

---

---

## COMMUNICATION IN ONCOLOGY: A QUALITATIVE ANALYSIS BASED ON PSYCHOANALYSIS

Daniela Bianchini  
Ana Carolina Peuker  
Fernanda Bittencourt Romeiro  
Elisa Kern de Castro<sup>1</sup>  
*University of Vale do Rio dos Sinos (UNISINOS), Brazil.*

**ABSTRACT.** This article discusses the findings of an exploratory qualitative study about patients' perceptions of communication with the health care team during chemotherapy. Interviews were conducted with 14 patients undergoing cancer treatment at different stages of the disease. The instruments used were: sociodemographic data sheet and semi-structured interview. The interviews were audio-recorded and transcribed. The data were analyzed regarding reading nonjudgmental; structural analysis and content categorization; critical interpretation and discussion. Two independent judges evaluated the interviews contents and evaluated concordance index (Kappa = 0.834). Three categories of communication were created: 1) Technical Communication; 2) Technical Communication with Emotional Support; 3) Insufficient communication. The psychoanalytic theory offered a comprehensive view of this issue and joined subjective aspects of illness with the empirical evidence. The results showed that communication with emotional support contributed to greater satisfaction and psychological health of the patient during cancer treatment. Wellness feeling and support feelings were mentioned by patients to refer this type of communication. The technical communication with emotional support provides the patient trust in reality and extends hope in life and comfort before death. More negative perceptions regarding communication with health professionals were linked to failures in the exchange of information, sense of emotional detachment and lack of interest on personal aspects of the patient.

**Keywords:** Cancer; communication; psychoanalysis.

## COMUNICAÇÃO EM ONCOLOGIA: UMA ANÁLISE QUALITATIVA SOB O ENFOQUE PSICANALÍTICO

**RESUMO.** Trata-se de um estudo qualitativo exploratório sobre a percepção de pacientes com câncer e a comunicação com sua equipe de saúde. Foram entrevistados 14 pacientes em tratamento oncológico em diferentes estágios da doença. Os instrumentos utilizados foram: ficha de dados sociodemográficos e entrevista semiestruturada. As entrevistas foram gravadas em áudio e transcritas na íntegra. Os dados foram assim analisados: leitura inicial sem julgamentos ("naive"); análise estrutural e categorização do conteúdo; interpretação crítica e discussão. Dois juízes independentes avaliaram os conteúdos das entrevistas e realizou-se o índice de concordância (Kappa=0,834). Foram criadas três categorias sobre a comunicação: 1) comunicação técnica; 2) comunicação técnica com suporte emocional; 3) comunicação insuficiente. O embasamento psicanalítico utilizado ofereceu uma visão compreensiva dessa temática e uniu aspectos subjetivos do adoecimento com as evidências empíricas. Os resultados demonstraram que a comunicação com suporte emocional contribuiu para maior satisfação e saúde psicológica do paciente durante o tratamento oncológico. Sensação de bem-estar e amparo foram sentimentos apontados pelos pacientes ao experienciarem esse tipo de comunicação. A comunicação técnica com suporte emocional fornece ao paciente confiança na realidade e amplia a esperança na vida e conforto perante a morte. Percepções mais negativas em relação à comunicação com os profissionais de saúde estavam vinculadas às falhas na troca de informações, sensação de distanciamento emocional e ausência de interesse por aspectos pessoais do paciente.

**Palavras-chave:** Câncer; comunicação; psicanálise.

---

<sup>1</sup> E-mail: elisa.kerndecastro@gmail.com

## COMUNICACIÓN EN ONCOLOGÍA: UN ANÁLISIS CUALITATIVO BASADO EN EL PSICOANÁLISIS

**RESUMEN.** El presente artículo trata de un estudio cualitativo exploratorio sobre la percepción de pacientes con cáncer y la comunicación con su equipo de salud. Se entrevistaron 14 pacientes en tratamiento para el cáncer en distintos niveles de gravedad de la enfermedad. Los instrumentos utilizados fueron: ficha de datos sociodemográficos y entrevista semiestructurada. Se grabaron las entrevistas en audio y transcritas. Se analizaron dos datos de la siguiente manera: lectura inicial sin juicios; análisis estructural y categorización del contenido; interpretación crítica y discusión. Dos jueces independientes evaluaron los contenidos de las entrevistas y fue evaluado el índice de concordancia (Kappa = 0,834). Fueron creadas tres categorías sobre la comunicación: 1) Comunicación Técnica; 2) Comunicación Técnica con apoyo emocional; 3) Comunicación insuficiente. La teoría psicoanalítica ofreció una visión comprehensiva del tema e integró aspectos subjetivos de la enfermedad con las evidencias empíricas. Los resultados mostraron que la comunicación con apoyo emocional contribuyó para una mayor satisfacción y salud psicológica del paciente durante el tratamiento oncológico. La sensación de bienestar y amparo fueron sentimientos revelados por los pacientes a partir de la experiencia de este tipo de comunicación. La comunicación técnica con apoyo emocional da al paciente la confianza en la realidad y amplía la esperanza en la vida y el conforto delante de la muerte. Percepciones más negativas sobre la comunicación con los profesionales de salud estaban relacionadas a fallos en el cambio de informaciones, sentimiento de alejamiento emocional y ausencia de interés por los aspectos personales del paciente.

**Palabras-clave:** Cáncer; comunicación; psicoanálisis.

---

### Introduction

Communication in oncology is essential for both the process and result of the treatment of cancer (McCarthy, 2014; McCormack et al., 2011.). Communication plays a key role in providing quality care and, consequently, improves the results for the health of the patient (Thorne, et al., 2014). It is a dynamic process, which includes not only information but also emotions and values of those who are inserted on it. The professional communication on health-patient in oncology relates, among other things, to the creation of a good interpersonal relationship and the effective exchange of information between them (Skea, MacLennan, Entwistle, & N'Dow, 2014).

Falling sick constitutes a moment of crisis and a shock to the idea that the human being seeks to maintain about the invulnerability before death, his primary anguish. In the search for reflection on the communicational phenomena and the suffering caused by the cancer, the knowledge brought by the psychoanalysis can promote the understanding of the demands referred by the patients. Psychoanalysis makes of the language its primordial material and understands that the exchanges offered by the individual and his environment, including language/communication, as long as healthy, provide an adjustment in the emotional state of that person who suffers (Freud, 1920/1996b; Freud, 1895/1996a).

In this sense, the psychoanalysis understands the experience of cancer as something traumatic for the psyche and that can escape to any form of subjective elaboration (Vidal y Benito, 2010). The therapy proposes the possibility to symbolize the trauma, from the space constructed by the word (Lacan, 1998). As the patient finds opening to communicate and feels genuinely heard, different alternatives can be created to what is presented as excess to the mind, before, impossible to apprehend (Ferreira & Castro-Arantes, 2014). Feeling supported and identified by another, in this case the health professional who will accompany him, can expand the universe of meaning of his emotional experiences (Castro-Arantes & Lo Bianco, 2013). Finding the possibility of metabolizing the "indigestible" of the traumatic experience, from an effective communication process, gains new life, as two minds can interact accurately (Ferro, 2011).

This understanding implies in the construction of health staff capable of reducing the traumatic experiences of patients during the course of cancer treatment. This scope facilitates to find a good level of communication and shows ideal in delivering a quality care. The creation of places for reflection on this issue, with the help of the psychoanalytical approach, expands the perspective to achieve this goal. Thus, the present article sought to investigate the professional-patient communication from the perceptions of patients under treatment of cancer.

## Method

### Participants

Participants were 14 patients under outpatient chemotherapy treatment for cancer at different stages of the disease (seven of them were metastatic patients). Of these, eight were men and six were women, they were around the age of 50. Patients were from a private hospital of a large size city in southern Brazil. The selection was for convenience among those who were in the hospital for completion of chemotherapy at the time of the data collection, which occurred on alternate days and at different moments to achieve higher heterogeneity of the characteristics of the participants. Fifteen patients were invited, of whom one had to interrupt the interview because he was emotionally affected to answer the questions. For this patient, there was a psychological care after the interruption and provided the Psychology Service of the institution so that he could follow in the monitoring throughout his cancer treatment. The socio-demographic and clinical data of the participants are presented in Table 1.

**Table 1.** Socio-demographic and clinical data of patients (N=14)

Patients	Sex	Age	Diagnostic Age	Marital Status	Schooling	Type of Cancer	M	S	R	C
1	F	37	37	Married	Higher Education	Uterine	Y	N	N	Y
2	F	64	62	Single	Post-Graduation	Intestinal	Y	Y	N	Y
3	M	70	68	Married	Higher Education	Colon	Y	Y	N	Y
4	M	58	58	Married	Secondary Education	Colon	N	N	N	Y
5	F	44	44	Married	Higher Education	Stomach/Esophageal	N	Y	Y	Y
6	F	65	65	Married	Secondary Education	Ovary	N	Y	N	Y
7	M	52	52	Married	Higher Education	Intestinal	N	N	N	Y
8	F	45	44	Separated	Primary Education	Intestinal/Colon	Y	N	N	Y
9	M	66	63	Married	Secondary Education	Intestinal	Y	Y	Y	Y
10	M	65	65	Married	Secondary Education	Intestinal	Y	N	N	Y
11	M	54	54	Married	Higher Education Inc.	Melanoma	N	N	N	Y
12	M	33	32	Married	Higher Education	Testicular	N	Y	N	Y
13	M	30	30	Single	Higher Education Inc.	Rectal	Y	Y	Y	Y
14	F	50	49	Single	Higher Education	Uterine	N	Y	N	Y

Note. F (female); M (male); Y (yes); N (not)

M: metastasis

S: surgery

R: radiotherapy

C: chemotherapy

## Instruments

A form of socio-demographic and clinical data to characterize the participants, and a semi-structured interview about the relationship between patient and professional were used, in which guiding questions were formulated by the authors of the study, referring to the following themes: bonds; group work; psychological suffering; oncological diagnosis. From this interview that involved a broader theme, we analyzed the reports concerned to the professional-patient communication.

## Procedures of data collection and ethical

After agreement of the oncology staff to start the research, data collection was carried out in collaboration with the nursing staff of the hospital. The nursing staff indicated the possible cases to participate in the study, using the criterion that the person must be in chemotherapy treatment and physical condition to talk. From this, the patients identified were invited to participate in the study through face-to-face approach. The interviews were conducted at the hospital itself, during the course of chemotherapy. All participants signed the Informed Consent Form (ICF). The same researcher, with clinical experience, conducted all the interviews. The participants were individually interviewed and in a single occasion, in a private place (booth of chemotherapy), free from interference. The interviewer explained the objectives of the study and presented herself to all participants. Her interest related to the subject was only of research, free from conflicts of interest. The duration of the interviews was approximately 20 minutes. The interviews were audio-recorded and subsequently fully transcribed, respecting the confidentiality and the non-identification of the participants. The period of data collection was extended from August to November 2013.

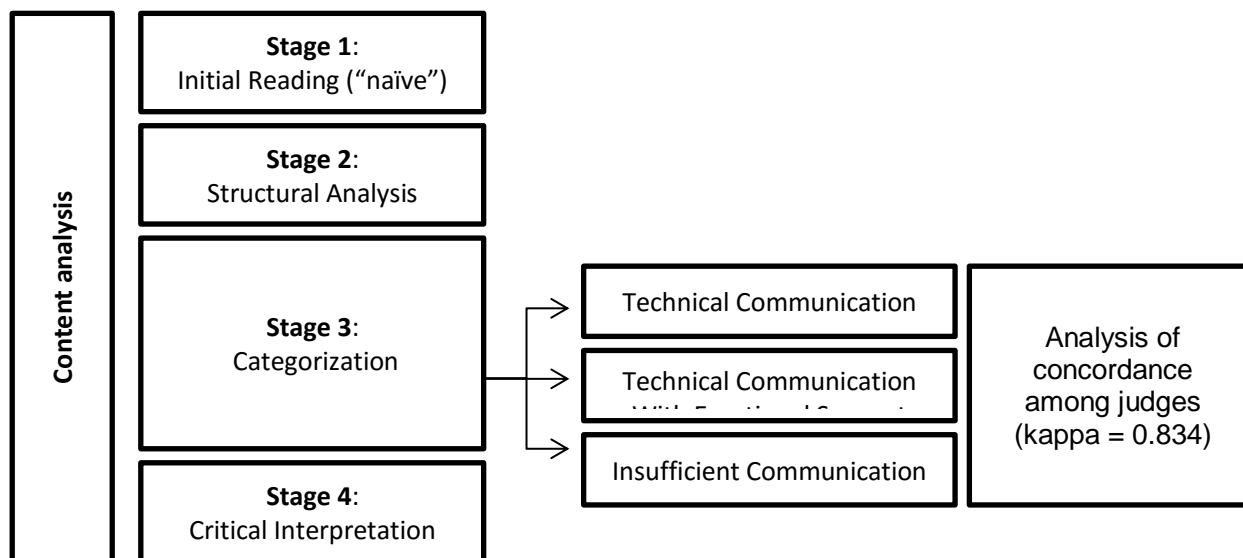
The study was conducted considering all ethical procedures required, according to the guidelines and regulatory norms involving researches with human beings. The research derived from a main project entitled "Relationship between Patient and Professional in Oncology: A Transcultural Study of Brazil and Spain", which was approved by the Committee on Ethics in Research, in which the data were collected under process number 247917.

## Data Analysis

The data from the interviews were analyzed qualitatively. It was used the protocol COREQ (Consolidated Criteria for reporting qualitative research), a checklist of 32 items aimed at ensuring that the quality criteria of a qualitative article that uses interview or focus group are met (Tong, Sainsbury, & Craig, 2007). In all, 04 hours and 14 minutes of recording were transcribed. It was performed the content analysis (Hounsgaard et al., 2013.) to identify similarities and peculiarities in the reports of the patients according to the thematic proposed by the study: communication. Although the interview plan has not objectively encompassed issues related to communication, this theme emerged from the data (a posteriori) and revealed as an essential point of the discussion. Thus, the data were subjected to analysis in three stages: a) non-judgmental initial reading; b) structural analysis and categorization of the content; and c) critical interpretation and discussion. Once created the categories and done the training with two independent judges, previously trained, they evaluated the contents of the interviews and categorized them according to the categories created from the emerging contents. The judges were researchers of the Group (group name and university were omitted). The degree of agreement among the judges was assessed using the kappa index. The value obtained was 0.834, which represents an excellent agreement.

## Results and discussion

Considering the reports of patients about the relationship established with the health team, three categories related to the central theme were identified. The diagram of content analysis presents the steps of the process of categorization (Figure 1).



**Figure 1.** Stages of the Content Analysis Process

The first category, named Technical Communication, refers to the type of provision of information from any member of the staff of professionals with the patient about his diagnosis, treatment and/or prognosis. In this category, the information does not have as objective to offer emotional support, but the direct and objective transmission of the information about the disease. The second category, named Technical Communication with Emotional Support, encompasses the provision of targeted information addressed to technical aspects relative to diagnosis, treatment and/or prognosis, but also embracing emotional aspects of the patient. The emotional support can be characterized by the professional concern with the psychological well-being of the patient. The third category is about the Insufficient Communication, and is related to technical communication, however having missed content so that the patient can understand what was told to him. This relates to the failure in understanding the communication. The patient feels with doubts and insecure. The communication process professional-patient was explored during the data analysis, considering the different stages of the treatment by which the patient with cancer patient undergoes: investigation, diagnosis and treatment.

During the investigative process of the disease, while the patient was not sure about his diagnosis and was not linked to a professional of reference, the communication was perceived by the patients as technique and, sometimes, reported as insufficient. In this phase, the patients generally are subjected to different procedures (blood examinations, image and biopsies) generators of uncertainties and that, in turn, raise the levels of anxiety. The content analysis demonstrated a transparent and intellectualized way of communication of the professional at a time of emotional fragility of the patient, in which they needed to be alone with their fears:

*When she (the doctor) took the exam, she touched ... Then she said: 'You definitely have something here in your left ovary. You will really have to investigate'. Then I thought: 'How so'? (6); "I was at the doctor ... in fact it was not even the doctor, it was the person who took the exam ... he did not give the precise diagnosis: 'There is an alteration, we will have to see what it is. It can be anything from a ball of fat, a knock, or even a tumor" (12).*

At this stage of diagnostic investigation, there seems to be a lack of care by the professionals, regarding the emotional aspects in reports of the patients. All patients who reported the investigation period of the disease perceived that the communication was only technical and/or insufficient. The professional-patient communication has multidimensional nature that involves the content of the dialogue, non-verbal behaviors and the affective component. Poorly established communication can engender an

essentially traumatic encounter with reality, since the psychic apparatus of the individual is unable to integrate it as an experience (Winnicott, 1958/1983; Winnicott, 1958/2000).

Some reflections can be made with respect to the limit of the capacity of what the patient can hear in a diagnostic investigation and the way in which this is reported. When there is excess of information there seems to be a psychic blindness. Lacan (1998) have already stated that neither the sun nor death could be seen from the front. In order to see the sun, the individual needs some kind of protection that filters the intensity of light. Thus, in the face of a possibility of the diagnosis of a disease full of stigmata, the patient also seems to need to protect himself with some kind of “filter” so that he can gradually face the reality that is presented. It is role of the health professional to serve as a filter and provide to his patient, a feeling of care in the information transmitted (eg. show empathic attitude, ask if there is some family member together, keep hope, answer questions, etc.).

It was present in the speech of the patients the direct and objective way with which the physician communicated them the confirmation of the diagnosis of cancer, showing the communication in a technical way: *“I walked into the room and he said: ‘Take off your mask that you do not need it’. I said: ‘do not I have tuberculosis?’. ‘No’. ‘And do you already know what I have?’. ‘Yes, I know’. ‘So tell me’. ‘Then he said: ‘You have lung adenocarcinoma”* (2).

The diagnosis of cancer opens wide the reality that the human being systematically tries to hide from himself: death. The fear of death is natural in the face of its imminence, and the anguish arises as a result of this threat, because this conflicts with the projects and life expectancies built up to then (Dolto, 1971). Cancer invades the body also producing psychological marks. Faced with traumatic situations such as the discovery of a cancer, Psychoanalysis indicates that the presence of another human being can serve as a support for those who suffer, allowing holding and organizing him psychically (Winnicott, Shepherd, & Davis, 1989/1994). The physician is the one who communicates the confirmation of the disease, however he does not have a bond formed with his patient due to the little contact established up to then, and he cannot prevent the emergence of feelings of anguish and helplessness felt by the patient. Although, from the way he communicates, he may provide a sense of relief for what is unknown and is to come (Almeida & Santos, 2013).

In this sense, the patients reported that at the time of the diagnosis, the physician could, in addition to the accurate technical information on the disease and treatment, show concern with issues of emotional order: *“He gave me the news after the lunch, thus suddenly. You have this, this and this. You know, I did not even have a relative there, at that moment”* (8). Botella and Botella (2002) present the theme of the traumatic unrepresentability for the psyche. The main characteristic for the trauma is the unbearable overload of anxiety and an excess of excitation together with a lack of direction. The psychoanalytical ideas, together with the speeches of the patients of this study reinforce the importance of finding effective ways of professional-patient communication to facilitate the feeling of bonding, support and safety for the ill patient.

One patient mentioned that the communication of his diagnosis was insufficient because there were failures due to the medical professional when transmitting the information. For him, there was no understanding of what was being said: *“The doctor told me: ‘You have lung adenocarcinoma. Perhaps you may have to operate’. The more he talked, the more I cried, and the less I understood what he was talking about”* (2). On the other hand, some patients considered the communication of the diagnosis as a technique with emotional support. They stated that they felt supported when the physician oriented the treatment demonstrating concern such as well-being and quality of life.

Considering the fragility and psychological vulnerability imposed at the moment of the diagnosis, the patients feel often unable to use own resources to deal with reality. Professionals able to develop a capacity to identify with those who suffer, meeting their basic needs, decrease the feeling of being alone, reported by the patients (Campos, 2005). In the containing model of Bion (1967/1994), the author states that the presence of a human being who allows to be invaded by feelings and emotions that cannot be thought by the patient and that are terrifying for them, soothes and helps in the psychic elaboration of reality. Every patient facing the imminence of death will need another human being, who do not be frightened as much as the patient, who do not to distance from the suffering and, therefore functions as his continent (Freud, 1895/1996a; Freud, 1920/1996b; Bion, 1991; Marco et al., 2013).

After the diagnosis, throughout the course of his treatment, the patient is exposed to different interventions, often invasive, mutilating and painful. In this period, the relationships established are expanded, as well as the forms of communication with the healthcare team. It is at this moment that is available to patient different professional patient who can offer specialized assistance to his broader needs (Silva & Hahn, 2012). In the stage of treatment, the patients reported how the inclusion of different health professionals throughout the course of the treatment provided a greater sense of care. From the content analysis, it was noticed that the patients perceived professionals willing to establish a technical communication with emotional support: *"You have the confidence of being among people who will take good care of you. People, who are doing that thing there for having a relationship of care, friendship. The more you feel good with the team, the more the treatment will flow"* (13).

Also regarding the technical communication with emotional support, the patients reported to notice, mostly, a health team willing to communicate in order to support and welcome them with their doubts and anxieties in relation to the disease and therapies: *"You perceive that there is a more sentimental involvement. This helps, gives you that good feeling that there is someone worried about you, that someone is watching you"* (13). As well as the technical communication with emotional support on the part of the physician, the patients also reported this, during the treatment, as a facilitator of feelings of support, hope, and closeness with the professional: *"Moreover, when a surgery was required, the surgeon was excellent. Always giving optimism and hope"* (09).

From the content analysis, it was perceived that during the treatment, the satisfaction felt by the patient seems to be more related to the emotional support offered than the communication related only to the disease. When the team of different professionals can articulate the care beyond the cancer, the feeling of well-being increases, as well as the feeling of being cared for and supported in their difficulties (Porto, Thofehm, Amestoy, Gonzáles, & Oliveira, 2012; Silva & Hahn, 2012).

The feeling of emotional well-being may have been allowed by the treatment stage itself, in which there is already a greater familiarity with the professionals, with the disease and with all that surrounds it, such as effects of the treatment, routine examinations, etc. In addition, during the treatment, the physician is allowed to divide the medical care with his team, being no longer the only professional in the face of the patient with cancer. Thus, the patient can find within a team, professionals who can more easily communicate in a technical way with emotional support (Grilo, 2012; Veit & Carvalho, 2008).

When there were failures in the provision of information, whatever the stage in which the patient was found, the communication was regarded insufficient. The content analysis showed that the patients perceived the distancing of the professional in relation to their illness and did not feel supported in their needs. The professional communicated the therapeutics of the treatment and the perception of the patients was that there was no interaction between the professional and the patient. The situation caused discomfort and dissatisfaction in the patient, since he left the consultation with doubts about the illness: *"I said to the doctor: 'I do not stop bleeding, during all day. Give me a remedy; give me something, for God's sake. I can't stand it any longer'. Then she said: 'No, we have to wait the immunohistochemistry'. What is it? So I suffered a lot during this period"* (1).

The reports from the patients during this study demonstrated the need to establish effective actions for health professionals, which provide technical information combined with the emotional support. Winnicott (1963/1990) affirmed that every time that the need of a patient is deeply understood, and when this is demonstrated to him through a genuine communication, it is possible, in fact, to sustain the one who suffers.

The literature points out how the professionals can achieve the effective communication. For instance, relevant conversations for the treatment should be conducted with at least one more person linked to the patient; communicate news only with the presence of the patient, increases the responsibility of the information carried and future decisions on the part of the patient, reducing his feeling of support in this moment of crisis (Almeida & Santos, 2013; Arbabi et al., 2014.). Furthermore, the technical information should be used together with moments of elaboration of the patient, with the use of silence between one speech and another, and if possible, returning in other conversations to what was spoken in previously conversations. Another important proviso relates to the validation of the emotions that appear before these communications, allowing the patient to express their fears, fantasies and doubts and that these can be recognized and clarified by the professionals (Almeida & Santos, 2013).

## Final considerations

It was investigated the communication between professional and patient from the perceptions of patients under cancer treatment. It was found that the phases of the investigation of the disease and the diagnosis itself seem to be the most difficult moments of establishing an effective communication. Health professionals poorly linked with the patient and that, sometimes, will not continue taking part of his treatment, seem to have more difficulties to make him to feel supported. In contrast, during the treatment process, patients report feeling more easily welcomed in their emotional demands, and the communication and bond with the professionals who care for them are already strongly established.

In general, the content analysis showed that the patients' perceptions, about the communication during the treatment period were permeated by a feeling of support and satisfaction. Similarly, the communication with the staff of various professionals obtained a key role in meeting the different demands of these patients. In this sense, it is possible to suggest that the course of treatment can facilitate the process of psychological elaboration and adaptation of the patient to the new reality of living with cancer diagnosis. Therefore, in this case, the effective communication professional-patient could be established in an easier way.

A multi-professional staff, with knowledge that complement each other and that know how to communicate technically with emotional support seem to be the ideal in the context of the attention to the patient in oncology. Even if not all professionals of the staff can achieve this type of communication at the same level, the fact that some of them are available for this can provide a sense of integral care to the patient. If it is role of the physician to communicate bad news, it can be responsibility of the psychologist, for instance, the task of providing a favorable space for the elaboration of the harsh reality and the ways to cope with it. The nurse, for being the closest professional for the patient, could have the task of serving as a bridge in the communication between the patient and the team. The other professionals, each with their knowledge, have the role of providing a safety net that favors the feeling of being supported and having the suffering mitigated. This network can only be established upon the scope of the extensive process that involves the effective communication.

Thus, providing space to the patient to communicate about what afflicts him, in addition to the physical aspects of the disease, makes the cancer experience gain a new meaning, less terrifying. The perception about the suffering is more prominent when the patient cannot reorganize and communicate his feelings and anguishes with the help of the one who cares for him. It is giving way to the word that it is provided relief to the anguished subject and possibility of psychological growth. In this sense, propitiating a supporting environment that allows the process of integration of the subject, according to the Winnicott's thought, allows that the agonizing feelings turn into words and better-elaborated experiences.

Possibly, studies conducted in other contexts, such as public assistance, could bring divergent results. The fact that the participants evaluated the communication with the staff that cared for them in that moment may have restrained the free expression of negative feelings. On the other hand, the interviews were conducted during chemotherapy, which may have been a precipitating factor of emotions. Besides, issues relating to secrecy and confidentiality were specified and reinforced by the researcher, in order to ensure the secrecy and reliability to the data of patients.

It is recommended the deepening of the issue on the communication between patient and professional in oncology considering different contexts, different populations and with the inclusion of variables that may be relevant for a better understanding of this complex phenomenon. From a theoretical and methodological point of view, this study had innovative character when understanding the phenomenon, combining empirical evidences and psychoanalytical concepts traditionally applied in clinical psychology.



## References

- Almeida, M. D. & Santos, A. P. (2013). Câncer infantil: o médico diante de notícias difíceis – uma contribuição da psicanálise. *Mudanças – Psicologia da Saúde*, 21(1) 49-54.
- Arbabi, M., Rozdar, A., Taher, M., Shirzad, M., Arjmand, M., Ansari, S., & Mohammadi, M. R. (2014). Patients' Preference to Hear Cancer Diagnosis. *Iranian Journal of Psychiatry*, 9(1), 8-13. Recuperado de <http://ijps.tums.ac.ir/index.php/ijps/article/view/704/41> 417 em 01 de maio de 2015.
- Bion, W. R. (1991). *O aprender com a experiência*. Rio de Janeiro: Imago.
- Bion, W. R. (1994). *Estudos Psicanalíticos Revisados*. Rio de Janeiro: Imago. (Trabalho original publicado em 1967).
- Botella, C. & Botella, S. (2002). *Irrepresentável: mais além da representação*. Porto Alegre: Sociedade de Psicologia do Rio Grande do Sul/Criação Humana.
- Campos, E. (2005). *Quem Cuida do Cuidador: uma proposta para os profissionais da saúde*. Rio de Janeiro: Vozes.
- Castro-Arantes, J. & Lo Bianco, A. C. (2013). Corpo e finitude: a escuta do sofrimento como instrumento de trabalho em instituição oncológica. *Ciência & Saúde Coletiva*, 18(9), 2515-2522.
- Dolto, F. (1971). *Psicanálise e Pediatria: as grandes noções da psicanálise - dezesseis observações de crianças*. Rio de Janeiro: Guanabara.
- Ferreira, D.M. & Castro-Arantes, J.M. (2014). Câncer e corpo: uma leitura a partir da Psicanálise. *Analytica*, 3(5), 37-71.
- Ferro, A. (2011). *Evitar as emoções, viver as emoções*. Porto Alegre: Artmed.
- Freud, S. (1996a). Projeto para uma psicologia científica. Em: *Edição Standard brasileira das obras psicológicas completas de Sigmund Freud* (Vol. 2, pp. 39-189). Rio de Janeiro: Imago. (Trabalho original publicado em 1895).
- Freud, S. (1996b). Além do princípio de prazer. Em *Edição Standard brasileira das obras completas de Sigmund Freud* (Vol.18, pp. 11-75). Rio de Janeiro: Imago. (Trabalho original publicado em 1920).
- Grilo, A. M. (2012). Relevância da assertividade na comunicação profissional de saúde-paciente. *Psicologia, Saúde & Doenças*, 13(2), 283-297. Recuperado de [http://www.scielo.oces.mctes.pt/scielo.php?pid=S1645-00862012000200011&script=sci\\_arttext](http://www.scielo.oces.mctes.pt/scielo.php?pid=S1645-00862012000200011&script=sci_arttext)
- Houngaard, L., Augustussen, M., Moller, H., Bradley, S. K., & Moller, S. (2013). Women's perspectives on illness when being screened for cervical cancer. *International Journal of Circumpolar Health*, 72, 1-7.
- Lacan, J. (1998). Função e campo da fala e da linguagem em psicanálise. In J. Lacan, *Escritos*. Rio de Janeiro: Jorge Zahar.
- Marco, M. A. D., Degiovani, M. V., Torossian, M. S., Wechsler, R., Joppert, S. M. H., & Lucchese, A. C. (2013). Comunicação, humanidades e humanização: a educação técnica, ética, estética e emocional do estudante e do profissional de saúde. *Interface-Comunicação, Saúde, Educação*, 17(46), 683-693.
- McCarthy, B. (2014). Patients' perceptions of how healthcare providers communicate with them and their families following a diagnosis of colorectal cancer and undergoing chemotherapy treatment. *European Journal of Oncology Nursing*, 18(5), 452-458.
- McCormack, L. A., Treiman, K., Rupert, D., Williams-Piehot, P., Nadler, E., Arora, N. K.,..., Street, R. L. (2011). Measuring patient-centered communication in cancer care: a literature review and the development of a systematic approach. *Social Science & Medicine*, 72, 1085-1095. doi: 10.1016/j.socscimed.2011.01.020
- Porto, A. R., Thofehn, M. B., Amestoy, S. C., Gonzáles, R. I. C., & Oliveira, N. A. (2012). A essência da prática interdisciplinar no cuidado paliativo às pessoas com câncer. *Investigación y Educación en Enfermería*, 30(2), 231-239. Recuperado de <http://www.redalyc.org/articulo.oa?id=105224306008> em 01 de maio de 2015.
- Silva, D. S. D. & Hahn, G. V. (2012). Processo de trabalho em oncologia e a equipe multidisciplinar. *Caderno Pedagógico*, 9(2), 125-137.
- Skea, Z. C., MacLennan, S. J., Entwistle, V. A., & N'Dow, J. (2014). Communicating good care: a qualitative study of what people with urological cancer value in interactions with health care providers. *European Journal of Oncology Nursing*, 18(1), 35-40.
- Thorne, S., Hislop, T. G., King-Sing, C., Oglov, V., Oliffe, J. L., & Stajduhar, K. I. (2014). Changing communication needs and preferences across the cancer care trajectory: insights from the patient perspective. *Support Care Cancer*, 22, 1009-1015.
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32 item checklist for interviews and focus group. *International Journal for Quality in Health Care*, 19(6), 349-357.
- Veit, M. T. & Carvalho, V. A. (2008). Psico-oncologia: definições e áreas de atuação. In V. A. Carvalho et al. (Orgs.), *Temas em Psico-oncologia* (pp. 15-19). São Paulo: Summus.
- Vidal y Benito, M. C. (2010). *La relacion medico paciente: bases para una comunicacion a medida*. Buenos Aires: Lugar Editorial.
- Winnicott, D. W. (1983). *O Ambiente e os Processos de Maturação: estudos sobre a teoria do desenvolvimento emocional*. Porto Alegre: Artes Médicas. (Trabalho original publicado em 1958).
- Winnicott, D. W. (1990). Communicating and not communicating leading to a study of certain opposites. In: *The maturational process and the facilitating environment*. London: Karnac Books, 1990, p. 179-192. (Trabalho original publicado em 1963).

Winnicott, D. W. (2000). *Da Pediatria à Psicanálise: obras escolhidas*. Rio de Janeiro: Imago. (Trabalho original publicado em 1958).

Winnicott, C., Shepherd, R., & Davis, M. (Orgs). (1994). *Explorações Psicanalíticas: D. W. Winnicott*. Porto Alegre: ArtesMédicas. (Trabalho original publicado em 1989).

*Received: Nov. 04, 2015*

*Approved: May. 16, 2016*

---

*Elisa Kern de Castro*: Associate professor of the Postgraduate Program in Psychology of the University of Vale do Rio dos Sinos. Researcher on productivity at CNPq.

*Daniela Bianchini*: Clinical Psychologist, master in Psychology by the University of Vale do Rio dos Sinos (UNISINOS).

*Ana Carolina Peuker*: psychologist, master and doctor in Psychology by the Federal University of Rio Grande do Sul (UFRGS) and is currently a post-doctoral student and a Docfix/CAPES/Fapergs scholar in the Postgraduate Program in Psychology of the University of Vale do Rio dos Sinos – UNISINOS.

*Fernanda Bittencourt Romeiro*: Clinical Psychologist graduated by the University of Vale do Rio dos Sinos (UNISINOS).