutual attitudes, the level of intimacy, liking and trust. Another aspect is the phenomenon of the invasion of personal space (getting closer than 40 cm), as well as the 'invasiveness' of sights, sounds and smells.
- Posture during conversation – the level of tension or the level of tension release and openness.
- Organization of the environment.

There are ill people who crave contact but, in order to reach them, specialist methods have to be applied. For mentally impaired children, especially those with a profound impairment, speech is too abstract. If nonverbal communication is developmentally primal it is, therefore, more accessible for children who are in the initial stages of development, and it provides them with four times more information about the surrounding reality than verbal messages. Consequently, it should be used alongside verbal communication in teaching children who are mentally impaired. There are other methods of communication that can be used with the disabled, e.g. mime and pantomime. They are used to support communication. Mime is a technique of presenting moods, feelings, emotions, some activities, and representing concrete and abstract entities using facial expressions and head movements. Using this method of communication does not require great skill. In general, learning and using mime does not take much time if it is used in natural play with a child. Pantomime is a technique of narration or the presentation of moods, feelings, thoughts and opinions by using gestures, movements of the whole body and facial expressions. It differs from sign language as pantomime uses all of the mobile parts of the body and not just the upper body parts. Using pantomime as a means of alternative communication creates a whole range of benefits for the child. It enables the child 'to speak' with the language of their own body, thereby making it easier to transmit and decode information.

2.6. Selected examples of communication with an ill person

Communicating with persons suffering from a speech disorder

Persons with a speech disorder can feel misunderstood in their immediate environment and usually express this through outbursts of impatience and a lack of emotional control. The nurse, in such circumstances, should show considerable patience and an understanding of the patient's situation. It is important to display a positive emotional attitude towards the patient when talking to them and we should take the following into consideration:

- Eliminate any sources of noise which makes it harder to concentrate e.g. switch off the radio, close the window etc.
- Pronounce words clearly.
- Use simple vocabulary that is understandable to the person we are talking to - adjust vocabulary and use dialect words familiar to the patient if necessary.
- Use short and understandable sentences – complex sentences like 'Do you want milk, soup, a cheese sandwich, or a roll with ham for lunch, Mrs. X?' should not be used.
- In order to be understood, it is better to ask just one question at a time and, if necessary, to repeat this question using the same words.
- Avoid asking open questions.
- Avoid putting pressure on the patient to answer.
- Avoid providing the patient with ready-made answers or words that the patient has difficulty in finding.
- Observe nonverbal behaviours (body language) and analyse the meaning of them.
- Write down questions and answers in those cases where verbal communication fails.
- Use simple speech therapy devices such as boards with pictures, files with the words that are most frequently used, and a chalkboard or whiteboard.
- Avoid making the patient too tired - take a break to let the patient rest when their concentration is limited.

Communicating with persons suffering from a hearing impairment

When addressing a person with a hearing problem, the nurse should stand in front of the patient so that they can see the nurse's face. In the case of a person who is lying down or sitting, the nurse should touch the patient's hand to attract their attention, and should stand in front of the person up to a distance of about 1 metre. The nurse should speak slowly, use short sentences, clearly pronounce individual words and repeat the statement as often as they think it is necessary in order to be understood by the patient. Sometimes, the patient will have better hearing in one ear than the other – in this case, the nurse should stand and talk on the side that has less impaired hearing. If the patient is still unable to hear then writing in large letters can be used.

The level of amblyacousia (loss of hearing) increases with age. When caring for persons with hearing impairment, the same rules as those used for patients with a speech disorder apply. Amblyacousia in advanced old age is, in most cases, diagnosed late, because those who are suffering from it do not notice the condition or they cover it up and adapt to the situation. However, when it becomes a progressive process, a hearing aid is necessary. The nurse or caregiver requires a lot of patience and should consider the patient's situation from the perspective of using a hearing aid. The nurse should get the patient into the habit of using their hearing aid and should teach him or her basic activities connected with the operation of the device such as: putting the hearing aid into the ear, cleaning it, switching it on and off, and setting the volume.

Due to the high cost of hearing aids and the unlikelihood of replacement more than once in several years, the hearing aid should be treated with special care. It should be protected from shock, impact and water. If the nurse plans to shower the patient or wash their hair, the nurse should, after having informed the patient, remove the device and put it in a safe place. A lot of elderly people, especially those who suffer from slight amblyacousia, do not have a hearing aid and do not see the necessity to own one. When communicating with a person who has impaired hearing and who does not use a hearing aid, we must remember several rules:

- Maintain eye contact – the deaf compensate for their impairment by trying to lip read and interpret what has been said on the basis of facial expression and gestures.
- Communicate in full light so that the speaker can be clearly seen.
- Speak slowly and distinctively in a voice that is not pitched too high.
- Talk close to the better functioning ear as amblyacousia is not equal in both ears.
- Use simple and understandable phrases, and repeat them if necessary.
- Use multi-channel communication – speak, imitate described activities, use gestures, and point at objects.

Communicating with persons with a sight impairment

There are different types of sight impairment. Mild sight impairment is common and can be compensated for by appropriately chosen glasses. Severe impairment, leading to partial or total blindness, significantly reduces the ability to care for oneself, or even makes it impossible. Thus, the ability to communicate with the immediate environment is limited. Among the elderly, the most common causes of partial or total blindness are aging and diabetic changes in the eye.

When treating patients with severe sight impairment, the nurse's understanding of the situation and mutual trust are required. The blind, because of their impairment, usually develop a heightened sense of touch and hearing. The nurse must be aware of this, encourage their development and skilfully use these senses in everyday commu-

nication. When communicating with persons who are partially or totally blind, there are several rules of communication that should be observed:

- Only touch a blind person after indicating that you are going to do so.
- Explain everything that you are going to do to a blind person.
- While moving around familiar and unfamiliar environments, describe in detail all of the orientation points. As an option, allow the patient to touch objects and furniture that they are passing, and make him or her aware of space limitations (walls, stairs). Explain which obstacles may be met on the way to toilet, how far it is to the toilet (measured in steps), and warn against dangers such as steps, sharp edges on furniture, and hot beverages.
- Always put items needed by a blind person in the same place so that it is easier to find them.
- Take the patient's hand and show them where drinks are, and where a plate of food or cutlery have been placed.
- In conversation, teach and encourage the self-reliance of the partially or totally blind, motivate them to gain new abilities, praise achieved success and support patients to try again after failure.

Communicating with a sick child

There is sufficient scope to establish a relationship between the nurse, other members of the treatment team and the parents of the sick child.

Communication between the nurse, the child and their parents is an important element of cooperation within the field of child care.

Caring for a sick child also involves caring for the parents by:

- Building trust between the parents, nurses and other members of the treatment team.
- Supporting the patient and their family.

In the case of a young child (up to three years old) and when the child is not yet able to verbalize about their health, it is necessary to build the appropriate relationship with the parents. Communication can:

- Provide a lot of relevant information about the child (in a very short space of time).
- Prepare the parents to care for the sick child.

The range of data provided by the parents includes comprehensive information about the child, which may have potential implications for their current state of health and for the planning, implementation and evaluation of effective activities and therapeutic nursing.

2.7. Communication barriers

As has already been mentioned, the speaker sends a message and the receiver receives and interprets it according to their knowledge and expectations. This is, therefore, the first plane in which a disruption of communication can appear:

- **Interference in sending the message** - the speaker sends a message that is not precise, or is contradictory or not comprehensible to the receiver. The speaker is either unable to, for various reasons (shyness, fear of rejection or conflict), or does not want to transmit clear information Such circumstances lead to a poor selection of content and distort communication – the speaker does not send the information that they consider to be most important. In time, contact between the persons communicating becomes shallow and less agreeable, which in turn leads to a natural tendency to discontinue the contact. This type of relationship is characterized by tension, especially from the speaker, because it is the speaker who must control the message, and who makes it impossible to convey their real feelings which, when suppressed, lead to frustration. Such circumstances and the act of communicating in such a distorted way leads to a so-called 'game'. The relationship is fake, and satisfaction is only felt by the speaker who sets the rules of the game and who decides what will and will not be said.

  However, the opposite situation should also be noted – messages sent by the speaker that are too effusive and too candid may make the receiver feel a sense of threat, embarrassment, boredom, or fear of being forced to respond in a similar way. This may also lead to a discontinuation of communication.
- **Transmitting contradictory messages** - this type of message lacks coherence between the verbal and nonverbal components, i.e. words that express joy while facial expressions show boredom, reluctance or even sadness. In such a situation, the receiver is disoriented. They do not know which information is true – the words or the facial expression. This type of misunderstanding in communication between people breeds reluctance, anger, mistrust, and an inclination to cease contact. It is especially dangerous in the case of children. In extreme situations, people who experience disrupted communication in childhood are not able to establish normal relationships in adult life, and continue to play a game.
- **Interference in receiving a message –** the problem, in this situation, lies with the receiver:
  - A lack of concentration with regard to the content of the message sent by the speaker.
  - Misinterpretation of transmitted information despite the full concentration of the receiver.

  Omitting some elements of a message may be the result of a lack of attention or selective attention. Disregarding facts in a sent message can change its sense. It is often the case that a receiver hears what they want to hear and that which is in accordance with their expectations. This occurs when the receiver has a hostile attitude towards the speaker or thinks that the source of information is unreliable.

- **Situational distortion of information –** the message is transmitted at a specific time, in a specific place and under certain conditions. This may be favourable or otherwise as far as the exchange of thoughts or opinions is concerned. If the conversation occurs in haste or in a noisy environment, or in the presence of strong emotions, a distortion in the transmission and reception of information occurs. A factor that directly influences the quality of the message is a high level of tension in the communicators. The speaker and the receiver try to release the tension rather than come to the point.
- **Non-partner style of communicating –** this situation occurs when the speaker and the receiver focus only on themselves and do not take each other and each other's needs into consideration. **Conversely, in a situation where there is only concentration on the other interlocutor, there is no consideration of one's own needs and desires**. This non-partner style of communication does not allow for an opportunity to express and transmit one's feelings and receive feedback. Such contact does not lead to the formation of an understanding between the interlocutors.

Communication behaviours that may be confusing or frustrating include (Mutha, Allen, & Welch, 2002):

- Smiling or laughing when there is nothing to laugh about (may be a sign of nervousness).
- Giving a soft, limp handshake.
- Standing very close while talking.
- Speaking with a heavy accent or with limited English.
- Making small talk and not getting to the point.
- Not providing the necessary information.
- Not taking the initiative to ask questions.
- Calling or not calling you by your first name.
- Asking personal questions.

2.8. Summary

Communication is the key for people to get to know one another and their surrounding reality, to organize their mental world through the naming of objects, phenomena, events, and by identifying their attributes and the relationship between them. The ability to communicate with others is a source of discovery and a way to test their ability to influence the environment. It is also – besides relating to the thinking and emotional-motivational sphere - one of the key determinants of mental health.

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COMMUNICATION WITH THE PATIENT - A THEORETICAL PERSPECTIVE*

1. Philosophical and psychological sources of communication with the patient

Communication with patients considered from the point of view of medicine or other sciences has its deepest source in human philosophy, and within this philosophy, in the art of dialogue.

In a medical context, dialogue is inspired by the idea of providing assistance to others, as well as to oneself. However, in order to provide assistance to others, the sacrifice of oneself must reach very deeply. In order to understand the patient, their fears and despair, we must experience this ourselves. This eliminates the presence of two separate languages in one dialogue (Buber, 1980).

Conversation plays an important role in the life of a dialogue. On an everyday basis, people speak only and exclusively to themselves, even if this takes the form of a dialogue. 'To themselves' – means that while talking with others we are not able to overcome our own problems and experiences. We are incapable of trying to experience the feelings and experiences of another person (today we speak about a lack of empathy), (Doktór, 1980).

The precondition of a good conversation is that we consider every person we meet as a partner. This means, that we accept that they are different and confirm their personality, even when we do not agree with them. To 'look inside' another person, is to perceive them as a unique whole, as someone who leaves an imprint on the world with their manifestations, behaviours, and attitudes. It is impossible to 'look inside' another person when we assume a purely cognitive position with respect to our

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conversation partner. In contemporary times, the majority of meetings are characterized by an analytical and reductive approach to the other person. At present, there is a notable tendency towards the unification of specific traits, and even to ascribe these traits down to the level of genetics. From the point of view of the philosophy of dialogue, such interpersonal relationships are a mutual objectification (Buber, 1980).

Another barrier limiting the dialogue between people is the attitude of imposing certain ideas on another person. For a 'propagandist', the individuality of a person does not count, exerting an effect on this person is the only real concern. The objective is depersonalization and taking possession of the other person. The counterbalance is an 'opening' attitude (Buber, 1968).

In summary, it should be remembered that the principles of a correctly conducted conversation, involve treating the other person as a unique partner, irrespective of the fact of whether we agree with them or not concerning the issue being discussed. Open expression concerning what we have to say about the problem is useful (avoid using nothing else but assertiveness, which can be turned into a career these days), but without any unnecessary 'babbling'. Avoiding any appearance of directing the dialogue, but instead, maintain its indirect character and spontaneous nature.

Humanistic psychology is a discipline which concerns the elaboration and new interpretation of dialogue. To be oneself is to be a complexity. We are internally complicated, and therefore, this must manifest itself in our behaviour. Finally, to be oneself is to 'make friends' with our own experience. Only after these preconditions are satisfied do we become a person ready for dialogue with another person. The whole of psychotherapy is biased towards the correction of mistakes and deficiency with respect to communication (Buber & Rogers, 1968). Contemporary man suffers from a distortion of communication, both internally, and with others. A therapist helps people to listen to themselves which, in turn, exerts a beneficial effect on wider contacts (Rogers, 1961).

Attempts to report the attitude of a conversation partner play a special role in dialogue. The person who is capable of the most precise expression of somebody else's thoughts will be able to present their views to the other party (today, this is referred to as feedback information). This obviously requires courage, because to strive to understand another person is to agree to a change which will happen in us under the influence of their attitudes. Interpersonal contacts, leading to the creation of new values, are a cure for any anxiety. As a result of meetings and conversations we begin to appreciate other people and their creativity, we can also appreciate its role in the growth of common knowledge (Rogers, 1991).

When describing a person, one cannot omit such concepts as: 'freedom', 'good', or 'generosity'. Each of these concepts is reflected in their relationships with other people. The person who tries to enslave others with any instruments known to mankind (by sex, authority, money, acc. to the author) cannot be free. When we allow another person to be themselves we experience our own freedom and the good resulting from it. Good is born from relationships, and not loneliness (Tischner, 1981).

Each of the very briefly presented theories defines the role of the participants in a dialogue, specifies the framework and language of a dialogue, presents the benefits and duties resulting from entering into a relationship with another person, and lays the groundwork for the theory of interpersonal communication in the medicine and health sciences area (Tischner, 1998), (Descartes, 1960), (Margasiński & Probucka, 2004), (Rogers, 1991), (Tischner, 2006).

2. Ethics of care as a foundation of the relationships between the medical professional and the patient

Medical ethics may be placed on the border of medicine and philosophy. Its medical character is determined by the scope of the problems undertaken, while the ways of thinking about problems of this magnitude and the attempts to solve them originate from philosophical areas, more precisely, from the scope of the philosophy of morality. The basic concepts of the presented theoretical considerations in the area of medicine are: the patient's wellbeing (approached in various ways), and the obligations of a medical professional (also possessing many definitions), (Hartman, 2005), (Witek, 2005), (Biesaga, 2005).

The greatest error, which allows distortions to occur in the medical professional–patient relationship, is a lack of balance between paternalistic and autonomic ethics. Where paternalism dominates the relationship the medical professional is excessively powerful, while in a relationship based on autonomy, the patient's freedom is placed above every other consideration (Bauman, 1996).

We may start by considering the verification of autotelic good, as presented in the ethical codes of physicians, nurses, paramedics, and physiotherapists. The medical code considers as its highest good: life, health, struggle with suffering, and patient care. The order of good is important. Life and health are most important, seemingly this is the correct hierarchy, however, when fighting for life, often, in spite of everything, medicine begins to prolong a patient's death in an unjustified way. The patient and their loved ones must pay for this, financial costs increase, which is not without importance from the point of view of other patients. In another part of the care process, the category of medicine which has the task of controlling pain may become a source of temptation to ultimately eliminate pain as a result of performing euthanasia. While fighting for life and health and struggling with suffering, a medical professional may relatively quickly begin to objectify the patient. The patient's wellbeing is no longer the goal, the patient becomes a mere vessel of abstract concepts, such as health, life and suffering – the person becomes, for the medical professional, a means to obtain a goal. Therefore, among the autolytic virtues in medicine, patient care should always be placed first. In the context of rescuing life, the restoration of health or the alleviation of suffering should be considered (Szewczyk, 2001).

In order to define patient care and justify its primacy among autolytic virtues, medical professionals should specify the patterns of the medical professional-patient relationship in terms of an I/Thou relationship. It is widely acknowledged that this

relationship is asymmetric, it seems that the medical professionals possess all of the knowledge and experience, therefore, certain thoughtful individuals propose a role reversal. The patient should become the master and teacher (Szewczyk, 2000).

The patient is an expert in their own pain and suffering, and have their own understanding of the world, including a unique perception of disease and death. The obligation of a medical professional is, by listening to the patient, to recognize their world, and assume an open-minded approach to the patient's statements (we should not exclude body language) (Szewczyk, 2001).

Nevertheless, medical obligation does not end with the activity of listening. Attentive listening should be followed by a response (Szewczyk, 2000).

In order to understand the patient's statements and properly respond to their requests, the medical professional must not only listen, but also be aware of the patient's entire sociocultural context. The lack of a proper understanding of the patient excludes the possibility of adequate care. A wide range of socio-psycho-philosophical knowledge concerning the patient and their environment is, of equal importance to the process of care as medical knowledge *sensu stricte* (Szewczyk, 1998).

The concept of autonomy manifests itself in a relatively specific way, it is said to stand for freedom of choice with regard to ways for medical staff to do good, which in any case must be a response to the patient's request. The medical professional has a right, which is a positive freedom, to do good for a patient and to care for them. The patient's autonomy is restricted by compassion. Although a widely understood virtue is whatever the patient themselves considers to be of value, they are not allowed, in a moral sense to demand services, which would be a manifestation of unconcern with respect to the patient, or would be of an unjust character in relation to others (Szewczyk, 1994).

In the case of unrealistic patient expectations, the medical professional has an obligation to convince the patient about the moral inadmissibility of such a request. The dialogue between the medical professional and patient, apart from issues concerning care, has been framed by one more value – justice. This value inspires us to regard the care of the patient from the point of view of the moral health of society as a whole. The conduct of the physician or nurse who cares for the patient in an 'unrestricted' way (intent and means inadequate for the needs of the patient) may be considered as an example of injustice.

The basic values in the ethics of care are: occupational perfectionism, the abovementioned autonomy, patient's confidence, the patient's life, health, and the elimination of pain and suffering. In this context, pain and suffering are general concepts, their substantiation will include the comfort and dignity of the dying, as well as providing

a death which is widely known as a 'calm death'. In certain circumstances, providing care should limit activities which serve to sustain life. Dying and death are not relative, but are in fact the final stage of earthly life, and in some circumstances, a discontinuation of the fight for survival is the most appropriate course of action. The fight for survival is replaced by concern and care for the dying person. In the ethics of care, only the prohibition of euthanasia has an unconditional character.

The patient, within their scope of freedom, has at their disposal the possibility to break their relationship with the medical professional. In the cases where this relationship remains intact, in the ethics of care, another value is apparent – patient's confidence. The obligation of the medical professional is to respect the patient's confidence and never abuse it. The breaking of the relationship caused by the loss of confidence in the medical professional is considered to be a moral fault of the medical professional (Szewczyk, 1998).

In the process of building confidence, the space between people is filled with various emotions, ranging from sympathy, through to friendship, to love. The most appropriate state of emotion between the patient and the medical professional is sympathy, which may be understood as empathy (the understanding of someone else's emotions, and not feeling the same). Love brings about fear for the beloved person, which hinders proper care. Compassion should not be confused with love (Szewczyk, 1998 c).

Such a relationship has been termed the medical professional-patient relationship which is in accordance with the values of an alliance. This alliance has the character of a dialogue, and is based on trust on the part of the patient. In order not to cause a breakdown in the alliance, medical professionals must resign from their role of being experts and renounce their claims to being infallible. They do not have to have the final word in their dialogue with the patient, but rather, their attitude should be accompanied by an awareness that when they are in contact with the patient they are obliged to take into account the patient's sense of pain, suffering, helplessness, feelings of guilt and shame, as well as possible insincerity resulting from the shame of feeling guilty, and often also rebellion and aggression resulting from the feeling of being at a disadvantage. A medical professional should, in their relationship with the patient, simultaneously consider both occupational and moral standards. The maintenance of the patient's confidence consists of the activity of constantly striving to find a balance between one and the other. This is how, in the ethics of care, medical occupational professionalism is understood. A good medical professional is not only fluent in the technical part of their occupation, but most important of all they have a certain wisdom. Moral norms obtain their validity only due to ethical virtues. A wise man triggers the entire system of care. The most important virtues of a medical professional are moral sensitivity and the need to recognize and assimilate values, which must be accompanied by intellectual sensitivity. A wise medical professional constantly expands their medical and ethical knowledge, and respects the autonomy

of others, is tolerant, kind, patient, loyal and evokes trust. These virtues are the basis which allow for patient care.

Concern should always be accompanied by the skills of listening and empathy. Such knowledge and skills should be acquired as early as the basic educational stage. The acquisition of such knowledge should take place at every stage of occupational development.

In the patient-medical professional relationship, the latter must always be aware of the ethical goals of their current activities concerning healthcare, life, dignity or the comfort of the dying (Szewczyk, 1997).

Undoubtedly, an extensive interpretation of the ethics of care concerning behaviours with respect to the patient, such as caring, listening, responding, gaining knowledge of the patient's philosophical-social context, is a very humanitarian reference to another person which, in this case, is the patient.

It establishes high requirements for the medical staff, which are similar to the requirements of being a wise person, i.e. being sensitive, patient, tolerant, evoking confidence, being open to knowledge, and somehow combining all of this with developing medical and behavioural skills. This is indeed an unattainable ideal for the medical professional, however, it is worthy of attempts to attain it. In practical terms, this postulate concerns new methods of education for future medical professionals at medical universities.

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EMPATHY IN THE MEDICAL PROFESSION – THEORETICAL CONSIDERATIONS*

1. Empathy in selected concepts of morality and professional ethics

Morality has at least two dimensions. It may be regarded as a sphere of obligation and duty or as a sphere of values. In the sense of duty, it may be understood as a commitment to another person, resulting from respect for humanity in general. It results in good (appropriate in a social, psychological and religious context) deeds. Nevertheless, it is based on the definition of a person as a rational, free, inviolable being with a personal dignity. Ethical activities in this area are based on the ability to behave in a moral fashion, in other words, to have moral virtues.

Morality which is understood as a value system belongs to an area of ideal virtues that have a non-material character, e.g. love, friendship, beauty and goodness. Both dimensions may be considered separately, but it is necessary to remember that they must also be complementary. From this point of view, they will also be considered below in relation to the phenomenon of empathy (Hartman, 2012).

MORALITY AND EMPATHY

Empathy was widely recognized by philosophers (including Aristotle, Hume, Smith) as a condition that is necessary for moral behaviour. Unfortunately, the determination of the relationship between empathy and morality is quite difficult. First of all, the existence of multiple definitions does not allow one to completely distinguish between empathy and other emotional states, e.g. sympathy or compassion. In addition, a number of modern theoreticians define empathy as a condition of morality but a similar number of them reject this hypothesis. Attempts to systematize this concept include making a distinction between moral norms and social agreements, the significance of which is independent of politics or culture and referring the concept of empathy to them, as well as specifying that the actions taken as a result of empathy which are aimed at satisfying selfish desires are not of a moral nature (Hauser, 2006), (Prinz, 2011), (Printz, 2004).

The definition of empathy from a cognitive or emotional perspective is another empathic-moral problem. If we define the phenomenon of empathy emotionally, then its relationship with moral behaviour may be regarded as being based on intuition. A feeling of pleasure demonstrates the propriety of conduct, and anxiety is a sign of immoral behaviour (Ugazio, Majdandžić & Lamm, 2014). However, this approach is characterized by the difficulty of proving its authenticity. Cognitively understood empathy assumes that moral principles are based on getting to know the feelings of another human being, through the analogy of our own experiences or reimagining one's emotions, and on the rational assessment of whether the deed resulting from these feelings is morally valuable. Rational assessment is based on certain principles:

1. Don't treat other people as a means to achieve something.
2. You cannot discriminate against other people in your actions (DeVignemont & Singer, 2006).

Morality built on cognitive empathy lacks the aspect of motivation that prompts people to adopt an altruistic attitude (Schwartz, 2005). Both approaches have their weak points, which is why linking theories have emerged recently, i.e. complementary definitions of empathy. The emotional component is associated with motivation as a driving force for moral actions, and the rational component allows for the acquisition of knowledge about moral norms (Campbell, 2005).

People's empathic/moral behaviour is included in five dilemmas describing the individual's prosocial behaviour.

A human being is an emotionally unengaged observer of another person's pain and suffering whose origin is not significant (physical, emotional or material). One must decide if they are willing to help, and if not, how will they feel about it?

In the case where someone has harmed another person or intends to follow this course of action, should he refrain from such activity, and if not, will they feel remorse?

If a person is an unintentional perpetrator of harm to another person, should they, despite unintentionally inflicting harm, feel guilty? Many people make moral demands of one person at the same time. If they cannot help everyone, who should they help and will they feel guilty that they couldn't help everyone?

If we are dealing with the mutual abolition of moral principles, e.g. care and a sense of justice, which should be chosen and will the choice of only one of them result in moral anxiety in the individual? (Hoffman, 2006).

A comparison of the abovementioned research concerning the phenomenon of empathy, lead us to reflect upon the fact that empathy is not a necessary condition for the moral behaviour of a human being, but rather, it facilitates the systematization of

the social life of an individual (Kennett, 2002). It has an influence on the universal recognition of moral norms (Hoffman, 2011), and is a factor that activates moral behaviour (Eisenberg, 2000), it also affects the level of human moral sensitivity (Pizarro, 2000). Empathy mechanisms are the essential foundation for the formation of moral feelings (Hoffman, 1981), however, empathy alone may also be considered a moral feeling (Załuski). It may affect judgment and moral reasoning (Churchland, 1970), it may refer to moral actions at the present time or create their models (Damasio, 1999). It definitely influences the prosocial development of a human being (Cialdini, Brown, Lewis, Luce & Neuberg, 1997). Empathy is a source of altruistic behaviour (Wojciszke, 2006): this results from the distress caused by the suffering of others (basic form), this form of behaviour is also the result of empathic concern which is not focused on one's own emotional experiences (highly advanced form of empathic reaction). Empathy inhibits aggression and reduces the general level of anti-social behaviour (Batson, Sager, Garst, Kang, Rubchinsky & Dawson, 1997), it may be regarded as a reflection of one's conscience (in religious terms), (Stach, 2012). It is a fundamental aspect of the professional attitude in the caring professions (Strus, 2012), (Darwall, 1998).

2. Empathy and the professional ethics of a doctor and a nurse

Working with a sick person requires special psychological predispositions from nurses and doctors, as well as proper preparation and a knowledge of professional ethics (Kowalska, Jarosz, Sak, Pawlikowski, Patryn, Pacian, & Włoszczak-Szubzda, 2010). In brief, the Code of Ethics meets five goals (Ladd, 1997):

- It sets the boundaries of ethical behaviour for a professional group.
- It aims to increase the awareness of group members of the moral aspects of their work.
- It integrates the professional group and protects ethical standards in professional practice.
- It is a reference point in resolving moral conflicts.
- It indicates what the public may expect from a member of a given professional group.

Regardless of the level of detail of the codes of ethics that will be developed in the future, none of them may be able to refer directly to oscillating moral dilemmas, e.g. those that revolve around a conflict of values. In addition, to some extent, code ethics free their recipients from the obligation to practice moral reflection. After all, 'if we follow the rules of the code then we do no wrong' (Kołakowski, 1967).

Another argument against treating ethical codes as the sole and final expression of the moral attitudes of medics is that medical professional codes are often confined to the sphere of the theory of values. Everyday professional life creates mercantile and conformist attitudes. First of all, this happens because many moral principles are not universally accepted in the social environment in which medical professionals operate. It may also occur that medical professionals lack the proper attitudes which are based on generally accepted social principles. Another element of the relationship between ethical codes and moral attitudes, including an empathic attitude, is the teaching of attitudes based only on norms and code rules. Codified deontological rules alone will not guarantee proper conduct, and practice is necessary to shape moral (empathic) sensitivity. Good practice should be based on authorities in this field. Bearing this in mind, one might ask how best to evaluate the moral predispositions of a future doctor or nurse? Initial apprenticeships would probably play an important role in this assessment. In this case, a young person would learn, during their initial placement, not only the practical skills necessary for their future profession, but would also become acquainted with certain moral requirements, that appear when facing pain, suffering, fear, etc (Lazari-Pawłowska, 1994).

Codes of ethics in the medical professions have always had the benefit of the patient as their guiding principle. At the present time, bioethics interprets this fundamental virtue in a context that is broader than a purely medical one. The benefits to the patients include their right to make informed choices, the right to profess a belief in value systems other than that of the medic, the right to protect human dignity, to prevent suffering and the right to privacy and fair treatment. The patients have the right to self-determination and to obtain information about their health. The benefits of perceiving the patient in this way have clearly evolved in character. The multi-faceted character of this issue makes it difficult to maintain moral attitudes without additional guidance beyond code norms (Przyłuska-Fiszer, 2007), (Marczewski, 2007).

A good source for supporting the codes is the knowledge derived from descriptions of the experiences of individual medics. Unfortunately, so-called case studies, which are the source of practical medical knowledge, are devoid of a psychological and moral description. They do not mention the activities that the medics had to take moral responsibility for, which moral tools, such as empathy, they had to use for the benefit of the patient and how they used them.

As a result of a lack of this type of knowledge derived from moral experiences in medical practice, at present, an attitude of pseudo-professionalism prevails, which is devoid of references to morality or only refers to it in a twisted way. This pretence of professionalism and an improper reliance on moral codes causes a great deal of social damage to patients, their families, and above all to the medics themselves. Being truly professional at work may be manifested in various ways. In a caricatured form, it is limited to obtaining a professional title, doctor or nurse, and in addition, it is based on codes, medical professionalism is turned into a kind of ideology, the followers of which primarily protect themselves and their own interest group and explain their bureaucratic behaviour using some sort of self-defence (Pellegrino, 2002).

True professionalism may be noted in the attitude of a medic only if they have the qualities required to be a moral human being, with an outlook based on empathy, and they are more than just a technically efficient representative of the medical profession.

The list of moral virtues of a medical professional is a fairly extensive collection. Starting from intellectual honesty, through to kindness, humility, trust, compassion, prudence, justice, bravery, moderation, honesty and modesty to avoiding avarice. However, it is not enough to adhere to such values, an empathic, moral medic must be able to practice them (Szymańska, 2007). Practice raises many ethical dilemmas. The principle of faithfulness to the truth, i.e. providing patients with full medical information about their state of health, when used without empathy, i.e. the ability to sense the patient's actual needs (sometimes the patient wants to know the truth in part, and sometimes, although seemingly asking about it, does not want to know it) may cause harm in many ways. It may, for example, deprive the patient of the will to

fight the disease, it may diminish or even eliminate their trust in the medic, which will adversely affect further therapy, etc. There is no one right answer, the codified norm alone, which offers guidelines for correct behaviour in given circumstances, resembles a game of chance without an empathic approach based on the medic's own experiences and perceptions of appropriate behaviour. When one considers the principle of not harming the patient, one should also appreciate that, at the present time, this should not be understood in purely physically terms. However, even this way of understanding harm creates a multitude of possibilities, not to mention situations where other aspects of humanity such as mental, social or spiritual ones are taken into account. Each of these factors may collide with one another as far as the welfare of the patient is concerned. The professional everyday life of nurses also carries many moral dilemmas. These problems include the undermining their authority, by another nurse or by a doctor, this may diminish the patient's trust. Another potential problem is the appearance of iatrogenic errors and the attitude of the nursing staff towards them, mutual accusations, a lack of guilt, avoidance of responsibility, etc. The failure to maintain professional secrecy is associated with dilemmas concerning who is permitted to be the recipient/sender of information and who isn't. Showing disrespect for the patient's human dignity, manifested e.g. in excessive subjectivity or labelling, is a serious cause for concern. Resolving these dilemmas is associated with numerous choices of conduct that are not always a good compromise. The decisions which must be made become ever more difficult, the more that other people may be potentially harmed as a consequence - the patient, their family, another medic, or the ideals of the profession of a nurse or doctor may be violated. So how is one supposed to cope with ethical dilemmas that change over time and cultural context and which are not resolved by ethical code standards? (Janus, 2019). Perhaps, in a similar manner to that of Socrates, we could begin by asking emotional and moral questions of ourselves and others, with an openness to change and with the appropriate tools for exercising compassion, such as empathy. Empathy, which allows medical professionals to recognize their own and the patient's moral needs, as an altruistic act, will be able to satisfy those needs (Pellegrino & Thomasma, 1993), (Pellegrino & Relman, 1999).

3. Empathy in the doctor-patient relationship

Patients questioned in satisfaction surveys express their approval when they experience good communication with a medic. They look for information and understanding, kindness, tact and gentleness (Hartman, 2012).

Personal requirements from patients which are presented in such a way may only be seen from a psychological and social perspective (personality traits, social attitudes). Therefore, they may be situational, the doctor or nurse may be empathetic depending on external conditions. Only the moral roots of empathy guarantees its stability and, as a consequence, the invariability of the proper, reliable attitudes of medical staff (Hartman, 2012).

Therefore, if empathy has its foundation in morality, thus maintaining stability, it can undergo a transformation to the stage of being a psychological tool necessary for good communication with oneself and with other people. Such a tool makes it easier to imagine oneself in the role of other people and, as a consequence, to adopt the appropriate helpful attitude towards them (Hartman, 2012).

Most doctors, when asked about the basic feature of a professional approach to patients, mention professional competences in a purely medical sense. However, when patients are asked the same question, they list the psychological features of a medic, and these are built around empathy (Włoszczak-Szubzda & Jarosz, 2013), (Włoszczak-Szubzda & Jarosz, 2012).

Following the principles of empathy, let's try to imagine ourselves as patients and attempt to answer the question of what they might expect from a doctor. It may seem like they would mainly expect help in fighting against their illness, and this is undoubtedly the ultimate goal. However, over the course of an illness, there are various goals, and they become predominant in the immediate situation that the patient finds themselves in. If we assume that it is not known for certain whether the doctor will be able to cure the patient or not, then personal interest – and not only medical understanding and support - comes to the fore. The fulfilment of these elements is conditioned by empathy. One sign of personal interest is a conversation that mentally empowers the patient, while at the same time allowing for the development of a constructive medical practice. Such a practice extends the existing knowledge about the circumstances of the illness over time. The demanding attitude of the patient is also minimized, for example, for patients with a medical internet knowledge, which they acquire in order to minimize their own fears, but

quite frequently multiply them instead. Taking an interest in the patient, and developing understanding and support might form the basis for enhancing the patient's interest and openness. At the same time, a factor that should not be overlooked is that empathy which may be understood as co-suffering harms both the patient and the doctor. It emotionally disrupts the medic, thereby depriving them of the mental strength necessary to make professional decisions, and if continued over time this may result in a burnout, with all of the associated personal consequences, from depression to self-aggression. The compassion shown by the doctor may deprive the patient of the opportunity to receive effective treatment, and on occasion it may even lead to a deepening of the patient's emotionally difficult condition. In summary, when observing the doctor-patient relationship from the point of view of the latter, it is obvious that the empathic approach, if properly understood by the doctor, benefits both sides of the relationship.

Now let's take a look at the position of the doctor in this relationship. In numerous satisfaction surveys, patients accuse doctors of behaviour that may be described as the objectification of the patient (Du Mont, Macdonald, White, Turner, et al., 2014), (Kilgert, Rybizki, Grottke, Neurath & Neumann, 2014), (Challenor & Perry, 2014). There may be many reasons for this. These may include personality deficiencies - moral, psychological, social – all contributing towards a lack of skills or reluctance (e.g. based on malice) to read the emotions of others. These are the deficiencies that may or may not be corrected (psycho- and sociopathy). However, it may also be the case that the doctor is able to read the patient's emotions very well, but due to a lack of proper empathic tools, they are either unable or afraid to refer to them. A formal 'ladder' of medical consultations may be a useful tool in overcoming this type of anxiety (Pendleton, Schofield, Tate & Havelock, 1984).

The basic goals of these consultation are defined by seven principles, and each of them uses empathy as a cognitive tool and a factor that triggers the act of helping the patient. At the same time, they benefit both the patient and the doctor, the latter in the form of reducing their fears of the patient's emotional world, imparting a sense of agency and improving self-esteem.

Within the framework of these principles one should:

1. Define the reason for the patient's presence (Tate, 1994).
   This is not however limited to the determination of the disease problem. The doctor needs to be aware of the full medical history of the patient as well as their fears and expectations. Ask the patient about their thoughts and feelings. Diagnose whether or not the patient is clearly aware of them and any competing motives (what the patient really expects, if there is an expectation of healing). Learn about the role of loved ones, more particularly, which role they can play in the process of therapy, and whether or not it is motivational.

2. Doctors may need to consider other problems (Byrne & Long 1984). Undoubtedly, a doctor should start their assessment by determining the risk factors that may have affected the current health status of the patient (e.g. smoking or obesity). However, this rule is not only limited to the above-mentioned findings. A good doctor-patient relationship assumes a knowledge of the broader social context of the patient. This knowledge will help the doctor to understand, e.g. why the patient is dirty, which might seem a trivial issue in the treatment process, but is often raised in the defence of the dignity of a doctor. It will also allow, commensurate with the patient's material resources, the use of the appropriate medication, which will give the patient the assurance that they have been fully understood and respected.
3. The doctor should choose the right course of action that is suitable for the patient (Balint, 1964). Most often, this should be a clinical activity, although sometimes it is enough to comfort the patients, refer them to or treat them in cooperation with another specialist (including a psychiatrist or psychologist) or to listen with attention to their complaints. An empathic doctor has a greater chance of choosing the right method, and should also know if all of the activities within this method are necessary and in what order they should be carried out.
4. Doctors should strive to achieve a mutual understanding with the patient (Roter, Stewart, Putnam, et al., 1997). This does not mean that the patient must necessarily become a specialist in the medical field of their illness, but rather, it is important that they understand its aetiology, at least to an approximate extent, and are reasonably well informed about the therapy plan and agree to it. Patients should have a knowledge of what lifestyle changes would help them to achieve and maintain their health. They should understand why they are subjected to certain treatment regimes. This is important from the point of view of patients taking responsibility for their own illness and health. If the full responsibility for the therapy is on the physician's side, they must become a type of guardian who make sure that all treatment requirements are met throughout the therapy. And in this case, a therapeutic failure will be their personal failure. The achievement of the abovementioned goals is possible only if the patient is provided with genuine information (it is not enough just to provide knowledge, the medic should also check if the information is properly understood, while respecting the patient's dignity and treating the patient as a partner). Also, comprehensive listening promotes the sense of a therapeutic bond between the two sides of the relationship.
5. Involve the patient in managing their therapy (Stott & Davis, 1979). The involvement of patients in the process results in them taking responsibility for their health. Under this principle, it is of great importance that the physician builds up the patients' motivation, sometimes even to fight for their life, this may be accomplished for example, by including the patients in a discussion concerning alternative treatment methods. Patients are, for the most part, not equal partners in terms of competencies (apart from those patients who are also medics), but they are more familiar with their own bodies than anyone else, and have an intimate

knowledge of their capabilities and needs. Finally, it is worth noting that these are their bodies, their health and their lives, which are only entrusted to a doctor in good faith.

6. Use the time and resources intended for patient therapy in an appropriate manner (Deveugele, Derese, De Bacquer, van den Brink-Muinen, et al., 2004). Given that both are limited, the rule above may seem difficult to implement. A lack of time is a common reason used by doctors to justify their poor communication skills. Due to a lack of sufficient time, they claim that they cannot treat their patients properly, with care and dignity. Most often, however, the lack of communication competencies is the result of avoidance behaviour towards the patient. However, it is impossible to disconnect the aspect of the patient's physicality from the mental, social and spiritual spheres of the patient. These factors form an integral whole and, within the entirety, each of the spheres affects the others. Therefore, it cannot be said that, when dealing with aspects of the patient other than the physical ones, that the doctor is wasting time that could be devoted to proper medical activities. The appropriate use of medical means is not possible without the correct application of all of the principles above including the last one.
7. Properly build and maintain a relationship with the patient (Ogden, Bavalia, Bull, et al., 2004). In the emotional sphere, this means exploring the world of the patient's own feelings. It is a case of not trying to avoid emotionality, but also not becoming 'infected' by it either in a pseudo-altruistic way. It is appropriate to share sadness and suffering, or in a selfish way, showing an understanding of the level of aggressiveness shown by patients, by bearing in mind that the patient, due to their illness is emotionally disturbed. The emotional reactions of some patients may take extreme forms (arguments, quarrels, screams), and most often these behaviours are not aimed directly at any particular doctor. These reactions may occur as a result of the direct 'transmission' of emotions from a medic, they are manifested by a retaliation in the form of aggressive behaviour, usually verbal.

The appropriate doctor-patient relationship remains crucial for successful medical practice, where the patient, not the illness, should be the centre of attention.

Which set of skills in the area of communication competencies, and especially empathy, should a doctor possess in order to properly follow the principles of medical consultation?

There are many different skills that a doctor should possess if they wish to conduct consultations which are characterized by an openness to other people. A doctor should be able to speak, listen, ask questions and show emotions. These are seemingly simple skills (for some, only the last one is simple) for every educated person. But is it really that simple? Let's begin with an attitude that is centred around another human - the patient - from the very moment that they cross the threshold of the doctor's examination room. At this point, the process of the empathic behaviour of the medic should begin.

Physicians, through the use of their own experience or imagination and observational skills, should remember that the patient is most often in a strange place, in addition, they are often there for the first time. In the corridors of hospitals, patients often meet staff members who separate themselves from them with the use of a particular sort of body language (usually hardly anyone from the hospital staff looks at patients in the corridor, smiles at them, or even notices them), they wear uniforms and medical outfits, they may give the impression of being a compact group ranged against the patient. Therefore, the entire burden of ensuring the psychological comfort of the patient falls on the shoulders of the doctor. The medic must create an atmosphere that allows patients to confide their ailments. In their presence, the doctor should not, for example, complete his paperwork and leave the patient sitting on the chair next to him. Something that is a daily routine for the doctor is a one-of-a-kind experience for the patient, and one that may be potentially emotionally harmful.

Talking to the patient or asking them questions also follows its own specific path. The questions should usually be characterized by openness. Unfortunately, many doctors are afraid to ask open questions because they fear that the patient might bombard them with information, which would make it impossible for them to isolate the most important statements from the stream. However, practice has shown that, under the condition of following certain rules, doctors should not be at risk of such consequences. The patient's statements should be interrupted in order to seek an explanation or the clarification of details. In addition, the doctor should be attentive towards to the speaker, and should also take short notes from time to time to help them to return to the topics that seemed important. Body language in the form of nodding and verbal confirmation gives the patient the reassurance of being listened to. Of course, there may be patients to whom closed-ended questions are addressed, but in these cases, it is worth trying to establish the reason for reticence, which may be important in building a further relationship (Kurtz, Silverman., Benson., et al., 2003).

In part, in the description above, we began to discuss empathic listening. But this is only a small part of the art of listening. An important element of listening is paraphrasing, in other words an attempt is made to understand the words of the patient correctly, by communicating to the patient in their own words how they were understood. The basic benefit of paraphrasing lies in convincing other people, in this case the patients, that they are really being listened to. Paraphrasing often alleviates conflicts and prevents the growth of anger. It excludes guesswork, and instead provides the patient with a degree of confidence about mutual understanding. It helps the interlocutors to remember what the conversation was about. And above all, it diminishes many barriers to empathy, such as judgment or unfair comparisons. Paraphrasing should be accompanied by attempts to clarify the situation, i.e. a request for more information in order to understand the patient. In addition to this, during a more precise review of the patient's case, not only a mental but also an emotional context

appears. Active listening cannot exist without feedback, i.e. information about the reception of the speech by the listener. This feedback gives one the chance to correct an erroneous interpretation and change it to a correct one, thereby quickly resolving misunderstandings (McKay & Davis, 2001).

Empathic listening means listening with the right attitude, and when experiencing a patient's aggression, it allows one to ask important questions such as - what unmet needs of the patient have produced the anger that has appeared? What perception of danger is our patient experiencing? What does he really expect? (Jamrożek & Sobczak, 2000).

As a part of their medical explanation, in conversation with the patient, the doctor should use language that the patient understands. The most important information should be given first. The repetition of information is also important (AC: However, this should not be done in a pushy way, so as not to create the impression that the patient is perceived as an intellectually disadvantaged person). By asking questions, the doctor should ensure that the patient has memorized the information they were provided with. And it is also worthwhile supplementing the whole conversation with a short note for the patient and possible visual aids (Neighbour, 2004). Empathy in all of the dimensions of the doctor's practical conduct in relation to the patient is an important element of therapy. And in relation to the therapy of some patients it is the most important element (Bub, 2004).

4. Empathy in the nurse-patient relationship

Let us now move on to the phenomenon of empathy with regard to nurses and their empathetic behaviours. From a formal point of view, the nurse takes care of the patient's body in terms of therapy, hygiene, healing and other aspects, they perform basic medical procedures and administer or provide help with the administration of medication. However, their list of their responsibilities is not limited to the above. First of all, patients expect nurses to support them, this helps patients to relieve their anxieties and fears, sometimes this is accomplished through the provision of information, and sometimes with (AC: as much as!) conversation alone. Unfortunately, these expectations and the guidelines of how to meet them have never been clearly defined, which causes a lot of mutual frustration. It remains unclear how much information nurses should provide to patients about their illness. Where is the boundary between providing help in the form of dispelling a patient's anxieties through specific information and disobeying an obligatory order to maintain discretion (e.g. informing loved ones)? Another issue is to determine the final measure of the effectiveness of a nurse's work. It would seem that it may be the speed of the recovery of the patient. This measure of progress, however, is closely associated with a sense of satisfaction. So how is one supposed to deal with the dissonance between striving to improve the patients' well-being and the difficulties involved in meeting their emotional needs? Furthermore, there is the issue of one's own emotionality, i.e. an inappropriate empathic attitude in the form of excessive emotional involvement (Kagan, Evans & Kay, 1986).

The correct empathic attitude of a nurse is based on the state of her emotional health. A nurse who demonstrates genuine interest, acceptance, care, compassion and joy, rather than anger, contempt, disgust or fear, creates a safe environment for the formation of an emotional bond with the patient at a professional level. The patient receives the nurse's emotions indirectly, not in a verbal form, in this form of communication the usage of appropriate phrases can be learned, but from their manifested body language that is a reflection of his or her true emotional state (Greenberg, 2007), (Pascual-Leone & Greenberg, 2007).

The appropriate emotional environment, and hence the adequate empathic attitude of nurses is, as shown by the research on this subject, the basic condition for successfully helping the patient. Patient health is not only influenced by the provision of proper medicine or care, there are other factors. For example, it is influenced by the method used to provide treatment and the general atmosphere of treatment and care (Benedetti, 2002), (Dulmen & Bensing, 2002).

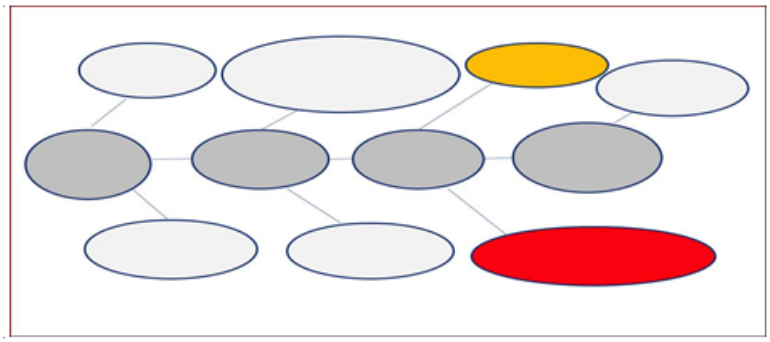
When considering the effects of empathy from the patient's perspective, researchers agree that they are only positive (Di Blasi, et al., 2001), however, the assessment of the effects of empathic attitudes on nurses is much more complicated. A nurse's empathy may be described in five ways (Kunyk & Olson, 2001):

1. As a personality trait.
2. As an attitude of helpful professionalism.
3. As an element of the communication process.
4. As an element of care.
5. As a special bond.

The phenomenon of empathy in the medical professions consists of moral, emotional, cognitive and behavioural elements, and also the fact that psychological concepts of empathy are very poorly suited to the daily professional practice of nurses (Morse, Anderson, Bottorff, Yonge, et al., 1992). Four patterns of communication based on empathy may be distinguished (Morse, Bottorff & Anderson, 1992):

- The empathy of a nurse leads to a mutual understanding (with the patient, another member of the medical team).
- The empathy of the nurse reflexively focuses on herself and is shown verbally and nonverbally (often leading to misunderstandings).
- An empathic response is a professional response to a patient on whom the nurse is professionally focused.
- An empathic reaction is the result of the nurse's focus on her own emotionality.

The negative effects of empathy have been described in the scientific literature using the term 'compassion fatigue', which was first mentioned in the nursing literature in 1992. The nurses concerned were questioned about aspects of the relationship between the stressful experiences of patients and the emotional state of the people helping them. The severity of the traumatic experiences of the dependants had an adverse effect on the emotional state of the caregivers which could be manifested in the form of secondary traumatic stress (in nurses) and compassion fatigue (Adams, Boscarino, Charles & Figley, 2006), (Figley, 2002). Ch. R. Figley built a model of 'compassion fatigue'. Starting from the personal empathic resources of the nurse through to the patient's distress and its reception by the nurse, we arrive at an empathic response that shows the strength of commitment and level of satisfaction. As a result, there may be negative effects in the form of a prolonged exposure to a stressful situation and the triggering for the nurse of her own traumatic memories, which in turn leads to compassion fatigue and the disruption of personal life to a varying degree.



Patient's distress	Emotional engagement	Exposure to stress	The degree of life disruption
Personal empathy resources	Empathetic response	Personal stress related to empathy	Compassion fatigue
Empathic motivation of a nurse	Satisfaction	Traumatic memories	

Fig. 1. Empathy Model.
Source: own study based on Compassion Stress and Fatigue Model by Figley (1997)

Personal resources of empathy ('empathic ability' after C.R. Figley) is the ability to see the pain and suffering of others. If the level of empathy of the helping person (nurse) is low, then the degree of stress resulting from compassion - and consequently fatigue - will be lower, but the ability of the nurse to help the patient will also be lower (Figley, 1982).

Nurse's empathic motivation – is the motivation to respond to other people's emotional needs. At its core lies the development of empathic predispositions through training and the broadening of the scope of knowledge (Figley, 2002).

Patient's distress, i.e. the direct exposure of the nurse's emotionality to the patient's traumatic experiences. The costs of this direct exposure to the suffering of others can be very high, especially when the helper (nurse) does not have the proper emotional protection tools.

An empathic response to the patient's emotional needs – this type of response consists of reducing the patient's suffering through empathic understanding. This insight into a patient's feelings is achieved by crossing one's own emotional boundaries and trying to perceive reality from the patient's perspective with all of the gravity of the pain and fear that accompanies the patient during the treatment process. In the absence of sufficient intrapersonal skills and an empathic response that is too strong, the helping professionals may also experience these unpleasant emotions themselves (Figley, 1989).

Emotional commitment – overexposure to strong emotions can cause stress to the nurse (AC: medic) as a result of compassion. Due to the insight into their own emotionality, caring professionals should be aware of the extent to which they can empathize with the sick, and from what level of emotional involvement this phenomenon will begin to harm them, by lowering their mental resilience, as well as resulting in their improper functioning not only in the work environment, but also in their personal lives.

Satisfaction – a sense of success is one of the factors that may reduce compassion fatigue. It most frequently appears as a result of a patient's health improving, but not only. Good interpersonal relationships, which very often result in patient feedback concerning satisfaction with the work of a nurse, also produce a sense of satisfaction and professional fulfilment. The ability to separate work and private life is also a form of protection.

Exposure to stress – in order for the stress not to be harmful, it is important to maintain the right emotional distance (AC: it cannot involve distancing oneself entirely from the patient's emotionality or take the form of a closeness that puts the feelings of the nurse into emotional turmoil). In addition, the nurses (medics) should be able to distance themselves from work-related problems after finishing work. The caring professionals must develop for themselves, based on intrapsychic reflection, a self-care program, which includes the tools necessary to build a sense of satisfaction at work and maintain the proper relational distance in their contacts with the patient and their family (Figley, 1995).

Responsibility beyond measure – an excessive sense of duty, and in the case of Poland, working too many shifts with insufficient breaks, results in a situation where the nurse's (medic's) emotionality is constantly affected by the sadness and suffering of patients. Empathic professionalism can only be provided while ensuring an adequate rest and proper breaks in helping other people (Figley 1995).

Traumatic memories – these are memories that may cause post-traumatic stress disorder, which is associated with anxiety reactions and depression. If such memories remain in the memory of the nurse (medic) and a caring professional is not able cope with them, the patients' suffering will recall and intensify them. As a result, the helpers will focus on their own emotionality, and not on the patient's emotional needs. Self-therapy plays an important role in protecting a nurse's emotional security (Figley 1995).

Fatigue of compassion leading to a disruption of life – the above-mentioned elements of the process of empathizing with the patient, especially the improper emotional distancing in the relationship, an overly long exposure to the suffering of others, being deprived of adequate breaks, and a lack of care for one's own suffering and sadness, leads to serious disruptions in the personal life of a nurse. More specifically, in the life of a nurse (medic), the tolerable level of anxiety is exceeded and the process of compassion fatigue begins, leading to pathological attitudes, even suicide (Figley, 2002).

One factor that protects against burnout is for medical staff to become more aware of compassion fatigue, proper communication with the patient as well as the appropriate level of intra- and interpersonal communication. There are therapeutic methods for reducing sensitivity to traumatic stressors (AC: this does not involve emotional isolation from the patient). From this therapy, nurses (medics) increase their ability to empathize properly with the patient but without encountering the risk of their own emotional losses. Another issue is related to the doses of exposure to the sadness and suffering of patients. It is not appropriate for nurses to separate themselves completely from the emotionality of their patients, but rather, they should combine their work with a sufficiently long period of relaxation. Such practices allow the medical professional to maintain an appropriate emotional distance from excessive exposure to the patient's feelings (Figley, 2002).

A final issue relates to the treatment of compassion fatigue and is related to increasing social support, for example, with the opportunity to discuss one's own feelings with a professional group or other friendly listener. It should be remembered that a nurse/doctor is first and foremost a human being, and someone should also care for them empathically (AC: obviously not while performing their own duties). Mutual support groups should be run as a part of staff development. From time to time, toxic relationships or traumatic situations occur in the personal life of a nurse/doctor. In these cases, the clear duty of a true professional is to take care of their own emotionality because that is a part of their professional competence (Figley, 1997).

The concept of M.R. Alligood may be viewed as a specific continuation of the empathy model by C.R. Figley. The author divides empathy into two types: one that is basic and innate and that learned through theoretical education, apprenticeships and clinical work. Professional empathy is built on a foundation of elementary empathy, this is why a knowledge of innate empathic abilities as well as people's potential and limitations are important in the process of education about empathy. It is this assessment, according to the author, that should initially qualify candidates to join the medical profession. The appropriate choice of profession in terms of personality traits, supported by the appropriate training and extensive knowledge, represents a good opportunity to protect medical staff from compassion fatigue (Alligood, 1992), (Wal Walker & Alligood ker, 2001), (Alligood & May, 2000), (Kazimierczak, 2004).

An important premise for the appropriate expression of empathy is the suggestion of finding a balance between pathological altruism and extreme egocentrism. Both attitudes, according to many authors (McWilliams, 1984), (Neusner & Chilton, 2005) have a major impact on the empathy processes of people who help others, and on the possible negative effects of empathizing. And they also examine the so-called pseudo-helpful attitude. If the basic motivation to enter the profession of being a nurse or a doctor is the desire to help other people, then this desire must be built on the subconscious need to relieve one's anxieties (fears, guilt), this is namely pathological

altruism, leading, through excessive empathy, to compassion fatigue and ultimately, to burnout (Seelig & Rosof, 2001), (Oakley, Knafo, Guruprasad & Wilson, 2011).

Pathological altruism may be understood as an excessive focus on the emotional needs of others, which is detrimental to one's own needs, and may even appear at the level of a child's personality development. Interestingly, it can manifest itself as a mixture of positive traits, which generate unexpected problems. Such a child is usually well brought up, has no tantrums and shows the ability to focus their attention. The child is highly socialized, open to other people, a little shy and fearful, and at the same time is burdened by the sense of a high level of responsibility, which gives rise to anxieties, fears and feelings of sadness. On the basis of such a personality, pathological altruism may be constructed in adult life (Oakley, 2011).

It should be noted that the criticism of altruism concerns only its deformed form, in which being helpful (being empathetic) to another person simultaneously harms the helper. True altruism cannot be based on selfishness ('By helping others indirectly, I directly help myself'). Many researchers have emphasized that the proportions between altruistic and selfish motivation in the empathic attitude are not equal. In the appropriate empathic attitude there is more altruism than selfishness (Burks, 2012) (Dovidio, 1984), (Dovidio, 2006), (Piliavin, 2002).

In summary, an empathic attitude towards a patient does not harm the medical professional when:

- The personality of the helper predisposes them towards helping others and showing empathy to patients (AC: an ability to empathize without excessive empathic sensitivity).
- The motive for choosing to enter a caring profession (nurse, doctor) should not be the need to soothe one's own emotionality.
- A medical professional knows how to maintain the appropriate emotional distance in empathic relationships (AC: at the level which guards against the activation of empathy swings), at the same time, they are aware of the nature of the emotional distancing required.
- When working with patients, a medic should take care of their own comfort in the form of an adequate balance between rest and work.
- They should be aware of the extent of their own emotional resources (AC: traumatic experiences, and thus memories, toxic relationships, etc.), and in the event of experiencing psychological problems they should engage the services of a professional.
- They are able to build a sense of professional satisfaction based on appropriate relationships with patients.
- At the student level, through empathic behaviour training, they learn the correct way to empathize with their patients and loved ones.
- They have an extensive knowledge about the phenomenon of empathy, its appropriate models and the effects of undesired empathic behaviour.

- They are able to find a support group which allows them to examine their own emotions that may have arisen as a result of empathic contacts with the patient through the exchange of experiences.
- They are constantly working on their professional empathy, through training which expands their knowledge and also inter- and intrapsychic development.

The approach discussed above to the phenomenon of empathy shows its complex character. Undoubtedly, it has a dual, emotional and rational character. The first aspect of empathy includes: the emotional resources of medical professionals, their feelings and the patients' emotions. At the same time, only the patient's emotionality remains in direct empathic interaction. The other two elements affect the cognitive nature of empathizing for a nurse/medic. The preparation for the role of empathizer, although it always concerns the emotional environment, is also rational. If the phenomenon of empathy follows a different pattern, it may pose the danger of having detrimental effects.

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