

## SUFFERING AND LONELINESS: NARRATIVES OF PROFESSIONALS FROM ONCOLOGY'S SECTOR

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**ABSTRACT.** In the Oncology Ward of hospital institutions, aiming humanized care, the performance of professionals from different areas has been desirable. This study aimed to investigate the subjective experience of the different professionals who work in this sector. The research was developed with the participation of 23 professionals from the Oncology area of a public hospital located in Rio Grande do Sul. In this qualitative study, they were interviewed individually. Those interviews were mediated by the presentation of an interactive narrative, with the participants being asked to create an outcome and to freely associate. Two categories were identified, after psychoanalytic consideration, entitled 'I return the pain to others' and 'Dance of solitude'. From those categories, it was possible to identify, respectively, how professionals experience, in their daily work, their relations with patients and with their teammates. It was observed that, for the participants, the daily work is crossed by suffering because they have to deal with the discomfort of their patients, as well as the frequent losses, a suffering that is accentuated by not being able to share it with their peers at work. It is concluded that it is necessary to develop actions, especially the constitution of a clinical setting in which professionals can have affective exchanges with each other, which could, in just one time, help them to deal with the suffering aroused in the Oncology sector as well as help them to feel that they belong to this team made up of different areas of specialty.

**Keywords:** Hospital environment; caregivers; suffering.

## SOFRIMENTO E SOLIDÃO: NARRATIVAS DE PROFISSIONAIS DO SETOR DE ONCOLOGIA

**RESUMO.** No setor de oncologia das instituições hospitalares, visando o cuidado humanizado, tem sido desejável a atuação de profissionais de diferentes áreas. Esse estudo teve o objetivo de investigar a experiência subjetiva dos diferentes profissionais que atuam nesse setor. A pesquisa contou com a participação de 23 profissionais da área de oncologia de um hospital público situado no interior do Rio Grande do Sul. Nesse estudo

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qualitativo, os participantes foram entrevistados individualmente, sendo tais entrevistas mediadas pela apresentação de uma narrativa interativa, a qual eles eram convidados a inventarem um desfecho e a associarem livremente. Foram identificadas, após consideração psicanalítica, duas categorias intituladas 'Aos outros eu devolvo a dor' e 'Dança da solidão'. A partir delas foi possível identificar, respectivamente, como os profissionais experienciam, em seu cotidiano de trabalho, suas relações com os pacientes e com os seus colegas de equipe. Observou-se que, para os participantes, o cotidiano de trabalho é atravessado por sofrimento por terem de lidar com o mal-estar de seus pacientes, bem como as perdas frequentes, sofrimento esse que fica acentuado por não terem condições de compartilhá-lo com os seus pares no trabalho. Conclui-se que se faz necessário o desenvolvimento de ações, em especial a constituição de um enquadre clínico em que os profissionais possam ter trocas afetivas entre si, o que poderia, num só tempo, tanto ajudá-los a lidar com o sofrimento despertado no setor de oncologia quanto ajudá-los a se sentirem pertencentes a essa equipe composta por diferentes áreas de especialidade.

**Palavras-chave:** Ambiente hospitalar; cuidadores; sofrimento.

## **SUFRIMIENTO Y SOLEDAD: NARRATIVAS DE PROFESIONALES DEL SECTOR ONCOLÓGICO**

**RESUMEN.** En el sector de Oncología de las instituciones hospitalarias, con miras a la atención humanizada, ha sido deseable la actuación de profesionales de diferentes áreas. Este estudio tuvo como objetivo investigar la experiencia subjetiva de los diferentes profesionales que laboran en este sector. La investigación contó con la participación de 23 profesionales del área de Oncología de un hospital público ubicado en el interior de Rio Grande do Sul. En este estudio cualitativo, los participantes fueron entrevistados individualmente, siendo dichas entrevistas mediadas por la presentación de una narrativa interactiva, a la que fueron invitados a inventar un desenlace y asociarse libremente. Se identificaron dos categorías, después de una consideración psicoanalítica, tituladas 'Devuelvo el dolor a los demás' y 'Danza de la soledad'. A partir de ellos, fue posible identificar, respectivamente, cómo los profesionales viven, en su trabajo diario, sus relaciones con los pacientes y con sus compañeros de equipo. Se observó que, para los participantes, el trabajo diario está atravesado por el sufrimiento porque tienen que convivir con el malestar de sus pacientes, así como con las frecuentes pérdidas, sufrimiento que se acentúa al no poder compartirlo con los demás compañeros de trabajo. Se concluye que es necesario desarrollar acciones, especialmente la constitución de un entorno clínico en el que los profesionales puedan tener intercambios afectivos entre sí, que puedan, en un solo tiempo, ayudarles a afrontar el sufrimiento suscitado en el sector de Oncología, además de ayudarles a sentirse parte de este equipo formado por diferentes áreas de especialidad.

**Palabras clave:** Ambiente hospitalario; cuidadores; sufrimiento.

### **Introduction**

Despite significant advances in recent decades in terms of diagnosis and treatment of cancer, it remains one of the main causes of death before the age of 70 in most countries,

according to the National Cancer Institute José Alencar Gomes da Silva [INCA] (2019). To deal with this public health problem, diagnostic and therapeutic advances have been accompanied by an improvement in the care provided to patients, to whom more comprehensive care has been dedicated. Thus, in Brazil, similarly to what has occurred in other countries around the world, the care provided to cancer patients is no longer restricted to medical knowledge or limited to a treatment centered on medication and surgery (Silva, Issi, Motta, & Botene, 2015; Tremblay, Roberge, Touati, Maunsell, & Berbiche, 2017), to be supported by professionals from different areas of expertise, who, together, can intervene in a non-reductionist way, overcoming monocausal solutions (Craving, Campo, Boro, Chiarella, & Marco, 2016; Reis, Farias, & Quintana, 2017).

Since it is possible for the different subjects to transit in different ways, the specialized literature has used different terminologies to refer to the team composed of professionals from different backgrounds. The term 'multi-professional' has been adopted when, despite the co-presence of different subjects, it is noted that professionals from each area of knowledge are organized to respond individually to the patient's treatment. Thus, the different professionals simultaneously deal with the same issue, without being involved in systematic exchanges. The term 'interdisciplinary' has the 'inter' character and has been used when there is effective reciprocity between the members of the different subjects, with the exchange of information expanding the general education of each of the specialists, who intervene, in this case, in a non-fractionated way (Cliche-Galarza, 2019; Silva, Sant'Ana, Cardoso, & Alcântara, 2018; Veloso & Silva, 2018).

There seems to be a consensus that the ideal for achieving comprehensive care would be for professionals to form an interdisciplinary team, rather than intervening in a multidisciplinary way (Silva et al., 2018). According to a study by Tremblay et al. (2017) with 1,379 Canadian patients, when patients noticed a high level of exchanges between Oncology professionals, they felt better cared for, to the point of not even seeing the need to always be attended by the same professional, given the finding that there was a good exchange of information within the team.

The interdisciplinary work can not only benefit the patient but also the professional in the Oncology ward, since it allows to overcome the particular way of thinking and intervening in each specialty area, creating the opportunity for the professional to relativize certainties and develop self-criticism (Craving et al., 2016). Furthermore, professional exhaustion, so present among caregiver professionals, tends to be potentiated among Oncology workers (Colombat, Lejeune, Altmeyer, & Fouquereau, 2019). In this sense, interdisciplinarity presupposes greater solidarity between professionals, in which each member can count on the support of the other, amid shared care, without having to carry the suffering caused by work individually (Cliche-Galarza, 2019).

Given the perception that interdisciplinary work proves to be doubly beneficial, both for patients and professionals, in the scientific literature on Oncology, although studies focused on the professional practice of Nursing still predominate (Luz et al., 2016), more and more studies have been published in which the different professionals who make up the Oncology team are being listened to (Bianchini, Romeiro, Peuker, & Castro, 2016; Dias, Mendonça, Diaz, Ribeiro, & Alvez, 2019; Dias, Pereira, & Finelli, 2020; Pacheco & Goldim, 2019; Silva et al., 2015; Tremblay et al., 2017; Wanderbroocke, Baasch, Antunes, & Menezes, 2018).

Among these less expressive investigations, the central concern has been to think of operational strategies so that the different professionals are effectively capable of

constituting an interdisciplinary unit, overcoming the experiences of competition, exclusion, domination, and intolerance, among others (Veloso & Silva, 2018). To illustrate it, Soukup, Gandamihardja, McInerney, Green and Seudalis (2019) analyzed for two years the meetings of professionals from an English Oncology unit, who were subjected to occasional interventions by the researchers with the aim of strengthening the team. Harshman et al. (2017), with Canadian professionals belonging to different interdisciplinary teams, concluded that the care provided by professionals should take place together, rather than separately, as is commonly the case.

Although we consider such studies valuable, from a psychoanalytic perspective, it is also necessary to identify the affective-emotional dimension of the experience of the different professionals working in the Oncology sector. Understanding that the difficulties for implementing interdisciplinary work have a multifactorial nature, in addition to these studies that have proposed different forms of work organization, we see the need for an investigation into the subjective experience of Oncology professionals, about the hospital environment, made up mainly of co-workers and patients. In this sense, how have Oncology professionals experienced affective exchanges with their work peers? And how have they experienced affective exchanges with their patients?

## **Method**

This was an exploratory investigation, using the clinical-qualitative method. Turato (2013) describes that this method deals with the possible impacts that the investigation of human sciences in health can have on the participants, in addition to recognizing that researchers are not mere spectators of the research, understanding them as active participants. Thus, the clinical-qualitative method does not differ from the qualitative method, becoming part of this methodological approach, since it consists of a method derived from the refinement of traditional qualitative research that has shown better suitability to health studies. Among the various possibilities of qualitative reference, in the present study we opted for Psychoanalysis, understanding that both in qualitative research and in psychoanalytic research, the goal is to understand the meanings and senses attributed by the subjects to the investigated phenomena, without having as objective to reach universal and certifiable results since it works on the construction of a possible interpretation, among many conceivable ones, for the narratives of the participants (Aiello-Fernandes, Ambrosio, & Aiello-Vaisberg, 2012).

After approval by the Human Research Ethics Committee (CAAE:70641417.9.0000.531), all professionals from the Oncology sector of a teaching hospital in the state of Rio Grande do Sul were invited. This is a hospital where approximately 3,000 patients are served every month, whether they are admitted to the institution or being followed up in chemotherapy sessions, hospitalized at home under palliative care, or in outpatient consultations. In the end, 23 professionals participated, including a physician, five psychologists, two occupational therapists, three physical therapists, and 12 nursing professionals. Among the 23 participants, 19 were women and four were men, whose ages ranged between 23 and 51 years and whose time in the area ranged from a few months to 10 years. Another fact worth mentioning is that 16 were employees of the hospital institution and the others were members of the hospital's multidisciplinary residency program.

The individual interviews were carried out at the hospital and conducted according to the psychoanalytical method. Thus, favoring the technique of free association, participants were not interviewed according to a structured script of questions, which could even prevent them from speaking spontaneously and in-depth about their professional experiences. However, as the interviews had a scientific objective, unlike what happens in the exclusively clinical context in which patients can talk about whatever they want, it was necessary to turn the participants' attention to the topic of interest in the research, without this becoming in an overly directive and anti-psychoanalytic way. Thus, we opted to use a dialogical resource that could facilitate significant emotional communication on the research topic of interest, aligning ourselves with researchers who have been using the Winnicottian legacy to think creatively about methodological research strategies (Aiello-Fernandes, Ambrosio, & Aiello-Vaisberg, 2012).

Winnicott (1994) used a game, which he called the Squiggle Game, through which he and his patient randomly made scribbles, which could favor the patient's deep subjective communication. Through this play, Winnicott (1994) believed that a ludic environment could be created, in which his patients could get in touch with distressing issues, in a relatively relaxed way. In this way, inspired by this winnicottian play, in the interviews we used a dialogic resource that is paradigmatically analogous to the Squiggle Game. However, instead of using the Squiggle Game, we used an interactive narrative, a dialogical resource already used in psychoanalytic investigations (Aching, Biffi, & Granato, 2016; Moraes & Granato, 2014).

The interactive narrative consists of a fictional story, invented by the researchers, in which an episode is narrated, related to what is intended to be investigated, without an outcome. Although all the elements of the interactive narrative are invented, paradoxically, they all evoke something that concretely crosses the human dynamics focused on the investigation and that ends up favoring the participants to identify with it and freely associate from it (Granato & Aiello-Vaisberg, 2016). The interactive narrative elaborated for this study, and which we presented to the participants as our initial squiggle, was as follows:

The alarm clock rang. Joana turned it off, hardly believing that it was time to get up again and go to the hospital. She kept thinking that the year wasn't even halfway through yet, but she already seemed to feel as tired as if it were already the end of the year. As she headed to the hospital, automatically taking that path that was already so familiar to her, she began to remember the last patient she had attended the day before. He was accompanied by his wife. In the waiting room, she was crying a lot, all the while holding a tissue in her hand and ignoring all the movement going on around her. He, sitting next to his wife, already maintained a very erect posture, almost glued against the chair, looking forward, with a somewhat angry countenance. Joana kept remembering this couple because, among the many patients and family members that she accompanied daily at the hospital, that one had marked her. This because [...]

After reading the interactive narrative, the participants were invited to write an outcome, completing the 'squiggle'. Then, through free association, respondents were invited to talk about their day-to-day work, as well as their relationship with professionals and patients in the Oncology ward.

The interviews were recorded in audio and transcribed in full. In this way, the material consisting of the transcripts of the interviews and the outcomes created by the participants based on the interactive narrative presented was analyzed. This analysis was carried out according to the psychoanalytical method, so that in scientific meetings a reading work guided by psychoanalytic listening was carried out, similar to what occurs in the clinical context, in which one seeks to identify the nuances and stumbles of the discourse (Irribary,

2003). From this psychoanalytical reading, in which the transference movements (which the participants may have presented) and the countertransference reactions awakened in the group of researchers were taken into account, it was possible to organize the material into two categories that crossed this investigated group.

Importantly, in this research, we followed the determinations of the Resolution of the National Health Council, 510, of April 7, 2016, which standardizes the conditions of research involving human beings. Ethics, the preservation of participants' identities, and their protection against risks or losses were considered. The participants were informed about the subject of the investigation and its implications, having clarified their rights as research participants, and signed an informed consent.

## **Results and discussion**

Based on the analysis of the material, two categories were identified, entitled 'I return the pain to others' and 'Dance of loneliness', inspired by the songs of Marisa Monte.

### **Category 1 – 'I return the pain to others'**

The category 'I return the pain to others' refers to the suffering of professionals, faced with the daily work crossed by the loss of patients, as well as the defensive strategies adopted. In relation to suffering, it is evident in the excerpt referring to the interview with one of the participants:

Participant 2, a nurse, writes the following outcome for the interactive narrative: "[...] it was also very important because it was Joana who sought the support the patient needed, psychologists, social workers, medical oxygen at home. The story 'does not' end because the patient continues to be readmitted to continue the treatment and the team waits for her in the sector" (emphasis added). Further on, the participant says it is common for team members to comment on patients: "[...] Sometimes, when we talk about a patient, it is impossible not to remember others who have already died, because the stories are similar. Something always reminds us of a patient. Our memory brings us the experience with another patient because we already know the end of the story [...]"

This material was selected because, when creating the outcome of the interactive narrative, the participant commits a slip, first writing that the story of the fictitious couple was over (which can refer to death) and, later, adding a 'does not' that would give the opposite meaning, that is to say, the continuity of life. We see, therefore, how this hospital environment is marked by so many deaths, to the point where Participant 2 commented that she already knows how the patients' stories end, causes great suffering, and it is even necessary to deny death, literally adding a 'does not' to the end of the interactive narrative and thus creating a less unhappy ending to the story.

Other studies point out, in line with ours, that the different professionals who make up the Oncology team experience profound suffering when dealing with death on a daily basis. In the study by Silva et al. (2015), in which nine Oncology professionals were interviewed, it is evident how the suffering of the patient's death is closely related to the fact that professionals take on cancer treatment as a fight against death so the loss of a patient awakens feelings of powerlessness. It is precisely for this reason that Dias et al. (2020), who conducted a survey in which six professionals from different specialties were interviewed, suggest that it is necessary to rethink the training of health professionals, who, in general,

are not prepared to deal with terminality. According to Moraes and Granato (2014), we live in a culture so incapable of reflecting on the finitude of life that this reverberates even in undergraduate courses in the health area, with academics being prepared only according to the logic of healing.

Perhaps, precisely because they are crossed by this imaginary that refuses terminality, when professionals need to live with patients affected by a silent and treacherous disease, which can attack any human being (Craving et al., 2016), they end up being 'run over' by it, with some of them presenting imaginative productions that it could unleash on their family members and even on themselves, as in a phenomenon of psychic contagion. Thus, similarly to other empirical studies with Oncology professionals, among which Dias et al. (2020) and Pacheco and Goldim (2019), we came across professionals who not only told us about the suffering of being so close to death, through their patients, but also the suffering of imagining that this death could still happen closest to them. To illustrate this point, we chose the following material:

Participant 5, a nursing assistant, writes a list of questions as an outcome for the interactive narrative: "How would we react when we receive a diagnosis of cancer? How is our life, plans, family, children, etc...?". She comments, throughout the interview, on a case that was very important to her:

One day there was a boy here at the hospital who died at the age of my son. He was 19 years old and spent the whole afternoon in pain, agonizing, slowly fading away. And then he died and I cried all afternoon. But now I don't cry anymore. But there are days when I leave here with pain in my body, tiredness, a very high overload, which is not so much because of work, you know? But it is the emotional load that we get from them.

Crying a lot, she comments:

During the first few months, I didn't feel like taking care of myself, I didn't feel like getting ready, I didn't feel like doing anything else. Then people kept asking what was happening to me. But now I don't even think about my work here when I go home. I don't know if I'm not thinking, but I'm keeping it because all this pain I'm feeling could be coming because of that because I'm keeping a lot of things emotionally and it's coming physically, right? This morning I wanted to get up early to go for a walk. I even woke up, but I couldn't get out of bed, because I woke up too tired.

From this vignette, the participant's imagination is explicit that the fatality that crosses cancer patients can arrive in her life (either through her son, mentioned in the interview, or through herself, as she questions in the interactive narrative). It is also clear that, even though she does not have cancer, there is a feeling of being sick, so much so that the participant reports waking up feeling drained and in pain. Through this material, it is also possible to reflect on how the suffering of professionals can be so intense that a movement of non-differentiation can arise, with some of them not being able to properly discriminate against their patients; on the contrary, they keep imagining themselves in their place and confusing what would belong to them and what would belong to others.

We noticed that, in some cases, there would still be a complex intergame of introjection and projection, with professionals identifying in themselves aspects that would originally belong to the other (introjection) and, at the same time, defensively expelling what they feel (projection), returning to the other the suffering felt. This movement of 'returning the pain', in order not to succumb to the suffering aroused by the patient, can be observed in the following vignette:

Participant 9, an occupational therapist, wrote the following outcome for the interactive narrative presented: "[...] had received the result of the biopsy confirming an

esophageal CA". Then, the participant questioned whether the research was just about concluding the interactive narrative, saying: "Oh, it's just that I don't identify with this because I don't stay at home thinking about the patients. What happens in the hospital stays in the hospital [...] Not that I'm frigid, but it's just a moment, right?"

We chose this material because the movement of defensive detachment adopted by the professional is clear. This detachment can be observed in different ways: 1) through the manifest statement that patients and the hospital are configured exclusively in momentary concerns; 2) through the invention of an outcome, for the interactive narrative, that resembles more a technical writing in a medical record; and 3) through the derogatory remark about the interactive narrative presented, which transferentially distances interviewer and interviewee more than it brings them closer.

This affective distancing movement was also noted in other studies. Craving et al. (2016) interviewed seven members from different areas, who made up the Oncology team of an Argentine hospital, and reported that they needed to impose a barrier between themselves and their patients so that they would not suffer too much along with the patients. Moraes and Granato (2014), in turn, who conducted interviews mediated by interactive narrative with 10 nursing professionals in a Brazilian ICU, noted that, as a defensive strategy, professionals tried to cultivate an attitude of indifference, restricting the bond with patients to make it as technical as possible.

In line with Moraes and Granato (2014), we consider it natural and even desirable for professionals to be able to use a 'safe' distance to deal with patients who are dying. Because, if the professional remains too undifferentiated with the patient, they may experience a confusion of roles, literally feeling like a relative of the patient (Dias et al., 2019) or, as it happened with Participant 5, being traversed by the fantasy that cancer could break into her life or that of a family member, even having her own body affected by physical pain and other symptoms.

On the other hand, we are in full agreement with Bianchini et al. (2016), for whom the caregiver needs to be able to minimally come into contact with the patient's affective states, otherwise the 'frigid' bond established between professional and patient can prevent the first from sensibly identifying with the needs of the second, producing automatic and protocol care. In this sense, it could be said that work in Oncology not only requires a multiplicity of specialties but also demands that each professional can offer multidimensional care, which combines technical skills and sensitivity.

This reflection on the 'suitable' distance between the professional and the patient can be discussed in the light of Winnicott's concept of the false self (1983), a concept that he developed to refer to a protective layer that would cover up the true self. self, that is, the subjective constitution of the individual. Winnicott (1983) postulated the existence of a healthy false self, which would allow the individual to renounce the illusion of omnipotence and manage to live socially. But he also understood that there could be a level of the false self where the true self would be completely hidden by the false self, with a loss of spontaneity, total submission, and a feeling that life is not worth living. In this sense, we can think that, among the professionals interviewed, we found those who seemed to lack a protective false self, immersing themselves intimately in the pain of the other, as well as others who seemed to communicate an affective distance more linked to a dissociative defense, with the false self covering rather than protecting the true self. It would be necessary, however, for the professional to adopt a third existential position, one that was

neither total distancing from the patient nor personally emotionally harming the professional (Moraes & Granato, 2014).

Precisely because of this reflection, we understand that the solution to better train the Oncology professional to deal with the phenomenon, as pointed out by Pacheco and Goldim (2019) and Silva et al. (2020), should be relativized. We agree with these authors regarding the need to demystify the theme of death, understanding that, for professionals to be able to better deal with terminality, the hospital environment must propose strategies; otherwise, it is as if it were up to the professional to develop the ability to tolerate frustration in the face of losses, from an individual perspective. We understand, however, that, at the extreme, technical courses can enhance the defensive mechanism of rationalization, with professionals assuming a more intellectualized and distanced posture. Following the Winnicottian reasoning, the programs can either genuinely be equivalent to a strategy that will further qualify the professional or, on the contrary, to a false self-attempt to resort to more intellectualizations that would culminate in more mechanical and distanced care. In this sense, one sees the importance of training courses taking into account not only informative aspects, appealing only to the rational side of the professional but also strategies that enable the expression of suffering, sensitivity, and creativity, favoring a humanized care.

## **Category 2 – ‘Dance of Loneliness’**

This category refers to the professionals’ feelings of loneliness in their day-to-day work in Oncology. Thus, if in the category ‘I return the pain to others’ what was on the agenda was the suffering of professionals for witnessing the pain of their patients and needing to distance themselves defensively, in the category ‘Dance of Loneliness’ what stands out is the suffering of professionals because they feel that there is no one, in the team composed of professionals from different specialties, who witness their suffering. In other words, this category refers to a subjective experience marked by loneliness, which is evident from the following material:

When presented with the interactive narrative, participant 2, a nurse, comments on a case that had really marked her a lot, in which a patient, who had been hospitalized for eight months, died. She says:

Her sister, who accompanied everything, came to ask for help for us there, and then we took her inside the unit, where she cried a lot. But after that, how was the worker? Nobody wants to know! I think you need a professional who takes care of the professional. I see that we have a structure of concern in the field of Psychology and Occupational Therapy with patients, but not with the professionals themselves.

The participant then says that she had already asked the worker’s health sector to provide a psychologist to the professionals, understanding that, otherwise, “[...] all professionals will get sick”. But, given the lack of answers, she understood that she should look for alternatives, such as enjoying her dogs as soon as she got home from work.

Participant 2 highlights that, although there are different professionals dedicated to the suffering of patients, with regard to care for professionals among themselves, it does not exist. It is even possible to think that, based on her statement that “[...] all professionals will get sick”, participant 2 would be communicating that, as there is no care relationship between the professionals themselves, the illness of a professional, turning them into a patient would be the only possibility to be cared for by another professional.

Thus, from this material, it is evident that, although the hospital is managing to commit itself to the needs of patients, the professional does not have their role recognized as someone who also has needs to be met. According to Silva et al. (2015), this occurs because the professional is expected to meet an idealized image of someone who is not affected by emotional discomfort so hospitals end up constituting a true hiding place of suffering on the part of professionals.

Although Participant 2 spoke about the importance of psychological work dedicated to professionals, in an attempt to stop dancing alone with her work suffering, other participants, on the contrary, did not envision the possibility of sharing their subjective experience of work with their peers. An example that illustrates this point well is shown below:

Participant 7, a Nursing technician, invents, as a conclusion to the interactive narrative, that the couple of characters in the narrative had marked the protagonist Joana because the man kept “[...] showing off being strong, firm, while his wife burst into tears because she was already aware that it could be the end for her loved one, perhaps her foundation in their home”. Then, throughout the interview, the participant reports that she believed that professionals should have more days off so that they would have more time for themselves. When asked if she believed that a space for exchanges, among professionals, would be valid as a care strategy dedicated to professionals, she says:

There could be something like a conversation circle or even a professional who could assist us individually, but sometimes I think that if there were, there wouldn't be much demand, because we don't have time for that. Sometimes we barely have time for coffee. Can you imagine going to have a conversation?

We selected this material because Participant 7 expressed her unwillingness to be part of an emotional care device for the team, if it existed, given the lack of time. The professional who works in a hospital environment has, in general, a fast-paced routine crossed by multiple care demands, so that, to be able to effectively turn to themselves, an institutional culture change would be necessary (Silva et al., 2015). However, when we analyze more closely the material related to the interview with Participant 7, something that stands out was the fact that she was asked about the possibility of having a space for affective exchanges with other co-workers and, through free association, transforming this group space into individual conversations between different team members and a specialized professional. On top of this speech, it would be possible to question whether, in addition to institutional impediments, the participant had not also communicated the feeling of not being able to count on the team of professionals for affective exchanges. Does the dance of loneliness, in this sense, also have to do with a certain emotional unavailability of the team to share in solidarity the suffering experienced? This is very evident from the excerpt of another interview:

Participant 17, a physical therapist, completes the interactive narrative by writing that the couple had marked the protagonist Joana “[...] due to the difference in behavior between the two people [...]. How do people react differently to the diagnosis of such a devastating disease”. Throughout the interview, she comments that, despite all the different professionals having difficulty dealing with the patient's death, she felt that the physician's reaction was the most difficult. She explains: “They want to cure the disease. But, when there is nothing else to do for the disease, they give up on the person, so much so that, in many cases, we see that Physical Therapy could still do a lot for the patient, improve their quality of life, but, as it will not cure, that is left out”. When asked if there was a possibility of

exposing these feelings to other colleagues, the interviewee reports that only with those from the Physical therapy team. She says: “We end up keeping our pain in our pocket to take care of the other’s pain. We repress feelings until we get out of there. But, when it comes out, we talk about it with the (Physical therapy) team”.

We selected this material because, although, at the end of the interactive narrative, Participant 17 talked about the difference in posture of the members of the fictitious couple, throughout the interview, she spoke mainly about the differences that cross the Oncology team, composed of professionals from different areas. At first, what draws attention is the fact that the participant felt tensions when dealing with certain cases with professionals from other specialty areas, which has been widely discussed in the scientific literature, especially in relation to the figure of the physician, who, given the predominance of hierarchical culture, tends to be the one that centralizes decision-making, arousing feelings of injustice in others (Craving et al., 2016; Horlait, Baes, Dhaene, Belle, & Leys, 2019; Veloso & Silva, 2018; Wanderbroocke et al., 2018).

In a second moment, however, we noticed that Participant 17 reveals another type of suffering, in relation to her work colleagues, which would no longer be related to the inability to collectively treat cancer patients: the suffering of not being able to share with colleagues from other areas of expertise the malaise awakened in the daily work. This is, therefore, a difficulty of a different nature than the one commonly addressed in the specialized literature, since it does not refer to the lack of exchange of information about the cases, preventing shared care for the patient, but rather to the lack of solidarity that members feel from other professional categories, with affective exchanges being restricted to the intradisciplinary context (Cliche-Galarza, 2019).

Although we consider it valuable that professionals in the same area of expertise are able to count on each other to face the dance of loneliness in the Oncology sector, we understand this team dynamic in which different professionals are invited to jointly discuss public issues as problematic (related to the management of cases treated) through ward rounds, feeling unable to share private issues (relating to the emotional suffering of everyday life in Oncology).

Here it would be possible again to allude to Winnicott, who understood that the healthy individual is the one who manages to inhabit a potential space, that is, an intermediary space between external and internal reality, which would be configured as a place of refuge (Winnicott, 1975). Although he associated the potential space mainly with playing, it is possible to expand this concept, as Lopes (2016) does, understanding that the potential space can be experienced, for example, by being part of a groupality in which each individual can ‘rest’ in this group zone. In this sense, although hospital institutions are betting on the constitution of interdisciplinary teams aiming at more integral care to patients, the groupality that has been experienced has had its potential wasted, with the different professionals only sharing the spaces to discuss together how to handle common cases (when they do), without having affective exchanges.

From this perspective, it would be possible to think that one of the conditions for these different professionals to effectively form an interdisciplinary team is that they can carry out affective exchanges (and not just technical discussions about the cases). We agree with scholars who have proposed solutions of a different nature to encourage a greater sense of belonging among the different professionals in a team. These are solutions that range from the inclusion of courses in undergraduate programs, so that health professionals learn to have a collaborative posture in an interdisciplinary team (Head et al., 2015), passing through

the discussion about the possibility of different professional categories are not separated, which creates different worlds within the hospital (Cliche-Calarza, 2019), to the establishment of rounds for different professionals to exchange information and make interdisciplinary deliberations (Horlait et al., 2019). Nevertheless, interdisciplinarity challenges us to recognize that, for the construction of unprecedented possibilities of care for patients, it is necessary that the different professionals also have the equally creative possibility of being linked, among themselves, also due to affective exchanges.

## **Final considerations**

From this research, although the hospital is the reference place to deal with bodily illnesses, dealing with emotional suffering is still a great challenge, so much so that professionals expressed: 1) suffering to deal with the discomfort of their patients and with the frequent losses and 2) suffering for not being able to share their discomfort with their peers. The first aspect is in line, as we have seen, with specialized studies on the subject. The second shows a dimension that is not much addressed in the specialized literature, it should be said, the difficulty of interaction in the team not only in the sense of division of work, exchange of information, and joint decisions about patients, but also in the sense of belonging, with the possibility of affective exchanges.

Although the number of study participants was limited, their narratives allowed access to the complexity of their experiences, especially about the affective-emotional dimension. Evidently, as the research was carried out only in one hospital, this may be a limitation of the present study. Thus, although we heard professionals from different areas, as they all belonged to a single team, it may be that the suffering faced with the impossibility of affective exchanges with the team may be, to a greater or lesser extent, crossed by some specific factors of this hospital context.

Despite this limitation, our findings allow to think that one of the fundamental foundations for the construction of interdisciplinary work is the constitution of a team that experiences, in addition to a shared discussion of the cases and the joint construction of interventions, affective exchanges, where feelings can be shared, welcomed and cared for. In other words, it seems necessary to form a team where the emotional fragility of each professional can have space and the belief in the need to maintain an idealized image can be deconstructed. This seems to be an important horizon for the humanization process of our health system to occur effectively.

Therefore, our study indicates important aspects that can help in the development of actions focusing on both the mental health of professionals in the Oncology ward and the process of humanization of services in this sector, which seem to be inseparable dimensions. Among these actions, we bet, like some more hopeful participants who were interviewed, in the creation of a clinical setting, within the hospital institution, in which professionals can share their subjective experiences, a fundamental space not only for them to feel emotionally supported, but also for them to develop a sense of belonging to the team, which would surely support more integrated and humanized interventions with patients. Perhaps this is the only way it will be possible for the professional to experience working in the field of Oncology without having to return to patients their suffering and without dancing alone.

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