

A Psychotherapeutic Exploration of The Impact of Working on Multidisciplinary Teams in Psycho-oncology

By

Milena Sobesto

Supervisor of Research: Dr. Gráinne Donohue

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*'The doctor is only effective when he himself is
affected'*

C.G. Jung

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Abstract

Psycho-oncology involves different professions working together to provide holistic care for cancer patients. Psycho-oncology as a newly established subspecialty of oncology caters for the psychosocial needs of cancer patients. The integration of professionals is an attribute of psycho-oncology, seeing the inclusion of nurses, doctors, psychiatrists, psychologists and in small numbers, psychotherapists. The character of the work with patients dying of cancer can have a significant impact on the individual professionals, bringing to question their own mortality and exercising their own compassion which can lead to certain dynamics such as performance or death anxiety, and denial of impact, which all affects the functioning of multidisciplinary teamwork. This qualitative study presents a psychotherapeutic exploration of the impact of working on multidisciplinary teams (MDT's) in psycho-oncology, which was examined through the experience of five professionals working in psycho-oncology. This study analysed the aspects of working with vulnerability, self and other, in the psycho-oncology wards. The research has described the unconscious and projective identifications that are an indication of the difficulty of working in psycho-oncology. It also looked at the notion of communication within the MDT's showing that the grouping can carry certain dynamics that impacts the professionals, their well-being, care effectiveness, and overall functioning of the team. The finding suggested more awareness of the psychological difficulty that the work of psycho-oncology carries. The study questioned the impact of the individuals working in psycho-oncology and added valuable psychotherapeutic insight to the limited research in the area.

Chapter One: Introduction

Cancer is described as the defining plague of today's generation (Mukherjee, 2011). The statistics indicate that cancer is among the leading causes of morbidity and mortality worldwide, with around 8.2 million deaths in 2012 (WHO, 2015). The prediction also shows that there is a risk of increase by up to 70% of new cases of cancer diagnoses in the next 20 years (WHO, 2015). Diagnosis of cancer is shocking and fearful and it is difficult to imagine what is the experience of the person that's newly diagnosed (Sessions, 2012). Cancer is a life changing experience impacting and shattering one's feelings of vulnerability and immortality on many levels (Mukherjee, 2011). The way people deal with it really depends on their coping skills and personality as well as on the support they receive (Watson and Kissane, 2011). Over the years the psycho-social care of the patient was overlooked and there was a huge need for the specialised field to care for the psychological well-being of the patient (Grassi and Riba, 2012). Psycho-oncology as a discipline is relatively new; the field has been developed in the late 1970s and has become a subspecialty of oncology since (Holland, et al, 2010).

Today the contribution of psycho-oncology is visible in areas looking at training of staff in psychological management and in 'collaborative research that ranges from the behavioural issues in cancer prevention and to the management of psychiatric disorders and the psychological problems during the continuum of the cancer illness' (Holland, et al, 2002, p. 206). The development of psycho-oncology departments over the years started to see greater inclusion of psychology and psychotherapy oriented professionals. Psychotherapy is one of the supports recognised within the area of cancer treatment and it plays a huge role while looking at the improvement of quality of life of people affected by cancer and serves as an important element in meeting the psychosocial needs of the patient (Watson and Kissane, 2011). Although, psychotherapy plays a

huge role in the supports for cancer patients, psychotherapists are still not seen on the multidisciplinary teams in psycho-oncology.

It is significant to underline that the work in psycho-oncology is extremely demanding from a psychological perspective. Menzies- Lyth (1988) who studied nurses working with cancer patients discovered that they were at high risk of experiencing intense work related anxiety. Interestingly, it is important to underline that some of the variables in the study also indicated the stressors coming from the multidisciplinary work (Menzies- Lyth, 1988). Meier (2011) in her study discussed the emotional investment of the professionals working with cancer patients and the reason for that, being the close relationship those professionals develop with their patients. People working in psycho-oncology experience strong compassion towards the patient and their suffering, which, sometimes affects them and leaves feeling vulnerable without the support of the multidisciplinary team (Keidel, 2002). Research reported that doctors working directly with the dying patients have the tendency to show extreme levels of devotion in the their work with dying patients (Swetz et al, 2009, Peters et al, 2013). Those studies add to the fact that the high psychological impact of professionals working in psycho-oncology is common among this group of individuals. However, the interesting aspect of the Menzies-Lyth (1988) study was that working in multidisciplinary teams has some input into the well being of the people working with dying patients.

The multidisciplinary work is very common in today's healthcare organisations because it sees integration of professions in the care for the patient, therefore, it is important to underline the difficulties that professionals face from the dynamics within the multidisciplinary groups. The presence of hierarchy on the multidisciplinary teams uncovers anxieties that individuals experience. The individual and group unconscious processes are at a play in the organisations, which impact the effectiveness of the care as

well as impact the communication among group members. It is a fact that the research around the impact of working on multidisciplinary teams in psycho-oncology is limited, therefore the choice to explore it from psychotherapeutic perspective aims at uncovering aspects of working with vulnerability and the unconscious processes involved in the care for cancer patients. The purpose of this research is also to contribute to the limited amount of research in the area.

This research will study through the psychotherapeutic lens the impact of the work on multidisciplinary teams in psycho-oncology. It will specifically examine the three areas:

1. The personal experiences of professionals working in psycho-oncology
2. The aspects of working with dying patients
3. The individual experiences of working on multidisciplinary teams.

Chapter Two: Literature Review

2.1 Introduction

This review of literature will examine the literature regarding the impact of the work in psycho-oncology on the professionals working on multidisciplinary teams. Firstly, it will look at the psycho-oncology field and different professions that are involved in the care of cancer patients. Secondly, it will outline the impact of working on multidisciplinary teams with patients affected by cancer. Thirdly, it will show the role of psychotherapy in psycho-oncology. Fourthly, it will discuss the contribution of psychotherapy to multidisciplinary teams in psycho-oncology. Fifthly, it will include challenges of psychotherapy in psycho-oncology. Sixthly, it will present the issues of countertransference and projective identification that occur in the psycho-oncology work. Further, it will then explore the impact the work has on the individual professions and the dynamics that occur in the care for cancer patients. It will examine the risks of compassion fatigue, burnout and its prevalence in psycho-oncology and the difficulties and impact of managing vulnerability. Finally, it will discuss the impact as well as the unconscious dynamics involved in working with the 'dying'.

2.2 Psycho-oncology

In the last few years there has been a huge change in how cancer is viewed from being a terminal illness to being a curable illness because of the advances in medicine. It is significant to mention that more attention is focused on psychosocial support for cancer patients (Holland et al, 2002). Psycho-oncology is a specialist service defined as beneficial in working with cancer patients because of the development of services, programmes and hospital departments, providing education, research and specific activities of clinical care (Grassi and Riba, 2012).

It is not a surprise that mental health problems such as depression and anxiety are something a lot of cancer patients experience (Hegel, et al, 2006). Previously to the development of psycho-oncology services, oncologists who overlooked those mental difficulties were not able to apply more attention to holistic care of the patients with the emphasis on physical, psychological, social and spiritual aspects of care (Dolbeault, et al, 1999).

Over the years it was clear to see that cancer care is a multidisciplinary area, with the strong integration and teamwork of specialists as oncologists, nurses, surgeons, organ specialists, clinical psychologists with the important contribution of psychotherapists and other support workers (Price, et al, 2008). Thus, the *multidisciplinary team* is a frequently used term in the health care arena bringing together a group of members from different backgrounds and expertise that can provide the best complimentary service, one that translates into quality of care (Jazieh, et al, 2008).

2.3 Multidisciplinary teams

It is crucial to underline that multidisciplinary work in psycho-oncology has provided fruitful outcomes for a lot of people diagnosed with cancer (Watson and Kissane, 2011). The National Cancer strategy from 1996, has underlined the integration of the multidisciplinary approach to patient care as one of the fundamental principles that should underpin the delivery of cancer services in Ireland (National Cancer Strategy, 2006). The multidisciplinary work has evolved over time in response to the increase in the complexity of patient care with each discipline contributing its particular skills and knowledge in order to benefit cancer patients (Catt, et al 2005, Edwards, 2011).

Catt, et al (2005), states that the core professions typically involved in providing multidisciplinary care for cancer patients are surgery, oncology, pathology, radiology, nursing, psychiatry, psychology, psychotherapy, genetics and any other kind of interventions.

The National Cancer Strategy also reports the underlying importance of providing holistic care with the emphasis on psychosocial care for cancer patients in Ireland (Shannon, 2012, National Cancer Strategy 2006). The report puts emphasis on structures to be developed in each managed Cancer Control Network, stating that each cancer centre should have dedicated psycho-oncology service available to the patients and their families (Shannon, 2012, Hynes, 2013). It also highlighted the need for reorganisation in the improvement of care which will allow for better patient outcomes (Hynes, 2013). For instance, the National Cancer Strategy (2006), puts emphasis on the psychosocial support for cancer patients as well as the collaboration of different professions working with cancer patients forming multidisciplinary psycho-oncology services. The evaluation of the strategy, saw a huge need for psychology and psychotherapy related professionals within the multidisciplinary teams in psycho-oncology departments (Hynes, 2013).

2.4 Role of psychotherapy in psycho-oncology

It is true to state that not every person responds to living with cancer in the same way, however, what seems to help in coping is sharing worries about their illness (Cefrey, 2004). It is significant to mention that psychotherapy is one of the most recognised ways of support for people suffering with the diagnosis of cancer. There are a large number of therapists working with cancer patients, as it is believed by oncology

professionals that psychological factors affect the progression of cancer (Lemon and Edelman, 2003).

It is also crucial to state that although psychotherapists are starting to be more and more recognised on multidisciplinary teams in psycho-oncology as there is still visible ascendancy of psychologists and social workers (Coleman et al, 2011). Research suggests that cognitive-behavioural therapy is one of the most common types of intervention from the psychotherapeutic spectrum as it is the one that has better evidence of effectiveness (Tatrow and Montgomery, 2006). Another psychotherapeutic approach that is commonly used within psycho-oncology is cognitive-existential group psychotherapy, psychodynamic integrative approach, and the person centred approach (Postone, 1998, Spiegel and Classen, 2008). The psychotherapeutic interventions are mainly aiming to provide some relief for patients in the areas of distorted thinking and concentration problems amongst others (Goldie and Desmarais, 2013). It is quite clear that there are still gaps around research showing the effectiveness of psychotherapeutic approaches that makes sense in relation to the recognition of such small number of psychotherapists working in psycho-oncology.

2.5 Psychotherapy contribution to multidisciplinary teams

The contribution of the psychotherapist to the MDT is the understanding of working with cancer patients as well as working on multidisciplinary teams and enhancing the team as a whole. It is a fact that psychotherapy not only helps the patient but it also understands the impact of the work has on the professionals working in the field of psycho-oncology. MDTs in psycho-oncology have seen over the years the integration of professions to provide adequate care for the patient (Catt et al, 2005). However, there also exists the importance of how these professions work together and support

each other in the decision making process, underlining the best possible treatment for the patient. The study by Coleman et al (2011), highlighted one of the principles of the effective teamwork on MDT's which underlined successful communication and supports, one that especially focus on reduction of compassion fatigue in individual professionals.

A study by Carter and West (1999), shows that professionals working on a supportive and well functioning team benefit from better mental health and better team functioning. Another study looking at MDT's in cancer care, shows that complex patient cases were accomplished easier when the professionals had clear goals and supported each other as well as being aware and respecting each other's role (Payne, 1999, Taylor et al, 2005). Therefore, the contribution of a psychotherapist is crucial here, not only for the patients but also for the team. It is true to say that the knowledge the psychotherapist acquires during their training enables them to recognise the signs of trauma or other dysfunctions that are troubling the individual and apply adequate timely interventions (Wise et al, 2013, Watson and Kissane, 2011). It is also quite important to underline that a lot of psychotherapy professionals would have certain knowledge around the thought of compassion fatigue or successive communication and dealing with it would be of assistance to the MDTs in psycho-oncology (Fallowfield and Jenkins, 1999).

2.6 Challenges of psychotherapy in psycho-oncology

It is a fact that different psychotherapeutic interventions would help relieve symptoms of emotional distress. Thus, interventions need to match the degree of one's distress, their energy, ability to reflect as well as what they set up for themselves as a goal (Watson and Kissane, 2011). Interestingly, the intervention might vary looking at the time restriction of how long the patient will stay in the hospital for example which

might change the focus of the intervention (Watson and Kissane, 2011). Holland et al (2010), stated that the psychotherapist is often faced with the challenge of establishing a rapport that is generated to assess the urgency and needs of the patient suffering with cancer as well as developing manageable goals for the psychological treatment. The distress with patients as it was mentioned before varies, thus the interventions may differ starting from anxiety related, to diagnosis, decision- making as to which treatment is best, communication with the emphasis on coping strategies as well as resourcing the individual (Watson and Kissane, 2011). Psychotherapy provides a safe space where the patient can express their struggle and explore the effect their diagnosis and illness has on them (Holland et al, 2015). Literature, (Holland et al, 2015), definitely underlines that psychotherapy is not always task orientated but it could be stated that it involves the human presence that is healing. Some patients experience an existential crisis, have trouble in processing their grief, experience difficulty with reaching to their family members or look at the fear that cancer brings, however, it is important that they can discuss that with their psychotherapist (Watson and Kissane 2011, Holland et al,2015). Psychotherapeutic intervention in cancer care also focuses on the well being of the individual and their relationships and family dynamics because it's a fact that the whole family is impacted by such a diagnosis (Bloch and Kissane, 2000).

Psychotherapists working in psycho-oncology often need to assess for themselves how much are they going to share in their notes, bearing in mind they are ethically bounded by confidentiality and the fact that the notes can be accessed by the multidisciplinary team members (Goerling, 2013). Holland et al (2015), gives an example of a patient who did not wish to give more detail about their past trauma for the medical team to see, thus the therapist used their clinical judgement to decide how detailed their notes should be. It is also quite interesting that various sources underline the flexibility of a framework that a psychotherapist might use with the patient (Goldie and Desmarais,

2013) . It is important for the therapist to be mindful of the health state the patient is in and allow the patient to take the lead in what they really want to bring into therapy as it allows for the authenticity and spontaneity of therapeutic process (Holland et al, 2015, Goerling, 2013). It is also crucial to take into consideration the therapeutic setting and aspects related to that, such as time, engagement in the process and physical space (Goerling, 2013). One of the defining factors is the state of health the patient is in. For example; if the cancer is progressing quickly, the therapeutic alliance might be time limited and the patient might have limited ability to be attuned to their experience because of effects such as tiredness amongst others (Holland et al, 2015). The physical space for psychotherapy might vary also and both the therapist and patient might be faced with these limitations due to the patient's situation (Griffith, 2005). Some patients might need to be seen at different settings as for example, the hospital bedside or chemotherapy infusion room, however, research suggest that this type of psychotherapy is as effective as in usual setting (Omer, 2000, Griffith, 2005).

2.7 Countertransference and Projective Identification

The work with cancer patients has an effect on the individual and it is quite common that psychotherapist would be triggered by the countertransference. Thus, it is important that they are able to notice that because feelings of countertransference are harmful if stay unexplored (Evans & Gilbert, 2005). Interestingly, Obholzer, et al (2003), stated that as in organisations it would be easier to associate one's behaviour with their private problems, than associate the link with dynamics that occur in certain institution. This link could be made through projective identification which in other words could be described when one acts out the countertransference from the material that was

projected onto him/her from the patient or another staff member in MDT's (Obholzer, et al, 2003).

Projective identification serves like a sponge when negative feelings are projected onto one group member who carries it on behalf of the group causing an unhealthy dynamic. Obholzer, et al, (2003), suggests that it is important to be able to recognise the difficult feelings and return them back to where they came from. It is important to reflect on those feelings and tolerate the impact, to learn how to contain it which can bring the change (Sedgwick, 2003). The notion of a container comes from the work of Bion (1962) who looked at the mother who has a ability to understand and receive the unbearable feelings of the infant and makes them bearable (Obholzer, et al, 2003).

This dynamic definitely needs time for the projection to be re-owned so that splitting will decrease, resulting in a reduction of the polarisation among individual professionals working on MDT's in psycho-oncology. This integration would improve the functioning of the group and its communication within and with other groups thus, it could be observed that paranoid-schizoid shifts towards the depressive position (Obholzer, et al, 2003). In the paranoid-schizoid position, the lack of insight or resistance to change may occur and in the depressive position, which involves guilt or grief over hateful attacks damaging internal and external objects (Segal, 2004, Obholzer, et al, 2003). The depressive position also is related to the one's ability to become responsible and develop this ability to separate themselves from the other (Klein 1933, cited in Segal, 2004, Steiner, 1987).

The countertransference reactions that become uncontrolled in relation to a patient dying are an active barrier as it stops the therapist or any other professional from questioning and exploring their own existential anxieties which then prevents the formation of safe and authentic relationship whether with the patient or within the

psycho-oncology department (Stokes, 1994). Thus, psychotherapy as a profession is able to offer the practice of self-reflection to multidisciplinary team and enhance the impact the work has on the individual professionals.

2.8 Impact on the professional

It has been established now that multidisciplinary work in psycho-oncology is beneficial for the patient as it provides more attention to the human side of the patient care (Dolbeault, et al, 1999). Working in psycho-oncology is characterised by the development of deep professional relationships with cancer patients and their families.

It is a fact that psycho-oncology professionals working within the MDT's are to some extent exposed to suffering and death anxiety (Medland et al, 2004, Dean, 1998, Montgomery, 1998). It is then understandable to argue the fact that this type of work is emotionally demanding for the professions involved. The expectation of providing cancer care of high standards is something that is one of the goals to provide for cancer patients (Coleman et al, 2011). Wakefield (2000) in his paper including nursing staff states, that it is extremely stressful and emotionally draining to maintain a sense of composure, while a patient is dying of cancer. The study presented by Wenzel et al, (2011) shows that the omission in care of the patient carried by oncology professions were associated with stress, as well as feelings of powerlessness, helplessness and hopelessness (Wenzel et al, 2011). Vachon (1998) for instance recognised in their study the increased stress levels in staff working closely with cancer patients especially when the death of the patient occurred.

It is also significant to underline that many of the professionals as they are exposed to grief and number of deaths, experience *grief overload* (Vachon, 1998). This is the

evidence that many of the professionals on MDT in psycho-oncology experience grief and bereavement after the patient dies and some might allow themselves to grieve some professionals as Rokach (2005) suggests however, would not and that can result in a sense of vulnerability as those feelings become repressed and an individual might become at high risk of compassion fatigue (Abendroth and Flannery, 2006).

2.9 Dynamics in the care

It is of relevance to bring Dartington (2010) into this discussion whose interest focuses on the dynamics of care in hospital environments and other agencies from psychodynamic approach. This approach could be applied to all kinds of human service organisations that draws from an understanding of individuals and groups. He underlines that systems theory takes a scientific approach to the whole, which is greater than the sum of its parts (Dartington, 2010). Applying this idea to MDT's in psycho-oncology, it is clear that the need for a collaboration of different professions in cancer care was crucial over the years and has provided huge success to the future. This explanation of working in the system offers an explanation on the role of 'the individual who has to understand and manage the boundary between his or her own inner world and the realities of external environment' (Miller, 1989, cited in Gould, et al, 2006, p. 6). It is true to say that this is quite difficult on the MDT's as it seems like as research suggests, professionals dealing with cancer patients are hugely impacted by it which then it is evident in the quality of their work (Wenzel et al, 2011, Feld and Heyse-Moore, 2006).

In the reality of care it would be extremely difficult to become indifferent to human suffering or a patient dying, as it was suggested by Keene et al (2002), nurses working with cancer patients found extreme relief when they could share their experience with

other members in debriefing sessions. The evidence suggests that many professionals working with cancer experience high levels of stress (Brennan & Moynihan, 2004).

It is also a fact that anxiety levels are highly present in nurses and doctors who work in palliative care, thus, many were able to justify different responses for example ignoring the impact and trying to keep busy without allowing themselves to grieve (Wenzel et al, 2011, Corner & Bailey, 2009). These responses are quite easily recognised as fight-flight and freeze (Stokes, 1994). It is of importance to state that when overly stressed professionals work in cancer care it can impact their cognition as well as behaviour (Corner & Bailey, 2009). The impact of this results in bad decision making, for example if one is being triggered by anything stressful in the workplace they become hyperaroused, which inhibits their decision making (Totton, 2006). In other words one's attention becomes absorbed by the threat and their ability to reason and assess the situation is impaired negatively by the increasing anxiety (Totton, 2006).

It is also interesting to look at Bion's (1962) theory of fight and flight that could be observed in the dynamics of the impact on MDT professionals in psycho-oncology. It is significant to argue that fight, flight and freeze responses are a part of every human psyche, therefore it is not a surprise to see those dynamics in groups and other organisations (French and Simpson, 2010). As Wakefield's (2000) study suggests, the nurses who were exposed to a patient's death, sometimes experienced freeze response, for example taking on more work and keeping busy and not showing the emotional response. Welker-Hood (2006) indicated that the accidents that occur in hospitals are partially a result of 'stressed out' professionals, furthermore that study also suggested that the way to improve the team working is to increase support for the members and organise team building with mentoring for the multidisciplinary teams in hospitals (Welker-Hood, 2006).

2.10 Compassion fatigue and burnout

Compassion fatigue is something many health professionals experience in a highly emotionally demanding roles when working on multidisciplinary teams. Research suggests that it's one of the causes of losing interest in the field (Sedgwick, 2003). Compassion fatigue being a risk for the professionals working in the psycho-oncology setting, is described as a state of 'physical mental and emotional exhaustion caused by involvement in emotionally demanding situations' (Figley, 2002, p.1436). This overexposure to suffering, pain or deaths causes high levels of stress and impacts one's capacity to show empathy (Christ et al, 2015). The stress is a result of the need to relieve one's pain or suffering, thus when one ability to cope with this need is exaggerated, then the individual may experience psychological symptoms as frustration, irritability, tension, sad feelings, anger withdrawal, numbness and emotional detachment (Christ et al, 2015). Burnout on the other hand is defined as job related stress with individuals feeling exhausted, having a sense of inability to accomplish tasks and loss of interest in the work (Figley, 2002).

It is important to state that one of the strategies to improve the self-caring of professionals working in psycho-oncology, would be the provision of training and ongoing awareness of compassion fatigue as well as supports available for the individual professions (Aycock and Boyle, 2009). The supports that are available include those formal and informal, which is for example the in-house supervision or debriefing sessions and the informal, for example, sharing with colleagues (Abrams et al, 2015). In other words the hospitals should provide the 'good enough' environment that is conducive to true multidisciplinary teamwork collaboration, mentoring the supervision and the permission to express vulnerability and sorrow in face of suffering (Aycock and Boyle, 2009, Abrams et al, 2015). Reflection, meaning making and

mindfulness interventions all have the power to enhance well-being of psycho-oncology staff and can be included as organisational strategies to enhance the well-being of professionals (Beach et al, 2013). Maintaining high quality psycho-oncology care requires supports to address compassion fatigue and burnout experienced by staff confronted with life-threatening conditions and facilitating resilience building approaches and activities (Christ et al, 2015).

2.11 Managing Vulnerability

Theory could be useful in the context of looking at vulnerability (Dartington, 2010). Anxiety has a genesis in the early years of a child when they experience loss and learn how to self-regulate (Dartington, 2010). Klein (1975, cited in Rosen-Carole, 2012) discovered this through taking the early experiences and the despair that child faces as crucial and she related this to child's later ability to handle stressors, traumas etc. It is important to state that stress is associated with vulnerability as it involves an element of change, which evokes anxiety in an individual who then experiences difficult feelings, pressure to perform etc. (Dartington, 2010). Work itself would bring anxieties, as for example professionals working on multidisciplinary teams in psycho-oncology are exposed to the transgression of many taboos to do with privacy, sexuality and nakedness as well as primitive anxieties about death and dying (Dartington, 2010). The coping then with the anxieties could take different forms whether functional or dysfunctional.

Klein describes the way people learn to recognise that things are not all good or all bad but contain elements of both, in other words what we want to possess and what reject (Klein, 1975, cited in Segal, 2004). In her theory then the depressive position can be put alongside the work of others in describing the conditions for what Bion (1962) called containment and reverie and Winnicott (1965) named as the holding environment. It is

also significant to mention that the processes of splitting and projection remain a way for people to organise the psychic experience and also become apparent in the organisations they work in (Dartington, 2010). Awareness of the potential psychological vulnerability of professionals working on MDT's and problems inherent in the work can enable the team to act to anticipate some of the issues. The responses really vary as some professions in psycho-oncology choose to ask for help, while, some find it difficult and the delay doing so until the situation becomes unbearable sometimes results in individuals experience compassion fatigue (Thomas, 2006).

2.12 Working with the 'dying'

Death is a most personal intense human experience. The combination of physical, social, psychological and spiritual issues involved in death, demands that those working in caring for terminally ill not only have a broad understanding of the issues related to death and dying but also need to be personally comfortable with those issues (Berzoff & Silverman, 2004). It is true to say that even if professionals are able to achieve this balance that still can be challenging. The skills of self-reflecting and the difficulty around accepting the uncertainty need a certain flexibility to deal with the nature of the work with dying patients (Berzoff & Silverman, 2004). Research found that attending patients with cancer means that clinicians are exposed to loss, despair and grief. All of which could be very stressful (Farber et al, 1999). Adaptation of positive regard for the patient is crucial and it adds to the relationship a sense of being approachable (Berzoff & Silverman, 2004).

One of the interesting dynamics is the observed positive attitude of the nurses in the work with the cancer. Obholzer et al (2003), sees that as a defence against death anxiety for the nurse or other professional as well as defence against the acknowledgment of the

difficult feelings that are associated with loss. This desire to be the perfect carer comes sometimes from the pressure the patient creates at the end of their life but also it could be evoked from other staff and their need to be more effective than others (Wise et al, 2013).

It is a fact that a lot of psycho-oncology staff experience stress that has existential dimensions, this stress is related usually to the care for dying patients (Ekedahl & Wengström, 2006).

The defences against death anxiety are also discussed by Yalom (1980) who distinguished two defences: 'the ultimate rescuer' and the 'specialness'. The first is related to feeling like one is invincible in protecting others and himself/herself from dying. It is true that some physicians come into this role of 'the ultimate rescuer', for example when they believe that no matter what they can save the patient (Yalom, 1980). The 'specialness' also is common for staff working in psycho-oncology as it circles around the idea that one can avoid death and that its laws do not apply to him or her, leaving them with the godlike feeling (Yalom, 1980, Berzoff & Kita, 2010). It is then essential for the individual on MDTs to become aware of their anxiety so it does not come into the patient-physician/professional authentic relationship (Wise et al, 2013).

Professionals working in psycho-oncology have the capacity to reflect on the difficult experience of a dying patient and as Tait and Hodges (2012, cited in Wise et al, 2013) state they can include reflection how those experiences improved the way they work. It is important for the professionals working in psycho-oncology to engage in the dialogue about dying and know that the 'good enough' care is enough for the patient. In the end, Block (2001) underlined that the reflection and the ability to speak about the stress in caring for cancer patients is healing and it 'challenges the physician to be present in the

face of suffering, to find ways of using one's self therapeutically when medicine's technical and curative limits have been exhausted' (Block, 2001 p. 2904).

2.13 Conclusion

The literature underlines many aspects of the difficulties, the impact and the risks of the work with cancer patients. However, it is observable that the literature although demonstrates the impact it is limited around the realness of the experience of people working in psycho-oncology. The multidisciplinary teamwork is evidently seen as having many advantages but on the other hand the unconscious dynamics of the group contribute on high scale to the well-being of the professionals working in health care organisations. Therefore, this study's aim is to explore through psychotherapeutic perspective the impact of working on multidisciplinary teams in psycho-oncology.

Chapter Three: Methodology

3.1 Introduction

This chapter will explain the research methods involved in the process of conducting this research and the steps involved in its realisation. This methodology design is qualitative and aims to explore the experiences of the individuals working on multidisciplinary teams in psycho-oncology through the lens of psychotherapy.

Qualitative research is set to discover the new insights into old problems and help produce accounts that provide justice to the human experience of people participating in the research (Vossler and Moller, 2014). As according to McLeod (2011), good qualitative research needs to include 'immersion' in some aspect of social life in order to capture the wholeness of that experience. It is true that the goal of this type of research is to change or provide different view to the quality of services provided to users (McLeod, 2011). Another goal of the qualitative research in psychotherapy is about generating new understanding of the complexity in the therapeutic process (Vossler and Moller, 2014). It is a fact that techniques related to qualitative research can be compared to the techniques used in therapy, drawing out experiences, active listening, showing understanding and evaluating the result (McLeod, 2011).

This is especially relevant to this research as the aim of this was to explore the personal experiences of professionals working on multidisciplinary teams in psycho-oncology and make sense of the individual intakes generated from interviews. The study seeks to examine from a psychotherapeutic perspective and capture the whole experience of the impact the work in psycho-oncology has on the individual professionals working on multidisciplinary teams in the field. The impact the work has on the individual was examined drawing from experiences of participants that added a flavour to the data outlining challenges and impactful experiences, the work in psycho-oncology carries.

The reason the qualitative research was chosen is also the fact that this area is rarely researched and the researcher has particular interest in the field and dynamics present in psycho-oncology.

3.2 Aims and Objectives

This research aimed at exploring the impact the work on multidisciplinary teams in psycho-oncology has on the individual professionals. It is especially aimed at seeking a greater understanding of the challenges of the work with dying cancer patients. It looked at the phenomenon of working with the dying and aimed to interpret the experiences from psychotherapeutic perspective.

The objectives of the research include therefore:

- To critically evaluate from the psychotherapeutic perspective the impact of working with cancer patients on individual professions working on multidisciplinary teams in psycho-oncology
- To explore the literature around the implications for individuals working with cancer patients in psycho-oncology
- To find out the challenges the work has on the professionals and the dynamics involved in the coping with that work
- To seek an understanding of what is the role of the individual on the team and how they contribute to the team-work and what challenges work on multidisciplinary teams carries in the field of psycho-oncology.

3.3 Research Method

The research method of this study includes thematic analysis, as it is one of the attainable qualitative analytic methods (Vossler and Moller, 2014). The nature of thematic analysis offers the researcher certain flexibility, which provides the research with rich data (Braun and Clarke, 2006). The process of thematic analysis involves coding the material, examining the codes to establish the themes that are arising which later should be examined to seek to classify them into 'superordinate and subordinate themes' (Attride-Sterling, 2001, cited in McLeod, 2011, p. 146). The study involved five semi-structured interviews that were conducted to explore the impact of working on multidisciplinary teams in psycho-oncology. The interviews were thoroughly analysed and the three themes were extracted that apply to the topic.

The interviews covered topics including:

- The participants background and interest in the work
- The challenges of the work in psycho-oncology
- The approach towards working with dying and vulnerability
- The nature of coping with the work and available supports
- The challenges of working on multidisciplinary teams.

3.4 Participants

The research involved five participants who work in the area of psycho-oncology and are active part of multidisciplinary teams in the field. All participants (illustrated in Table. 1) work in hospital psycho-oncology wards and are a part of different multidisciplinary teams. The experience of working in psycho-oncology of the people interviewed varies from thirty years to four years.

One of the participants is a psychiatrist and head of the psycho-oncology department in one of the biggest hospitals in Poland. The two other participants are trained clinical psychologists and the study also involved two nurses; one cancer nurse specialist and the other, a nurse who also has an experience in palliative care.

Table 1. 'Sample demographics'

Name of Participant	Position	Years of experience in psycho-oncology	Gender
Frank	Clinical psychologist	4	Male
Ruth	Oncology Nurse with palliative care experience	5	Female
Emily	Cancer nurse specialist	10	Female
Una	Clinical psychologist	16	Female
Donna	Psychiatrist	30	Female

3.5 Recruitment and data collection method

The recruitment of the participants started with setting the criteria, which originally was seeking all Irish participants but needed to be changed because of the limited interest in participating in the study. Originally the criteria included that the sample will include Irish professionals who work in the area of psycho-oncology and have at least 3-year experience in the field. Candidates were contacted by email and the information about the study (Appendix 1) was shared with them before any interview took place.

The recruitment firstly started with emailing potential participants but due to the slow process of replying the researcher contacted firstly the head of the psycho-oncology department in Poland as well as three different Irish hospitals and invited individuals to participate in the study.

After the first participant showed an interest the researcher used snowball sampling which involved selecting individuals who have similar interests or experience in psycho-oncology and ask them to refer for additional participants who would be interested in the research (Nezu & Nezu, 2008, McLeod 2011). This type of sampling allows for non-probability of data collected and allows for non-biased answers because in this research the participants were as diverse to each other as possible (Given, 2008).

All participants were presented with consent forms (Appendix 2) before each semi-structured interview took place. Two out of five interviews were conducted over Skype because of the availability and distance of participants and the other three were devised at places of convenience for participants. The interviews took from 40-50 min and asked eleven open-ended questions (Appendix 3) around individual experiences. The interviews have been recorded and then transcribed for the purpose of chosen thematic analysis technique.

3.6 Data Analysis

Thematic analysis was the chosen technique for data analysis, which seeks to establish themes and patterns across the data taken from interviews. This meaning making process broadens the experience of one individual while the attention is also given to social context and its meaning (Braun and Clarke, 2006). Thematic analysis is a method that reflects the reality and is able to look at the implicit patterns and unravel them (Braun Clarke, 2006).

After the data was collected, the coding of it began and as coding in thematic analysis is organic, the coding emerged with the progression (Vossler and Moller, 2014). The boundary of codes expanded as sub-codes that began to overlap were joined into

themes. There were three original themes that emerged from the data but one of the themes was more accurate and rich and the overlap of the two was visible. Therefore, the researcher took the main theme and divided it into three, which refined focus on the question of the research. The purpose of that was to remain focused on the research question and eliminate distracting data, which was also rich but might have been as relevant to the purpose of the study. The three master themes that emerged were then applied to the literature to form a discussion.

3.7 Ethical issues

It is important to underline that qualitative research ethics place huge emphasis on the principles such as informed consent, confidentiality as well as avoiding of harm and fairness (McLeod, 2011). That is why the anonymity of the participants was maintained, storing data and protecting it under Data Protection Act, 2003 of which participants were informed. It is significant to mention that the researcher have obligation and should be responsible in considering the possible effects of the research on people participating and as well wider society (Frost, 2011). Therefore, the participants were advised about the purpose of the research that the participation would was voluntary and at any point of time the participant could withdraw from it. It is clear that the information that was be shared was personal therefore, it is important to maintain confidentiality as well as protect the individual anonymity. Importantly, the real names of the participants have been changed and the details were distributed carefully for example where participant have worked etc.

Chapter Four: Results

4.1 Introduction

The personal accounts of participants on the matter of the impact of working on multidisciplinary teams in psycho-oncology was interpreted and analysed from a psychotherapeutic perspective. It allowed for three themes to emerge from the data, extracted from personal experiences of the participants. The themes were a spontaneous product of the data analysis and were strictly focusing on the experiences that were given by the participants around the phenomenon of working with 'dying'. The three themes are as follows:

1. Managing vulnerability
2. Personal experiences (countertransference)
3. Compromised Communication

The themes will be outlined and analysed in the following section with the aid of actual extracts from the interviews to support the analysis.

4.2 Theme One: Managing Vulnerability

All participants brought in evidence of the difficulties that the work with cancer patients has had on them and how they see the work, their experience, the role they undertake, the support or care they provide for the patient and all that has its emotional undermining. Of particular relevance is the area of coping with the work or managing the stress while working with cancer patients was strongly expressed in various forms by all of the participants. They expressed for example, the hardship of the work and the need for a degree of self-awareness and perhaps being attuned to their own experiences, to be also able to spot the impact of the work and to introduce coping strategies. For

instance, Una presented her experience as feeling exhausted by the work and her need for acknowledging the impact.

Una : I've never felt unable to cope but there were times when you felt quite exhausted or frozen by the work. It wasn't very nice I guess it's not something I would've experienced before working with other groups of patients and I guess it's a time when it's really important to reflect on the work you doing and why it's having an impact on you like this.

Overlooking the impact, there also is the sense of privilege the work carries for the individual professionals. All of the participants reported having this feeling of certain privilege the work offers for them, the fact that they can help improve one's quality of life, ease their pain or offer support or simply offer human presence when they are dying.

For Frank it was particularly focused on offering the patient positive regard in a non-judgmental space and really meet them at where they are at that made him feel appreciated in the work.

Frank: I guess it a great privilege to meet people you know who are maybe very vulnerable and to potentially meet them in a way that they probably never been met before in medical system.

Interestingly, the fact that making a change is rewarding for the individual has helped the participants of the research appreciate the type of work they do. It is the relationship with the patient and the positive feedback that creates the sense of belonging for the individual professional and makes them feel grateful for what they do. For Emily it was the positive feedback and attitude about her work, which made her more efficient:

Emily: What sustains me in the work is that you meet people as well, most patients are very, very nice to you and if you get to make something better for them.

This was also strongly present for Ruth, who through the positive feedback was able to acknowledge for herself the privilege the work brings as she offers the support and assistance to dying patients. Ruth's answer really articulated the sadness of the realisation mostly for herself that this type of work is challenging not only professionally but also personally:

***Ruth:** People would say how do you keep going, do you not find it really sad? Of course it's sad because it's the most- I suppose special time in somebody's life and you are getting the privilege to be a part of it. I suppose it is motivating that you are able to make a difference at their end of their life.*

In the statements by Una and Donna similarly, it was visible that they both underlined that their need to do something good for the patient, to improve their quality of life was most rewarding:

***Una:** I think it's being able to see that you have the ability to help people improve their quality of life so you can make a difference so you can help people change how they are feeling emotionally.*

and

***Donna:** The reason was definitely that I started to work in a hospice as a doctor because I wanted to do something good. I was a psychiatrist already and was mostly interested in the field of individual psychology and in conversation with those dying patients there I realised that they shared a lot of emotional difficulties of having cancer.*

The interesting observation coming from both of the interviews was the confidence those two participants had in their skills and visible omnipotence over other professions which although is understandable because of their position and experience, however it seems that the real experience remains detached from their vulnerability.

In Una and Donna's interviews, these defence mechanisms presented as a means of protecting their individual profession and speaking from this defensive stance left out at

times, the personal impact and their own vulnerability around the impact of the work with cancer.

The defensiveness is something that allowed them to function in the work, although the emotional cut-off was present when asked about the experience of working with dying patients and here Donna denied any impact on herself, with significant boundaries and long experience as well as authority in the hospital she works:

Donna: No, I don't let it impact me. I have too much experience in the area. No, I don't have any problems with coping. I have never experienced burnout. I think it's about having boundaries and knowing what you can do for the patient and what not. You need to really learn how to accept the challenges to accommodate it to the work.

Una's answer to the matter was quite symbolic because of the sensitive nature of the question around working with vulnerable people that illustrated the defensiveness against the felt feeling and denial, which could be associated with her grieving process.

Una: I suppose its ehmm, it's not the fact that they are vulnerable that impacts because I worked in the different areas before and as psychologist we always work with people who are vulnerable. It's not their vulnerability that is upsetting or that it's emotionally challenging.

The resistance towards the realness of the experience or impact of both Una and Donna was present in their answers.

Managing vulnerability is associated with the fact that sometimes it is difficult to control for example, the effects the death of the patient might have on the professional and how the professional can work with them knowing that the patient will die. The work within psycho-oncology does have a huge number of patients who die and as it was mentioned before makes the professionals perform to their best to offer the care that will improve the quality of life or quality of ending for the patient. Two of the participants underlined the need for having confidence in their skills and knowing they are capable of caring or supporting the patient. The need to be efficient in the work was

present for all participants and some expressed that sometimes they need to put their feelings aside and do their job because that's what patients need them to do the 'good enough' job.

The experience of working with dying patients has enormous impact on professionals and it is important for them to be able to meet with their response towards death and process it. Frank reported that the awareness of knowing that the patient will die helps him to see them and offer the 'good enough holding', which again is rewarding for him as individual.

Frank: *For me the conditions under which we are meeting are very important. I am knowing that we wouldn't be meeting if the person didn't have a very serious illness and ultimately was going to die from that illness. So it's never too far from my mind that this is temporary and this is an opportunity to hopefully be of benefit to this person. For example to do some work together that would be beneficial and will be hopefully beneficial to how the person moves to their final weeks or days of their life.*

Donna similarly explained the her impact would not be as severe because she would know in what state the patient is so she can almost predict how long they have left to live.

Donna: *I know before starting the work with the patient that they will die because it is inevitable.*

Ruth added an aspect of although having the professional relationship with the patients but also not forgetting about the human response and feeling of sadness after somebody has died which doesn't deny the reality of the situation and doesn't take away from being a professional in field.

Ruth: *When you might have looked after them for a longer period of time you are just closer to them and that's hard because even though we try to lead our professional relationship but we are still human. We can be sad or vulnerable that they have died, grieve too.*

The vulnerability about witnessing dying turns into the need for turning for the support, for the conversation about it and all of the participants have seen the need for advising or engaging with older colleagues, supervision or partners. Those conversations evoked a sense of relief of sadness for the individual professions.

For Ruth, as well as Emily, the need to speak to their partner's served as a relief. Ruth stated that maintaining certain boundaries about having that conversation before going home from work was beneficial: she prefers that her personal life stay uncontaminated by the difficult feelings associated with the work.

Emily: I suppose among my colleagues it's important to have people who you can talk to and you know my husband is really good at but you can't really bring work home with you either.

And

Ruth: When it might be their first death it really affects them and they always feel if they could have done more and I think just to sit down and just to talk about it with somebody in your own profession. I am lucky that my partner is also in the health care profession. I suppose when we are on the way home from work in the car we can have a chat about it try not to bring it home with us. We would chat in the car going home but that's it then we don't bring it home and to our personal life.

Vulnerability is present in the field of psycho-oncology for both sides- the patient and the professionals working with them. It is a sensitive area, which evokes difficult feelings and makes coping with the work challenging experience. All participants spoke about death and how that affects them to a various degree; some denied the impact some and some underlined the realness of human response and grieving. The visible part was that although the work is difficult, the participants held the good object, which is the privilege the work brings for them.

4.3 Theme Two: Personal Experiences (countertransference)

It was visible from the interviews that the participants have expressed their own experiences, showing that the work has left its imprint on each individual and spoke about whether it motivated them to work it further or whether they allowed it to be repressed. All of the participants spoke about the motivation to help people and that the work sometimes is rewarding. All of the participants have seen the area of working with dying patients as challenging and it triggered some personal stories that the participants carry in the work which sustain them in it. Frank expressed that his motivation to the work is personal and also comes from a need to be useful to people. He expressed the fact that he is really aware of his own mortality while working with a patient who is dying.

The occurrence of personal impact was visible in all participants who brought in examples of how their life was affected by having cancer in the family, dealing with difficult medical case or identifying with a patient.

Ruth explained that what brought her to work with cancer patients, was the experience of having a sister with cancer who later died.

***Ruth:** I had a sister who was diagnosed with multiple myeloma and the hospice team at home coming to the end of her life they were just wonderful. I suppose it was such a hard time for all of us but they just made it for us that little bit easier. Sadly she passed away and she was very young. I always thought I would be able to make a difference to somebody's life at the end of their life.*

It is because of this experience made Ruth to put herself in the patient's position because this identification triggers the experience coming from her past.

***Ruth:** I always try to put myself into their position as to what I would feel like if this was me.*

Then later on in the interview she gave an example of a patient who was same age as her and because she was not used to working with young people she could not put a

rational to their death. She expressed that with older people, she would explain to herself that they had a nice life but with the younger person she experienced grief saying that they died too soon.

Ruth's identification with a patient enables her to offer the best care, but leaves the gap between how does she deal with being triggered by her past experiences with her sister for instance. Her emotional response might be also coming from a lack or weak implementation of boundaries in her role as a nurse.

The matter of feeling impacted by the young person with cancer seemed to be reoccurring in all of the interviews. Una's response underlined exactly that:

Una: For me the most challenging and upsetting part its specifically around patients who are facing death particularly when they are young people especially young parents.

Interestingly, Donna reported a situation when she let herself believe that one of her critically ill patients will get better.

Donna: The most difficult situation I had when I provided care for this young girl and the story was really emotional a lot of people prayed for her, came to visit and in one moment I believed with all of those people that she will get better and this was really bad for me. Of course she died and it left me shaken by it and really upset.

When Donna spoke about that, her voice changed and she really seemed like the memory came back to her leaving a sense of sadness. The interesting bit to interpret here is whether the sadness was for the patient or the fact that Donna let her boundary slip in this particular case. Boundaries have been very important to her especially and she would explain that by the fact that it is not about what she feels it is what she is able to offer to the patient which could indicate a dismissal of real felt experience.

Donna: *I don't concentrate on my feelings or on myself I think about the patient and how I can offer them the best possible care. I don't analyse my feelings that particular person is important. Every doctor cares only for the patient if the doctor is affected then they need to deal with that but in the moment the patient and their feelings become your priority.*

Emily for instance has described similarly as Donna, the task of providing the best care as a priority but unlike Donna, she admitted that sometimes although having a boundary, she would become attached to people and again the theme of being impacted by young person or same age identification is reoccurring.

Emily: *If you are for example able to draw a line between you and them it's extremely hard to do it for example when you have a patient at the same stage of life as you it's very hard not to see yourself in them and you do sometimes get emotionally attached to them but in other way you really need to be more definite, you are here to do a job. You are not good to them if you get emotionally involved or attached with them.*

Here again the need for having professional boundaries is seen as beneficial in the work because of the ability to perform better and maintain the professional relationship.

The interviewer was interested in the notion of boundary and it seems like some professions particularly medically related would see it as almost as a protection from feeling impacted or triggered by past experience. The notion of countertransference in the work is present in the work but perhaps not seen as a part of the process and is not acknowledged because it is rather repressed.

Dealing with emotions that have been triggered by patients or past experiences could be regarded as characteristic of psychotherapy and the notion of boundary too. It could be argued that the experience in the profession is a significant factor in recognising countertransference but as in Donna's situation, her reaction towards being triggered was to deny the realness of the experience. It is important however to look at her position in the hospital; she has been in the profession for over 30 years and she became the authority for other doctors because as she recalled in the interview, younger colleagues would come to her seeking advice or support.

Una similarly used her experience as an excuse to cover up her personal experience and that was visible in the interview because she rather spoke generally about her profession. Una when asked about challenges of the work became quite uncomfortable and answered questions drifting away from the felt feeling using her experience as a defence from being impacted. This was unlike Emily who saw her experience as beneficial because it added to how she would view the impact the dying patient had on her at the beginning of her nursing career.

Emily: *I guess there is some more dying patients that would get you more than others. I have to say I'm a different nurse that I was 10 years ago, I am a very different person as well it's about not to be afraid to talk about it and allow your patients to talk about it too.*

Emily statement of being a different nurse after 10 years of experience shines the light at the fact that she developed good boundaries for herself and learned to process the triggered feelings or emotions related to patient dying. Thus, it could be stated that her experience enabled her to grow to be more attuned to her own experience and also allowed her to learn that sharing with other professionals or colleagues is beneficial for her well-being personally and professionally.

Frank recalled the fact that his profession definitely has added more understanding of what countertransference is for the multidisciplinary team he worked in. He expressed that it offered different perspectives on the case presentation into the meetings and impact of working with for example difficult patients had on the professional.

Attunement to one's own felt feelings seems also a significant part of the work in psycho-oncology. It is important to be able to see how one's coping strategies can be implemented and when the work situations have triggered the individual's response. The denial of the personal response is seen as defensiveness and maybe a sign of uncovered countertransference that might be harmful for the individual and for their patient. The theme of countertransference was visible in all interviews.

4.4 Theme Three: Compromised Communication

Communication between the professions is a crucial part of working on multidisciplinary teams. The effectiveness of it predicts the quality of care provided to the patient and positive team functioning. All five participants who are actively a part of multidisciplinary teams in psycho-oncology have expressed different dynamics around power relations at work, underlining authority amongst oncologists or other well-experienced practitioners.

Where lack of successful communication is present the issue of making mistakes or errors is possible and it could be a danger to patients life or dismissal of patients wishes.

Ruth in her interview gave an example of the situation when a doctor had not signed the forms confirming not to resuscitate the patient who had ovarian cancer if she went into cardiac arrest. She expressed a frustration and sadness to see that the patient's wish was not respected when the patient went into cardiac arrest and the CPR was performed in the ambulance at the hospital car park.

Ruth: *Forms haven't been signed by her doctor and she went into cardiac arrest and they started the CPR and tried to resuscitate and it was just sad and frustrating that her wish of not being resuscitated wasn't respected because of miscommunication with the doctor. She was 90 yr old in the ambulance and they performed CPR on her in the car park and just looking at that it definitely wasn't what she would have wanted.*

This frustration around not being heard creates conflict between professions: three of the participants reported hierarchies in the workplace where medical staff would use their authority over for example, nurses. The opinions or suggestions of nurses would be overlooked by oncologists for example, who would push their views and ignore nursing staff. Ruth witnessed that in the department she works:

Ruth: *There were times where I don't know whether its ego or hierarchy sometimes the medical side might feel a little bit more that they would know best and they would push their views and maybe not take what the nursing staff had to say,*

we would feel we know the patient best so I suppose there would be a little bit of conflict in that.

In the interview it seemed like she wanted to defend her profession to see that nurses play a crucial role and that they become closer with the patient. Although she made a statement that nurses would not be able to take care of the patient without the involvement of other disciplines and medical professionals. However the lack of compromise with the doctors leaves her frustrated and does not offer healthy cooperation affecting her well being at work.

Ruth: *I suppose the nursing profession definitely has the most hands on approach .although we couldn't look after the patient without having the medical professional and the other disciplines but I suppose the nursing would know more about the patient than any of the other professions. I think we would be in the best position to act as the patients advocate, closer to the patient because we would spend more time with them.*

For instance, Emily similarly expressed that the challenge in working on multidisciplinary team in psycho-oncology would be the difficult people she would have to work with on the team. She underlined that she would try to avoid conversations or any contact with the person. It seems like a difficult task that she has to fulfil as avoidance makes the negativity build up and the failure to speak up and open up about being heard carries a burden, which will transform to anxiety. It seemed from the interview that Emily was not accepting the issue being the communication or the lack of it. When asked about challenges in the work she expressed the importance of everyone being on the same page and everyone being informed about the state of the patient but that's not always possible.

Her statement, '*I guess there is communication issue*' seemed like an acknowledgment because she then followed with;

Emily: *Sometimes there is an issue with one of the medical oncologist who would be very dominant at the meeting so it can be difficult to be heard.*

She also stated that at the psycho-oncology multidisciplinary meetings sometimes it is easier to speak up with some professionals than others. She reported being more open with for example with the palliative team, physiologists or social workers. It is an interesting correlation because if she as a nurse speaks from that point of view to physiologist or social worker, she would have a more powerful role or authoritative role over those professions too. The fact that nurses would feel overpowered at the meetings shows how fragile the profession is regarding managing this power relation. Nurses as Emily and Ruth expressed performing a lot of tasks around the patient and getting to know the patient and still be undervalued in the psycho-oncology department.

Frank's take on the inclusion of his voice on multidisciplinary meetings is that finding his place on those meetings is important and sometimes it is difficult just because in his words, those meetings could be medically orientated. It was interesting to see that he asked a question of the need of psychology professionals.

***Frank:** It's sometimes important to be asking about: Do people think that psychologist have a role here?*

This answer gives a taste of a sense of doubt around having a strong role on the multidisciplinary teams in psycho-oncology. There is uncertainty present in Frank's answers if the profession's contribution is fully valued on the team. It is also important to see that he is confident in his role but not confident if the others understand what he and his profession can offer.

He stated quickly after, that his profession is new but a valued member of the team but also said that there is not many psychologists or psychotherapists working on the multidisciplinary teams. Frank also expressed a lack of trust the team has in psychology profession making a statement:

Frank: *The teams are sometimes overly careful who do they refer to they don't want to overburden us.*

This shows that although there is a small number of psychologists or psychotherapists on the team, there is still no work done to add more of these professions.

Donna added that this is because of financial limitation that psychotherapy is not seen on multidisciplinary teams. She expressed that psychologists are mostly present in looking after psychosocial needs of the patient.

Una sees herself lucky to be part of multidisciplinary team at her psycho-oncology department and she expressed the challenge sometimes in the communication spectrum would be to explain the functioning of psychological formulations to the rest of the team. It really sounded that her confidence in her team and her role was strong and as she stated:

Una: *I suppose I am very lucky and the team I'm working on is very open to psychosocial issues and because of working there for such long time. I am a valued member.*

From the accounts of the participants, it could be seen that the communication is impaired among the multidisciplinary team members and the compromise is difficult to obtain with some members overusing their authority. The errors of the impaired communication are visible in the care for the patients thus, the need for training and education began to be seen as crucial part of the psycho-oncology profession. Donna and Una especially underlined provision of guidelines and training needing to be implemented to help the professionals to understand their role and help guide them in difficult situations as for example how to communicate with patients as well as enhance communication on the multidisciplinary team. It is also significant to mention that the participants have seen the field of psycho-oncology as new but fast developing. Therefore, it could be agreed that as with process of building a therapeutic relationship

it is a slow work, but the important aspect is the creation of the strong relationship in which the challenges can be exercised within a holding, attentive environment.

Chapter Five: Discussion

5.1 Introduction

The aim of this research was to explore from a psychotherapeutic perspective the impact of working on multidisciplinary teams in psycho-oncology on individual professionals. The study gathered evidence around the real experiences of the individual professionals; their feelings, opinions and individual intakes on the challenges and experience they have from the work with cancer patients. This psychotherapeutic exploration allowed for a highlighting of three important parts that make this research a whole. First, it is the aspect of managing vulnerability in the work of psycho-oncology and its impact on both individual professionals and their patients. Second is the exploration of the personal experiences, which includes the countertransferential phenomenon that occurs for the professionals. Thirdly, the research explored the compromised communication which gave evidence of what it is really like to work on multidisciplinary teams in psycho-oncology.

5.2 Managing Vulnerability

The study found that managing vulnerability is a stressful aspect of the work in psycho-oncology. It is important to clarify the two sides of the vulnerability here, which is the phenomenon of working with dying cancer patients and the feeling of being vulnerable that the professionals present with. Dartington (2010), claims that we are all vulnerable in different ways and some more than the other. It is clear from this study that the result of being exposed to vulnerability has had an effect on individual stress responses that could have roots in the early experiences that trigger early trauma's as Klein (1975, cited in Rosen-Carole, 2012) suggested. The vulnerability has a lot to do with how individuals deal with stress according to Dartington (2010). Some professionals might put a lot of pressure on their skills and because of the work overload and non specified

tasks that vulnerability is generated with dissatisfaction of their own performance leading to stress (Dartington, 2010, Ballatt and Campling, 2011).

The stress response is especially relevant here because as in the study devised by Wenzel et al, (2011), which suggested that high levels of stress and response to it affected the efficiency of nurses work and well being in oncology and palliative care. This adds to evidence outlined by Una who expressed exhaustion in the work and the need to acknowledge it for herself in order to perform well in the profession.

The work with vulnerable patients makes the professionals offer them the best care possible. This causes a certain impact on performance creating pressure on performing to their best ability. For instance all participants of this study reported the need for assurance of having control over improving one's well being which of course affects the individual professional when something goes wrong up to and including the death of a patient.

These interactions between the professional and the patients carry certain dynamics that could be characterised through Kleinian (1933, cited in Britzman, 2015) object relations. The good object here is the fulfilment of the work as illustrated by all of the participants in this study that the individuals seek in the work. The bad object could be created by change for example if the patients health decreases it leaves the individual professional experiencing feelings of sadness or vulnerability. Examples of this was reported by Emily who underlined feelings of sadness and vulnerability when a patient died.

Some clinicians when faced with dying patient experience certain trauma that results in the freeze response (Menzies- Lyth, 1988, Isikhan et al, 2004) this is especially relating to Una's recalling of feeling frozen by the work.

In Bion's (1968) terms they froze and in a lot of cases the doctors response to difficult change would be freeze or flight leading to avoidance of the matter. Grassi and Riba (2012) noted that a lot of doctors would struggle with coping, they also reported that a lot of them would put masks on to cover it and carry on with the work.

The need to perform successfully definitely comes from the pressure created in the environment and in a lot of cases there is the forgetfulness of the 'good enough' care as Winnicott (1965) explained. The ego of the individual seeks the success so it can leave a legacy. The need to be perfect in the practice was particularly discussed by Freud (1920, cited in Guntrip, 2011), who believed that this striving to be perfect comes from anal fixation when the child finds out that they are in control of holding and letting go at the stage of potty training (Freud 1920, cited in Guntrip 2011, Winter, 2005). For Sullivan (1953, cited in Guntrip 2011), the road to perfection is rooted in the insecurities and uncertainty, which comes from early family dynamics. This particularly relates to what Ruth said about her colleagues who sometimes think they could have done more for the patient and this uncertainty is present.

Another interesting aspect to discuss in the cancer care, is the fact that professionals have developed extreme ambivalence and vacillation in holding hope for the patient (Wise et al, 2013). This notion of death being present in the work is especially visible in Frank's account, who expressed being aware of his own mortality. It is then understandable that some professionals put themselves in the role of the 'rescuer' and as Yalom (1980) states is a defence against death anxiety, which is one of two defences and the other 'specialness'. Sometimes the specialness comes from the feeling godlike and it can lead for one to feel being exempted from being mortal (Wise et al, 2013).

Dartington (2010) also underlines that the pressure is on productivity, which then created the need for clinicians to be godlike and invincible in their work. This is the

challenge of it because as Frank suggests, he sometimes meets patients as they have never been met before in the medical system, which shines a light at how some professionals forget to bring their own humanness to the table.

Dartington (2010) also stated that the care system which provides for vulnerable people is drifting between the integration and fragmenting in relation to interventions. It is a fact that the pressure on performing is coming mostly from within the group and one's effectiveness is a subject that is constantly reassessed creating unhealthy pressure within the organisation.

This fragmentation is visible in vignettes presented by Una and Donna and their denial of any felt feelings related to the challenging work. This defence mechanism was also present in the study devised by Menzies- Lyth (1988) who studied cancer nursing and reported defence systems which deny the actual feelings experienced as anxiety, guilt, uncertainty being perhaps too deep to confront for the individual so the nurses chose to avoid it which then becomes harmful and can lead to compassion fatigue (Corner and Bailey, 2009).

An important part of experiencing guilt and anxiety is the notion of reparation and Klein (1937, cited in Britzman, 2015) spoke about it thoroughly as how it could be applied to the dynamic as the child in the early days experiences the guilty or anxious impulses as wrong and has a fantasy to repair it by suddenly, becoming 'good' thus the reparation means that for example professionals offer the best care possible repairing their guilt and freeing themselves from it.

Split off tendencies have other effects too and by denying the felt feeling as seen with Una and Donna, it could see the old structures here emerging as defence patterns that serve them as a boundary. Here the ego cannot bear the reality of the psycho-oncology work for example in which the ego is threatened when depressive position is present

(Klein, 1940, cited in Britzman, 2015). It determines how the individual is coping with the reality of the work which as the findings of this study suggest it triggers people's vulnerable response and some would try to avoid or deny the impact of the reality which occurs in the organisations they work in.

5.3 Countertransference

All of the participants of the study experienced reactions that have been triggering their personal experience in the work of psycho-oncology. Interestingly, when questioned people have answered from their frame of reference which could be suggested that the work has deep psychological impact. It is true to say that the finding suggests that the participants were not always aware of the countertransference issues while dealing with the patient which as Evans and Gilbert (2005) advise might be harmful for both the patient and the individual professional. Countertransference is a phenomenon broadly spoken about since Freud's times and is an active part of psychotherapy or psychoanalysis. Countertransference as according to Wise et al, (2013, p.309) is 'an interpersonal experience of the clinician with roots in his or her biography'.

It is significant to state that a lot has changed since Freud (1917, cited in Guntrip, 2011) discussed countertransference as it became something useful in the therapeutic relationship or any professional relationship here between patient and professionals of multidisciplinary teams in psycho-oncology. Racker (1988, cited in Berzoff and Kita, 2010) stated that it opened a compelling portal to gaining empathic access to the client or the patients' world. This is particularly visible with the professionals who participated in this study as they all showed empathy towards the patient in the provision of care and have spoken about experiencing deep feelings of compassion that triggered past experiences as shown in Ruth's situation when she expressed providing the best care possible because, that's what the other nurses did when her sister was dying of cancer.

The personal stories carry certain impact and definitely the presence of strong compassion is present in those. It is a fact that as Figley (2002, p.1434) puts it, compassion and empathy provide 'the tools in required in the art of human service'. It is especially relevant to the answers generated by Ruth and her experience of having a

sister who died of cancer. Figley (2002) focuses in his paper on exactly that aspect of effort made to see the reality from the suffering perspective. The risk involved in this is the compassion fatigue and burnout and this is definitely the price a lot of professionals pay as the findings suggest.

The notion of seeing the other suffering through the lens of their own suffering was common for Ruth and Donna who became impacted by the death of the young patient.

In this study Una, Emily, Donna, and Ruth especially drew attention to being impacted by caring for a young patient and that sometimes it was difficult to reason why this young person had to die so soon. For Ruth, the aspect of her biography that triggered her suffering made her understand the patient more and she started to put herself into their position. This especially relates to a Rogerian (1979) aspect of being client-centred and ability to resonate with one's feelings and almost trying to walk in their shoes.

This study also suggested that for Emily and Ruth over identification began to be present which could be argued that it is a part of countertransference or in Klein's (1945, cited in Summers, 2014) terms 'projective identification' from a patient they cared for. Projective identification as according to Klein (1945, cited in Summers, 2014) comes from the times when the baby projects the unbearable feelings or needs onto the mother to control her. Emily and Ruth have experienced such dynamics as they expressed being challenged when working with young people or that they would identify with the patient. Being aware of feelings that are projected onto the professional is something crucial that can help the development of the relationship (Summers, 2014). Interestingly, Gabbard (1995, cited in Berzoff and Kita, 2010) as well as Schaeffer (2007) argued that the ability of the professional to hold those projected unwanted feelings and needs for the patient is a crucial step the process, because, those feelings and needs can be returned to the patient in a more metabolised manner. This is the

unconscious process of the patient and it's not that the patient is trying to get rid of those objectionable feelings or needs but it mostly relates to how the professional is able to handle those and without a consequent reaction (Sedgwick, 2003).

Kohut (1984, cited in Lee & Martin, 2013) speaks about feeling of shame towards experiencing countertransference by the analyst which could be applied to Donna's answer when she admitted having experienced feelings of upset after a young patient died. Her experience suggested her feeling ashamed for giving up and starting to pray for this patient who later died. Donna seemed to feel shameful for not following her boundary and becoming emotionally involved in the reality of the patient.

In this situation Donna has become almost afraid of empathic failure which has its genesis in the childhood as Kohut (1971, cited in Lee and Martin, 2013), suggests and can lead to psychopathology. Donna as well as Una seemed to present a defence that they developed which allowed them to hide their real feelings under professional boundaries. It is a fact that both have long experience in the psych-oncology and they have met many patients and it can be inferred that they've seen a lot of suffering.

The findings also brought into light the fact that although the boundary is something all participants have learned a lot from and how implementing those boundaries protects their profession.

It is important to bring in Jung's (1913, cited in Sedgwick, 2003) insight on the countertransference and especially relevant to this study aspect of the 'wounded healer'. This particularly reflects the opposite to Donna's insight on focusing on the patient rather than the doctor's feelings. Jung (1961, cited in Sedgwick, 2003), assumed that only the wounded doctor heals and that is particularly relevant here because as people working in psycho-oncology have been wounded by the experience and developed the defences against the feeling vulnerable. Jung (1961, cited in Sedgwick, 2003), suggested that the

doctor or any professional should disclose and work through the difficult feelings with the patient when appropriate and his questioning of 'what the patient mean's to him?' is valuable here.

The study finding in relation to boundaries gives significant evidence that professionals in psycho-oncology implement them but it is a fact that it doesn't always protects them from the human reaction which is sadness and suffering (Berzoff and Kita, 2010).

This communicating or acknowledging the countertransference is healing and as Winnicott (1947, cited in Arundale & Bellman, 2011) states professional should not be ashamed of feeling the countertransference and it is not something one can get rid of. It is important to state that working successfully in psych-oncology is to be fully aware and allow the feelings to surface without blocking them as it is an art of being a human. (Fall et al, 2011).

5.4 Compromised Communication

Psycho-oncology includes different professions who work together in order to provide the holistic care for the patient with cancer. This research found out that although the collaboration and multidisciplinary teams are active part in the work of the participants, the biggest issue is the failures in communication, which effects the well being of professionals and impacts the care provided to patients.

In an ideal world the communication on multidisciplinary would be inclusive, collaborating, trustworthy, and respectful but it is not always the case (O'Daniel & Rosenstein, 2008). The participants of this study expressed different opinions about the functioning of their teams but the common theme was the miscommunication or hierarchy that is present on their MDT. This denies the trust and respect and promotes individuality, which not always can be beneficial for the patient (Fleissig et al, 2006).

It is the miscommunication or the lack of communication that creates the medical errors and as literature suggests it is one the most pervasive problems in today's medical institutions (O'Daniel & Rosenstein, 2008, Fleissig et al, 2006).

The findings of this study have been clear that the hierarchy has a lead on multidisciplinary teams. That is especially visible in Ruth's answers where she speaks about hierarchy and sometimes her voice as nurse is not being heard. Literature (Sutcliffe et al, 2004), suggests that improvement in communication for professionals on multidisciplinary teams is among factors that needs remodelling in the healthcare system

The study by Sutcliffe et al (2004) also supports what Ruth and Emily expressed in their intakes on communication failures in the hospitals they work, which underlined the frustration the staff experiences when the miscommunication between professions

occurs. Stokes (1994) in his work discussed the need for the professionals on multidisciplinary teams to join together but also remain separate and this is visible in Frank's answers where he talked about valuing his profession and being aware of what does psychology brings to the team.

The fusion and separation here is an interesting dynamic and although people strive to remain separate and value their profession, it is significant to look at their behaviour affected by unconscious processes when they enter the team (Stokes, 1994).

It is true to say that all the group members are coming from different professions and have different mentalities and preoccupations (French and Simpson, 2010). Stokes (1994) for instance, have been clear in his paper around the term 'team' being misleading as some of the multidisciplinary team meeting might not have a primary task and the purpose of it is to only give a false impression of the 'togetherness'.

Bion (1968) in his writings established two points particularly relevant to this study aspects of the life in the group or a team. He termed it 'work group mentality' and 'basic assumption mentality' which can be distinguished as tendencies to face reality and the second to avoid the painful conflictual reality (Stokes, 1994). In the 'work group mentality' the professionals perform their tasks with the desire to be effective and be assessed on that, in other words the professionals want to be recognised for their successes (Stokes 1994, Bion, 1968). In here it would be relevant to bring in the tendency of for example nursing staff to be overly 'nice' to the patients which creates the false impression of helping the patient to have 'good enough' death in a good place. This tendency protects the members in psycho-oncology profession to experience the disturbing feelings in the dying patient and clinician relationship (Obholzer et al, 2003). This suggests that the negative disturbing feelings need to be split off and Obholzer et al (2003) suggests that it usually is directed at for example management or as in Ruth's

vignettes it gets projected onto medical staff which has authority above nurses, affecting the functioning of MDT.

In the 'basic assumption mentality' on the other hand the group behaviour is not determined by the effectiveness of how the group performed but by the process that occurs within the group (French and Simpson, 2010). In this situation and as in MDT's Ruth or Emily work the groups focus is on satisfying the needs of other members and creating inner frustration causing conflicts but also creating a false impression of the team working 'together' (Stokes, 1994).

Bion (1968) in his writings established three basic assumptions which is the fight-flight, dependence and pairing. Flight-flight occurs when there is problem in the group and it has to be met with attack or avoidance and that is what Emily in her statement underlined when she preferred to avoid one of the difficult members of her MDT.

The dependency basic assumption underlines the role of the leader and people following that leadership (Hopper, 2003). Pairing is based on unconscious belief that future aspect of the group will solve all the problems, which arises within, it also allows for the couple to lead (Hopper, 2003). Although, the pairing involves a couple but looking at the findings both Donna and Una underlined the need for training and improvement in the education the professionals working on the MDT's in psycho-oncology thus, this pairing dynamic was visible in the group of professionals participating in this study. It is a fact that the hope or the future fact of the group improvements is held by the two members and sometimes and it sustains the members with false hope that all will improve (Stokes, 1994, French and Simpson, 2010).

The leadership is also an important aspect and literature suggest that MDT work more efficient with an leader (Fleissig et al, 2006) but it seems like Frank Ruth and Emily have really fought for their individuality on the team. Freud (1921, cited in Freud,

2014), argued for example that it is natural for the large groups to follow a leader because the leader would personify their ideals. The leader might provide authority and show group members how things need to be done but the group member's also can project different aspects onto the leader as thinking or decision making (Stokes, 1994). Freud (1921, cited in Freud, 2014) believed that people idealise the leader and follow them forgetting about their own power which then causes to criticise the leadership for being too manipulative.

The basic assumption thus illustrate the dynamic of the group members who protect the group from the frustration that comes from learning about the experience that requires facing conflicts and external reality (Stokes, 1994). Freud (1917, cited in Freud, 2014) for instance, spoke about the group being dominated by the pleasure principle where the pain is avoided with the hatred towards reality which occurs unconsciously. Although, the literature suggest the group sometimes tend to blame other professionals for mistakes or miscommunication and through that, a split of the MDT or whole department occurs (Stokes, 1994). It is caused by the powerlessness or hopelessness of professionals in the task fulfilling as Ruth expressed when she talked about the doctor not having signed the forms. Stokes (1994) suggests that this blaming others makes the individual almost disabled at their own fault and is a significant cause to stress in the workplace.

Communication and its compromises has to be taken seriously on the MDT's in psycho-oncology because its' lack affects the department and most importantly the patients (Foulkes and Anthony, 2014). The participants of this study have reported huge difficulty in communication with other members. The compromise is then to find the common ground and learn to express what needs to be communicated. The fear of compromising is related to the uncovering the suffering and that is inevitable to express

in the successful MDT communication (Foulkes and Anthony, 2014). The professionals need to become aware of the power dynamics improve the functioning of the MDT's in psycho-oncology.

It is true to state that the work in psycho-oncology is quite different to other organisations as the impact has more profound effects on the individual professions because of the unconscious dynamics seem to be playing out that have genesis from the work with dying patients. One needs to accept that they can only offer the 'good enough' care, which could be liberating to accept. The working through the depressive position in psycho-oncology invigorates one's capacity to become acceptable of the conflict and ambivalent feelings that arise from within the psycho-oncology work dynamic (Obholzer et al, 2003).

5.7 Conclusion

The work in psycho-oncology carries an important role for each individual: those of a helper, carer, compassionate listener; a person who fights for a patient's life, someone who holds hope when a patient is losing it due to chronic illness which is cancer. It is a fact most of the studies look at the patient side and the holistic care the patient needs (Holland et al., 2015). It is true to say that sometimes the role and the impact of the work on the professionals is left in the background (Wise, et al, 2013). This tendency is used with professionals working in psycho-oncology as they dismiss their own feelings that have been triggered in the care of the patient.

This research highlighted the real side of the experience of working with cancer patients and uncovered the dynamics of working on multidisciplinary teams in psycho-oncology. It was beneficial to explore their experience through the psychotherapeutic lens as it offered deep and personal insights, which allowed for an exploration of the countertransference and the unconscious communication. These are valuable insights offered by psychotherapy. The vulnerability of the participants was underlined and it brought to light the hardship of coping with the work and indicated how professionals tend to deny their real feelings.

This rejection of the impact and the failure to admit to the own suffering was a product of countertransference reactions that individuals presented with which also comes from own vulnerability towards the subject (Dartington, 2010). It was useful to see that and contemplate on the danger of those uncovered countertransference issues, which in a lot of cases lead to compassion fatigue or even burnout (Berzoff and Kita, 2010). The dynamic, which some participants spoke about is the notion of boundaries or self-care, however it could be seen that even the most experienced staff have issues with acknowledging the realness of the experience.

Finally, the research brought into light the nature of working on multidisciplinary teams and the fight for individuality and inclusion in the hope for the right to be heard and valued.

Therefore, it is significant to mention that although professionals do experience a significant impact from the work, they still do their best or 'good enough' to contain and process their emotions and provide effective care for the patients.

This research demonstrated a psychotherapeutic input through the interpretations of dynamics which were generated from the participants experiences. This psychotherapeutic exploration offered vital evidence that psychotherapy should be more involved on psycho-oncology MDT's. The evidence of this is the fact that psychotherapy offers an understanding of the impact of working with dying and has a chance to improve the functioning of the MDT's in psycho-oncology.

5.5 Limitations

This study examined the impact on the professional working on MDT's in psycho-oncology from the psychotherapeutic perspective. One limitation that could be recognised is the fact that the study originally aimed at interviewing only Irish participants but because of the difficulty with obtaining the sample this was impossible.

The recruitment of the sample also was impaired because again, originally it was set to interview the head and clinical leads of the psycho-oncology departments from two leading Irish hospitals. Unfortunately, that was impossible due to unavailability of the people asked to participate in the study.

Another significant limitation is the fact that two of the interviews had to be conducted over Skype thus it limited the experience of in-depth interview because of the interruptions caused by poor internet connections. However, it could be agreed that the Skype interviews have turned out successfully as the data quality wasn't different to face-to-face interview.

The research data provided rich intake on aspects such as strategies some individuals implement around self-care in psycho-oncology. The researcher unfortunately had to decide on choosing only the most valuable responses to support the study. It would be valuable to explore the self care strategies as mindfulness etc in relation to what works for the individuals working in psycho-oncology.

5.6 Recommendations

This study contributed to a small amount of research done in the area of psych-oncology around the impact on the professionals. It would be valuable to raise this topic as a priority in the psycho-oncology field and hopefully it will contribute to the training and education of professionals working on multidisciplinary teams in psycho-oncology.

There is a need to establish the role of psychotherapists contributing to the psycho-oncology field and as findings in this study suggest the role of psychotherapy is not yet seen as valuable on multidisciplinary teams for various reasons including the financial cost.

It is the belief of the researcher and a significant amount of literature that psychotherapy has a lot to offer for psycho-oncology but it is still difficult to see a psychotherapist working in the field. It would be of benefit to deeply explore why there exist such discrepancies in the numbers of psychotherapists in psycho-oncology and the reasons why psychotherapists do not seek to work in the psycho-oncology field. This although, would need a different type of qualitative study and perhaps not on Masters Level.

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Appendices

Appendix 1.

Participant information sheet

Introduction

My name is Milena Sobesto and I am a studying for an MA in Psychotherapy in Dublin Business School. I am researching the Impact Of Working On Multidisciplinary Teams In Psycho-oncology.

I am inviting professionals working on multidisciplinary teams in psycho-oncology field, to participate in this study by agreeing to a 45-50 minute interview. If you would like to participate please read the detailed information provided below.

Who is organizing this study?

This study is part of a Masters Degree in Psychotherapy being undertaken at Dublin Business School, Dublin, Ireland.

What is the purpose of the study?

The purpose of this study is to understand from psychotherapeutic perspective what is the impact of working on multidisciplinary teams in Psycho-oncology.

What are the criteria for participation in the study?

Participants in this study must be experienced professionals working in the psycho-oncology field for over 2 years.

What is involved in participation?

If you choose to contribute to this study, you will be invited to take part in a face-to-face interview at a place of your convenience. The interview will take approximately 45 - 50 minutes and will seek to understand your experience of working on multidisciplinary teams in psycho-oncology. The interview will be taped and later transcribed by the researcher. No names or location will be used.

Are there any risks/benefits?

There are no known risks to you from taking part in this research. The results of the study will be made known to you and may benefit the psycho-oncology field.

Will my identity be protected?

Your identity will be protected and known only to the researcher. All identifying information will be removed during transcription to protect your anonymity. Notes about the research will be stored in a locked file. Each person who participates in the research will be given a code

number so that the researcher will be the only person who can identify the participant. The key to the code numbers will be kept in a separate locked file. The audio recordings of the sessions will only be accessible to the researcher and will be destroyed once transcripts have been made of the sessions.

Can I withdraw from the study?

If you initially decide to take part you can subsequently change your mind. You can request to have your data removed from the study. Additionally, under the Freedom of Information Act (1997) you have the right of access to information concerning you, which you may request from the researcher in writing.

How can I get further information?

For additional
information please
contact Researcher:

Milena Sobesto

moscitoo@gmail.com

Research Supervisor:

Grainne Donoghue

grainne.donohue@dbs.ie

<http://www.dbs.ie/psychotherapy-ma>

DBS School of Arts,
13-14 Aungier Street,
Dublin 2.

Appendix 2.

***A Psychotherapeutic Exploration of the impact of working on multidisciplinary teams
in Psycho-oncology***

Consent Form

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

Yes No

*I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.*

Yes No

I understand that my identity will remain confidential at all times.

Yes No

I am aware of the potential risks of this research study.

Yes No

I am aware that audio recordings will be made of sessions

Yes No

I have been given a copy of the Information Leaflet and this Consent form for my records.

Yes No

Participant:

Signature: _____

Name in block capitals: _____

Date: _____

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/here to ask questions on any aspect of the study that concerned them.

Signature: _____

Name in block capitals: Milena Sobesto

Date: _____

Appendix 3

Interview Questions

1. Can you tell me a little about your experience of working in Psycho-oncology?
2. What interested you about this type of work at first?
3. What sustains/motivates you in the work that you do?
4. What would you consider as the biggest challenges in your role?
5. I suppose you see people (patients) at their most vulnerable. How does this impact you?
6. How do you manage when you are faced with a dying patient? What do you feel is useful for you during these times?
7. Has there ever been a time when you have felt unable to cope/or struggled in the work? What was this like for you?
8. As Psycho-oncology work is focusing on integrating different professions and forming multidisciplinary teams how do you see your profession contributing to the care of the patient?
9. What are the challenges of working on MDT's in psycho-oncology?
10. What are your thoughts on inclusion of psychotherapy professionals to the multidisciplinary teams in psycho-oncology?
11. From your experience is there anything else that you think might help in provision of adequate support for professionals working on multidisciplinary teams in your field?