Dire deadlines: coping with dysfunctional family dynamics in an end-of-life care setting

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Abstract

Working in a hospice and being able to focus on individualized, specialized end-of-life care is a privilege for the hospice staff member. However, it also presents the hospice staff with unique challenges. This descriptive study is based upon two cases from an end-of-life care setting in Denmark, where dysfunctional family dynamics presented added challenges to the staff members in their efforts to provide optimal palliative care. The hospice triad – the patient, the staff member and the family member – forms the basis for communication and intervention in a hospice. Higher expectations and demands of younger, more well-informed patients and family members challenge hospice staff in terms of information and communication when planning for care. The inherent risk factors of working with patients in the terminal phase of life become a focal point in the prevention of the development of compassion fatigue among staff members. A series of coping strategies to more optimally manage dysfunctional families in a setting where time is of the essence are then presented in an effort to empower the hospice team, to prevent splitting among staff members, and to improve quality of care.

Key words: Compassion fatigue ● Coping strategies ● Dysfunctional families ● End-of-life care ● Splitting

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Patients entering the final phase of their disease process are exposed to physical, psychological and existential distress. Besides burdens of often serious somatic symptoms, these patients – throughout the span of their illness, hospitalization and palliative treatment – gradually see the existential disruption of their autonomy, their personal roles and interpersonal relationships. Individual coping strategies as well as familial and social support in the terminal phase may differ.

End-of-life care presents a unique challenge to hospice staff members especially related to a pressing time factor. In general, hospice caregivers meet the task of getting to know not only the patient's current physical and mental health status, his/her social, cultural, religious and family background, but also a detailed knowledge of the family and significant others in this person's unique life. Care and management must, therefore, be individually tailored with a holistic focus.

Although seldom, hospice staff members face the fact that they may have to manage significant dysfunctional family dynamics. As the patient and family realize the dilemmas inherent to the last phase of life and closure, hospice caregivers can, therefore, experience the challenge of professional limitations with regard to involvement in such circumstances. This could be due to an acute family crisis in an end-of-life situation, individual personality traits or even personality disorders, which may further complicate clinical presentations such as depression, anxiety and a sense of hopelessness (Wilson et al, 2000).

Hospice staff members may find themselves drawn into intra-familial conflicts as participants, often unintentionally and unexpectedly, being primarily the patient's advocate but also finding a balance between the needs of the patient as well as relatives in order to achieve optimal end-of-life care. For the patient contending with physical, psychological, economic, social and existential burdens, dysfunctional family dynamics can add to this burden.

For the nurse, the risk of empathy becoming unhealthy may lead to psychological distress. Recent studies have found that stress from continuously facing unusually challenging family dynamics, a high frequency of patient morbidity and mortality as well as organizational deficiencies is associated with high rates of burnout (Wakefield, 2000; Keidel, 2002; Abendroth and Flannery, 2006). Furthermore, staff members may unconsciously identify with projected aspects of a patient or family member and display altered behaviour or attitudes accordingly (Nystrup, 2006). Through this projective identification, the risk of splitting within the professional group or organization may increase.

Research studies regarding the degree of satisfaction with healthcare systems shows a strong correlation to the age of the patient

(Rahmqvist, 2001; Nguyen Thi et al, 2002; Ishøy et al, 2005). In general, younger generations have more focus on details regarding relevant aspects of quality in health care, which also includes such variables as interpersonal relationships between patients and staff, planning and evaluation. Moreover, it seems that patients in the future, being better informed and well-educated, will be more critical in their evaluation of communication with healthcare staff. This increases the challenge of on-going development of competencies and improved quality of care, in particular relating to the communication skills of healthcare staff.

Little research is published regarding how nurses and other staff members cope with extraordinary family dysfunctions in end-of-life care situations. This article describes the above-mentioned dilemma through the experiences from two cases studies. A table of strategies for stress management intended to mitigate the latent possibility of splitting and compassion fatigue among hospice staff is presented.

Methods

Design

The essence of hospice work is the human experience. For this reason the descriptive method was chosen to present experiences and human interactions in the form of case studies. The descriptive method here utilizes anonymous case studies based upon nursing and medical documentation as well as the primary nurse's own experience. Hence, there are factors of interpretation, selection and objectivity that are less prevalent in the more statistical data of other types of research methods.

At the same time, the case study strategy presents some of the nuances and complexities of human interaction in this unique context that may otherwise be lost in other data collection techniques (Walshe et al, 2004). The two cases were chosen to present some of these complexities in family dynamics that added to the challenges during hospice admission. They provided groundwork for the establishment and further evolvement of intervention and management strategies. These are under continual revision as cases are reviewed and critiqued so that individualized end-of-life care can be optimal and teamwork among staff members is enhanced.

Setting

At Arresødal Hospice in Frederiksvaerk, Denmark, the hospice patients have a statistical average stay of 20 days, with the extremes of 2 hours as the shortest stay and 5 months as the longest. Arresødal Hospice is a modern 8-bed, publicly financed and non-profit specialized palliative end-of-life care setting located north of Copenhagen, Denmark. The unit provides a 24-hour service with a multidisciplinary team of experienced registered nurses, two part-time senior medical consultants, a physical therapist and a part-time psychologist. The nurse-patient average care-ratio in day shift is 1:2, in evening shift is 1:3, and in night shift is 1:4. Modern facilities in each single room include a flat-screen TV, DVD and CD player as well as access to the internet and a laptop. Furthermore, a jacuzzi spa is available for daily use by the patients.

To promote continuity of care and maintain a holistic approach, each patient has 2–3 primary contact nurses who are responsible for planning and coordinating care as well tending to familial and social issues and existential needs. The primary contact nurses also provide bereavement counselling following the death of the patient. Most patients are referred from hospitals (71%) and family doctors (27%). The average inpatient stay is approximately 20 days. The gender-ratio is 69% females and 31% males. The majority of patients are terminally ill in the late palliative phase, but nearly 20% are stabilized in a palliative adjustment programme and discharged from hospice.

Case 1

Male, 48 years, and diagnosed with glioblastoma multiforme. He received palliative care for 30 days in his final hospital admission.

The patient had two previous short-term hospice admissions for stabilization of symptoms and for respite care. During these admissions, he only received visits from his wife and some of his children. The patient was married for the second time and had children from both marriages. The patient's mother lived abroad for most of the year. He had a brother who also lived abroad and with whom he had no contact due to prior disagreements. Despite the family's limited contact with the patient's mother, the second wife did inform her of her son's serious condition and she thereafter travelled to Denmark.

From conversations with the hospice nurses, it became known that the family had long-term conflicts, and that the patient's mother and current wife were not on speaking terms and, furthermore, did not desire to be present in the hospice at the same time. Both of them expressed the desire to protect the children from the adults' conflicts.

During the course of care, the patient's mother primarily came to confer with the

‘The patient had two previous short-term hospice admissions for stabilization of symptoms and for respite care’

doctor and one of the primary contact nurses, while his wife preferred to confer with the psychologist and another primary contact nurse about the latent and more apparent family conflicts, which were increasing and intensifying in the hospice setting. These conflicts were directly involving the staff, who found it necessary to adapt a 'damage-control' strategy in order to provide optimal end-of-life care.

'The two sides agreed indirectly through mediation by the staff'

The two sides agreed indirectly through mediation by the staff that the mother visited during the morning hours, often to take walks with the patient in the surrounding park and forest. He was generally tired after this and slept the rest of the day. The wife and children visited in the afternoon, but she soon expressed her irritation over the fact that the patient was tired or slept when they visited him later in the day. The wife requested that the nurses limit the mother's visits, but was informed that at that stage in the admission, she and her mother-in-law should try to communicate and coordinate their visits. The patient had not requested that his mother's visits be denied.

The wife then made an agreement with a primary contact nurse that the family's future visits would be coordinated within the family by writing the designated visiting time in a small calendar that was placed in the patient's room. Within a few days, the wife insisted that the calendar should be kept at the nurses' station, and that the nurses were required to be in charge of administrating and indirectly controlling the visits for this patient.

The wife also made an agreement with one of the primary contact nurses that before any medications could be given to the patient, she was to be contacted for consultation and approval. These agreements created increasing tension and conflict among the nurses, resulting in a division between the 'good nurses' and the 'bad nurses', depending upon whether the nurses followed the patient's wife's demands or not. This phenomenon involved many members of the multidisciplinary hospice team. A multidisciplinary meeting was promptly arranged and here it was concluded that the nurses would not be responsible for recording the family's visits or agreements. Furthermore, the wife would be informed about changes in medication for the patient but would not be contacted if there was an acute need for medication.

The hospice staff would once again encourage the family to reconcile their differences for the sake of the patient. The visits were subsequently coordinated such that the mother called the patient's wife in the morning in order to agree upon visiting hours. However, the patient's condition deteriorated rapidly with advancing neuro-psychological symptoms. The mother had increasing difficulty in coping with her son's worsening symptoms and did not visit as often.

During the final days of the patient's life, his mother and his wife gave each other more space. When the patient became increasing somnolent, the mother contacted her other son to inform him that he should come to Denmark. However, the patient died that day with his wife and children around him. The mother first came in to see her son after he had passed away. The mother returned to her country of residence shortly after her son's funeral. Before leaving the country, she did return to the hospice for bereavement counselling. The wife came to two follow-up conversations.

Case 2

41-year-old male, diagnosed with pulmonary cancer with metastases to cerebrum, cerebellum, and pericardium. Additionally, the patient had dyspnoea due to pleural effusion, which was treated with continuous oxygen therapy. The patient had been receiving palliative and end-of-life care for 30 days in hospice.

The patient was married and had three young children. Prior to his admission to hospice, he was cared for in the home by his wife who, as a primary caregiver, had a paid leave of absence from work according to Danish law.

At the time of admission to hospice, the patient was cachectic with increasing dyspnoea upon exertion. He was mobilized only for use of the bathroom and of the jacuzzi spa. His neuropsychological functions were relatively adequate, and he desired as little help as possible. He reportedly had a good relationship with his wife and children. He had requested a limited number of visitors, primarily close relatives and selected friends. The relationship with his own parents was strained, since the patient and his father had a long-standing, unresolved issue of contention. At the time of admission, the patient was not willing to forgive or to discuss the issue. Moreover, the relationship with his parents was apparently characterized by many broken promises. Despite great fatigue, the patient was determined to prioritize quality time spent with his children.

One day the patient's wife and primary contact nurse discussed the fact that the patient's condition was deteriorating and he was only able to manage brief visits. The wife wanted the children to have a chance to say goodbye while their father still had a reasonable cerebral level of function, so they gathered in his room. All at once there was a knock at the door, and the patient's parents entered. The wife asked them not to enter. The parents were frustrated, angry and sad. They felt that they were being excluded from the family, and they admitted that they had a poor relationship with their daughter-in-law. The primary contact nurse intervened and told the parents that the patient and his wife were quite overwhelmed at this time. The parents had difficulty seeing that their son was dying, which greatly complicated communication between the parents and their daughter-in-law. The parents were informed that according to the patient's requests, they were only allowed short visits.

The wife felt divided between her children and the patient, as she wanted to be both places at the same time. The primary contact nurse encouraged her to prioritize the children, which the patient also supported. The patient wanted only his wife with him in the final phase of his life.

When the patient became comatose, the children and his parents were called in according to the wife's wishes. When he saw his son dying, the patient's father broke down emotionally. The wife cried over the poor relationship with her in-laws, but she also admitted that she could not handle them at that point in time. The parents said their final goodbyes to their son and left the hospice.

That night the wife laid down next to her husband and held his hand until he quietly passed away in his sleep. She helped the nurses to wash and dress her husband. The primary contact nurse made an agreement with the wife that she would call the parents and arrange a time the next day where they could come and pay their respects. This gave the wife time alone with her husband, and also gave the children the opportunity to see their father. The parents came the next day as arranged. The children had the chance to take a jacuzzi bath, as their father had done during his stay at hospice.

Subsequently, the patient's wife, children and his parents were able to go on vacation together and were able to re-establish a good relationship. The children are still receiving therapy from a psychotherapist. The wife had several subsequent follow-up conversations with the primary contact nurse at hospice.

Discussion

It is apparent that the basic competencies of experienced hospice staff are most often adequate to cope with the complex needs of terminally ill patients and their families. The staff members' diverse educational backgrounds, participation in continuing education, professional and personal experiences, as well as their values, morals and ethical standards play a key role in shaping the quality of care given in hospice. An essential first step for nurses and other hospice staff members, in order to optimally manage difficult situations, is the recognition of their own feelings as well as strengths and weaknesses. Other individual contributing factors include emotional resilience, clarity about personal and interpersonal boundaries, and ability to tolerate the intense emotional impact that the dying patient and the intra-familial crises can have on them.

The hospice triad – the patient, the hospice nurse, and the family member – forms the basic structure for human interaction in end-of-life care (Keidel, 2002). There can be positive and negative factors, both internal and external in origin, which may affect each part of the triad. Examples of such factors are societal norms, working conditions in hospice, familial dysfunctionality or standards within the healthcare system. However, there can also be positive and negative interactions between either part of the triad that maintains or disturbs the balance (Keidel, 2002). The balance within the triad, as depicted in *Table 1*, relies upon establishment and maintenance of trust between the three. Once trust is established, agreements within the triad flourish in an atmosphere of harmony and balance.

If disagreement occurs, and the level of trust is still preserved, discussion and negotiation in an understanding of mutual respect can lead to resolution and progress. However, if an atmosphere of distrust prevails, agreement within the triad maintains only the status quo, with no hope of moving forward. And if disagreement occurs in an atmosphere of distrust, the reaction will be 'fight or flight'; for example, the splitting that can occur among staff members, as described in case 1. If such an imbalance occurs within the triad, effective strategies are needed to identify and rectify the problem in order to re-establish the balance. The two cases described earlier provided an optimal opportunity among our hospice staff members and organization to reflect upon and to discuss different aspects of handling dysfunctional families. We recognized the imminent nature of such challenges, in particular if a strategy plan for management was not promptly put into effect.

A professional approach to 'challenging

> *'The primary contact nurse intervened and told the parents that the patient and his wife were quite overwhelmed'*

Table 1. Factors influencing the balance within the hospice triad

	Trust	**Distrust**
Agreement	Harmony	Status quo
Disagreement	Resolution and development	'Fight or flight'

> *‘Stressful experiences are not exclusively the result of concrete, actual events’*

families’ requires professional multidisciplinary teamwork, good communication skills and clarity of purpose, as without this team-approach, difficulties, misunderstandings, projections and splitting are more likely to occur. Continually updated information for all staff members involved through mono- or multi-disciplinary meetings is essential. The relevance of this exchange of information became evident in case 1 as small ad-hoc meetings prevented an overall focus and unity in direction and purpose. It is important that all hospice staff members maintain their loyalty in relation to the agreements that are made in the multidisciplinary meetings, even if they personally disagree with the decisions and plan.

To avoid splitting between members of staff, there must be recognition and understanding that dysfunctional families with conflicting dynamics may display completely opposing attitudes within short periods of time, as described in the incident regarding the calendar in case 1. This can be quite challenging to the hospice staff and requires vigilance in terms of interactions and agreements. It is important to recognize that relatives in conflict may project their issues onto others as a way to control fragmented or distressed parts of themselves (Nystrup, 2006). In case 1, the underlying conflict was inadvertently transferred to the primary care nurses. This occurred in conjunction with arranging that the patient’s wife and mother had separate contact nurses, and that all conversations were to be held separately. The family’s conflict then spread to other multidisciplinary team members, splitting the hospice staff as sides were taken with a loss of professional boundaries.

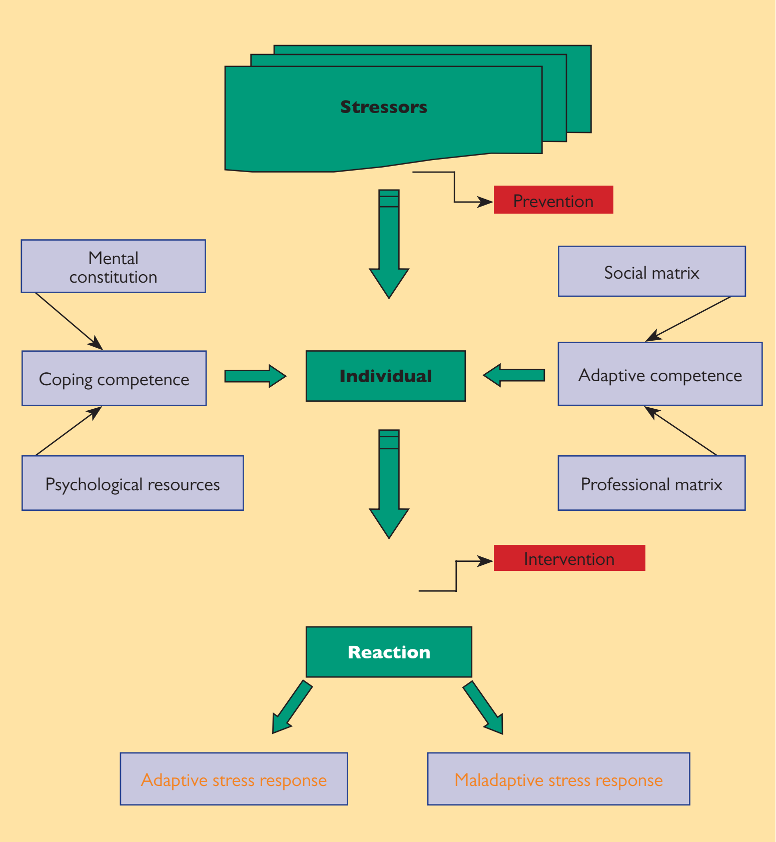

Figure 1. The Arresødal Hospice stress-prevention-intervention algorithm.

This process of reflection and discussion within the multidisciplinary hospice team in both cases resulted in a unique opportunity to understand in more detail the mechanism of coping: psychological and social burdens – ‘stressors’ - affect the individual, who modifies and effectuates his response on the basis of his resources (Lazarus and Folkman, 1984). *Figure 1* illustrates Arresødal hospice’s algorithm for the prevention and management of stress factors, which can be viewed as a modification of Lazarus and Folkman’s coping theory (Lazarus and Folkman, 1984).

Individual stress management in any part of the hospice triad – the patient, family member or hospice staff member – and more collectively even within an organization – involves two integrated systems based on coping and adaptation. Coping competencies, based on the individual’s inborn psychological characteristics and personality traits, are initiated by the individual through on-going evaluations and interventions to solve the problem and thereby reduce stress. The adaptive competencies – a life-time of adjustments and modifications, created over time and established through social, educational and professional experiences – are acquired capabilities that function as a stable framework in real-life situations. A negative outcome of stress management indicates a dysfunction of adaptive and coping competencies and may lead to personal disintegration and increased stress symptoms.

Stressful experiences are not exclusively the result of concrete, actual events (stressors). An extensive host of personal characteristics of a more or less objective nature play an essential role in how the impact of stressors is experienced, interpreted and acted upon.

Handling stressful situations may take different psychological pathways within an individual, ranging from avoidance and passivity to direct problem-solving strategies. Individual factors, such as inborn mental constitution and perceptive skills, education, training and experience as well as social, cultural and religious background are essential parameters. Furthermore, the organization’s leadership, moral foundation, and code of ethics are important factors in determining how stressful episodes will be coped with and managed.

Being confronted with a challenging family's overwhelmingly negative feelings and reaction patterns may suddenly tip the balance within the hospice triad and begin to cause deterioration in the integrity of hospice staff by crossing personal and professional boundaries. This imbalance occurred in case 1 as the staff was divided by disagreement and discourse. This is of course the impact of an acute stressor that still has to flow through the appropriate coping and adaptive channels (*Figure 1*). In this situation, it is important to enable hospice staff in an open, professional atmosphere to share uncomfortable, challenging or negative feelings brought on by sudden or unintentional involvement in conflicting family dynamics. This can take place in the multidisciplinary meetings, or there may be an indication for professional counselling with a psychologist. The latent risk of compassion fatigue or even burn-out has to be identified promptly, handled professionally and with great care.

Nurses and other staff members working in an end-of-life care setting are in a high risk group for the development of compassion fatigue (Abendroth and Flannery, 2006). There are numerous steps that individual nurses in an end-of-life care setting can take in order to prevent the development of this phenomenon. A recognition of and respect for individual strengths and weaknesses as well as self-awareness is the cornerstone for working in such a challenging environment. Time for individual reflection promotes this function and should be encouraged as a part of the daily structure for staff working in an end-of-life care setting. Cohesion, support and caring among co-workers and a sense of 'team' further this process.

A recognition of the concepts of 'professional bereavement' and 'multiple bereavement' focuses on the losses that the staff experiences repeatedly, sometimes on a daily basis (Keidel, 2002; Desbiens and Fillion, 2007). Attention should be given to this often powerful experience of loss, particularly in cases with conflicting familial relationships. Exit interviews for nursing and other staff members who have chosen to leave hospice would provide valuable insight into areas needing attention and improvement both at an organizational level and at a multidisciplinary level (Keidel, 2002). Regularly scheduled opportunities for continuing education are essential in the rapidly evolving world of palliation. A mentoring program for new nurses and other staff in hospice serves to promote cohesion and strengthens the bonds between staff members, again supporting the notion that the multidisciplinary, holistic approach is the foundation of hospice work.

A lack of adequate palliation of patients has been identified as a source of stress and a potentially significant contributor to the development of compassion fatigue among nursing staff (Abendroth and Flannery, 2006). A multidisciplinary review of cases will uncover areas of excellence and/or deficiencies and provide the framework for further development in the palliative care. Furthermore, the use of case stories, such as the two cases presented in this article, promotes excellence in the care of patients by encouraging reflection over practice and attitudes, as well as the results of the team approach. The nursing theory of Benner and Wrubel (1989), regarding the use of nursing paradigms, recognizes the value of case descriptions in the learning process as one strives to improve quality of nursing care; in our case, in a setting where time can be of the essence.

The guidelines presented in *Table 2* are strategies that can be utilized to optimally provide palliative care, in particular focusing on the challenges that family dysfunction can present to hospice staff members. To maintain a sustainable hospice triad it became imperative to implement management strategies that incorporate a more long-term outlook for future rehabilitation of the surviving relatives as described in the two cases. In case 1, the patient's wife and mother were able to achieve closure with the patient, each in their own way. They gave each other acceptance and space, and in the end they were able to acknowledge and respect each other's loss and grief. There were no expectations of an ongoing relationship once the patient had died. In case 2, a degree of cohesion within the extended family was re-established after the patient died.

When examining the process, the authors discovered that management strategies should include a flexible and differential approach taking into account the strengths, psychological resources, level of intellect and emotional state of conflicting family members before deciding whether to use interpretive or supportive techniques (Nystrup, 2006). It depends on the situation and the context at the time as to whether the supportive or interpretive techniques or a combination of both should be utilized.

Easier access to information influences both the individual's and society's understandings of the concepts of autonomy and authority. This has meant that healthcare workers have to respond

> *'A lack of adequate palliation of patients has been identified as a source of stress'*

‘Dysfunctional families are most optimally managed via distinct strategies and goals’

Table 2. Arresødal Hospice’s principles of management of intra-familial conflicts

Maintain the palliative perspective	Consider the possibility and implementation of palliative management strategies in certain subtypes of family dysfunction and (if favourable circumstances allow) to extend beyond this, incorporating a more long-term outlook for future rehabilitation of the surviving relatives
Maintain flexibility	Take into account the strengths, psychological resources, level of intellect and emotional state of conflicting family members before deciding whether to use interpretive or supportive techniques. Be prepared to reflect over strategies that have not been optimal and modify as necessary
Maintain neutrality, transparency and professionalism	Current information for all staff members involved through mono- or multi-disciplinary meetings is essential. It is important to handle conflicting family dynamics in an open, transparent and professional way, not to be unexpectedly absorbed as an active part of the conflict and avoiding covert behaviours. The principle of neutrality applies to this strategy in that involvement in long-term prior conflicts is to be avoided
Avoid splitting	Avoid, or at least identify and understand, splitting between members of staff by recognizing that dysfunctional families with conflicting dynamics may display completely opposing attitudes within short periods of time, which can be quite challenging to staff. In the worst case scenarios, relatives in conflict may project their issues onto others as a way to control fragmented or distressed parts of themselves
Avoid demonizing	Encourage and enable staff to share awkward, challenging and/or negative feelings brought on by sudden or inadvertent involvement in conflicting family dynamics
Set necessary limits	Limits need to be identified and maintained consistently if behaviours of a family member threaten the integrity or safety of the patient, other relatives, staff or the palliative-therapeutic relationship
Intervention	Encourage staff members to maintain the professional/personal balance through multidisciplinary discussions, counselling and prompt debriefing

to new demands within their professions. In case 1, the patient’s wife had found information about the patient’s medication on-line and then demanded to be an active participant in decisions regarding the use of this medicine. She lacked however the clinical experience that the hospice professionals have about how this medication can be used in a palliative treatment plan. It is the hospice staff’s essential responsibility to update and supplement the necessary information based on individual needs at the time.

Maintaining a neutral, professional position in managing patients and their families in an end-of-life care setting is essential. After admission, there is a focus on getting to know the patient and family by listening to their life history, recognizing that this gives valuable information as to the patient’s situation, background meanings and individual concerns (Benner and Wrubel, 1989). Strategies for management of each patient and family are discussed in the multidisciplinary meetings, and a plan is formulated using strategies as illustrated in *Table 2*. Agreements are made with the patient and family with regard to the primary contact nurses. The challenge for the hospice staff is to avoid striving to solve families’ long-term conflicts, but rather to focus on the optimal palliative care for the patient and the family members. In this way, the conflict is not allowed to overshadow the most important goal, that being a dignified and respectful closure both for the patient and for the family.

Conclusion

Dysfunctional families are most optimally managed via distinct strategies and goals, which are planned and implemented both on a mono- and multi-disciplinary basis. Teamwork, including loyalty and trust within the team, is essential. Establishment and maintenance of a neutral and professional position, especially with regard to patients and families in conflict, must exist on an individual and team level. It is of utmost importance that self-awareness (knowing one’s own ‘habitus’) is at the forefront, in order to utilize or modify strategies in one’s professional work. Moreover, trust within the hospice triad must be established and maintained, in particular where the individual differences are great.

The challenge for the hospice staff is not whether the patient and family can bring about a meaningful change to their maladaptive, even distorted behavioural or emotional patterns in the hospice environment. The question is rather how to expand upon their skills and resources and how to support and guide them toward mutual respect and allowing space for each other in a time of closure and loss.

Although both cases presented here involve younger families, family conflicts can exist in all age categories. However, the younger generation often has greater expectations from and even demands on the hospice staff. In today's modern information-based society, patients and family members possess a greater knowledge, due in part to increased access to higher levels of information, and, therefore, expect precise and detailed information. Many patients and relatives demand to be active consultants in connection with every treatment plan and intervention. For that reason, the healthcare industry faces a challenging task in the future to accommodate these needs and demands. IJPN

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