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PERCEPÇÕES E EXPERIÊNCIAS PROFISSIONAIS DE PSICÓLOGAS ATUANTES EM ONCOLOGIA PEDIÁTRICA

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RESUMO. Estudo qualitativo, descritivo e exploratório que objetivou analisar as percepções de psicólogas atuantes em oncologia pediátrica acerca dos processos e resultados de intervenções psicossociais realizadas na área. Cinco psicólogas que trabalham com crianças e adolescentes com câncer no âmbito hospitalar foram entrevistadas de modo presencial ou online, com base em um roteiro para entrevista semiestruturada. As respostas obtidas foram categorizadas com base na Análise de Conteúdo de Bardin. A partir dos relatos obtidos, foram desenvolvidas categorias em quatro eixos temáticos: trabalho com as famílias; atuação na equipe multiprofissional; avaliação dos resultados das intervenções; e desafios e benefícios da atuação profissional. O familiar foi visto como informante, aliado, foco de apoio e alvo da intervenção. O papel do psicólogo na equipe multiprofissional foi destacado como promotor de interações, interconsultor, mediador e auxiliador na comunicação de más notícias. Os resultados das intervenções psicossociais foram vistos a partir do alcance de alterações psicológicas nas crianças, feedback, aplicação de testes psicométricos e redução da demanda. Os desafios da atuação profissional consistiam, por exemplo, em lidar com crianças em fim de vida ou resistentes à intervenção. Os benefícios, por sua vez, estiveram relacionados a contribuições, reconhecimentos e fortalecimento da espiritualidade. Destaca-se a necessidade de mais ênfase em investigações qualitativas dessa temática e da discussão de suas implicações para a formação profissional em psicologia.

Palavras-chave: psico-oncologia pediátrica; intervenção psicossocial; psicólogo.

PERCEPTIONS AND PROFESSIONAL EXPERIENCES OF PSYCHOLOGISTS WORKING IN PEDIATRIC ONCOLOGY

ABSTRACT. This qualitative, descriptive, exploratory study analyzed the perceptions of psychologists working in pediatric oncology regarding the processes and outcomes of psychosocial interventions in this field. Five psychologists working with children and adolescents with cancer in a hospital setting were interviewed in person or online based on a semi-structured interview guide. The responses were categorized using Bardin's content analysis method. Four category themes were developed based on the reports: work with families, work within the multidisciplinary team, evaluation of intervention outcomes, and professional challenges and benefits. Family members were viewed as sources of information, support, and targets of intervention. The psychologist's role within the

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multidisciplinary team was highlighted as promoting interactions, acting as an interconsultant, mediating, and aiding in communicating bad news. Psychosocial intervention results were assessed based on psychological changes in children, feedback, administration of psychometric tests, and reduction in demand. Professional practice challenges included dealing with children at the end of their lives or those resistant to intervention. In turn, the benefits were related to contributions, recognition, and spiritual growth. There is a need for greater emphasis on qualitative research on this topic and discussion of its implications for professional psychology training.

Keywords: pediatric psycho-oncology; psychosocial intervention; psychologist.

PERCEPCIONES Y EXPERIENCIAS PROFESIONALES DE PSICÓLOGOS QUE ACTÚAN EN ONCOLOGÍA PEDIÁTRICA

RESUMEN. Estudio cualitativo, descriptivo y exploratorio que tuvo como objetivo analizar las percepciones de los psicólogos que trabajan en oncología pediátrica sobre los procesos y resultados de las intervenciones psicosociales realizadas en el área. Se entrevistó presencial o online a cinco psicólogos que trabajan con niños y adolescentes con cáncer en el ámbito hospitalario, a partir de un guión de entrevista semiestructurado. Las respuestas obtenidas se categorizaron según el análisis de contenido de Bardin. A partir de los informes obtenidos, se desarrollaron categorías a lo largo de cuatro ejes temáticos: trabajo con familias; actuando en el equipo multidisciplinario; evaluación de los resultados de las intervenciones; y desafíos y beneficios del desempeño profesional. El familiar fue visto como un informante, un aliado, un foco de apoyo y un objetivo de intervención. Se destacó el rol del psicólogo en el equipo multidisciplinario como promotor de interacciones, interconsultor, mediador y ayudante en la comunicación de malas noticias. Los resultados de las intervenciones psicosociales se vieron desde el alcance de los cambios psicológicos en los niños, las retroalimentaciones, la aplicación de pruebas psicométricas y la reducción de la demanda. Los retos de la práctica profesional consistieron, por ejemplo, en tratar con niños al final de la vida o resistentes a la intervención. Los beneficios, a su vez, estuvieron relacionados con aportes, reconocimiento y fortalecimiento de la espiritualidad. Se destaca la necesidad de un mayor énfasis en las investigaciones cualitativas de este tema y la discusión de sus implicaciones para la formación profesional en psicología.

Palabras clave: psicooncología pediátrica; intervención psicosocial; psicólogo.

Introduction

Cancer is a term that encompasses a group of diverse diseases characterized by the uncontrolled proliferation of abnormal cells. These diseases can occur anywhere in the body and affect people of all ages, races, and socioeconomic classes (Instituto Nacional de Câncer José Alencar Gomes da Silva [INCA], 2020). Technological, medical, and pharmaceutical advances in recent decades have made new drugs and surgical techniques available for treating neoplasms. Early diagnosis and these therapeutic advances have increased the likelihood of remission and cure. Despite rising survival rates, cancer remains the leading cause of disease-related death among children and adolescents in Brazil (Instituto Nacional de Câncer José Alencar Gomes da Silva [INCA], 2014).

Cancer debilitates children, inflicting painful experiences and requiring aggressive treatments that can be mutilating, as well as frequent or prolonged hospitalizations. Therefore, having a malignant tumor and undergoing its treatments can cause physical and psychosocial harm to pediatric patients, during the period of illness and also in the long term (Wiener et al., 2015). Consequently, there has been an increased focus on preventing or mitigating the effects that cancer can have on the mental health and quality of life of children, particularly survivors who resume pre-treatment activities such as regular school attendance and socializing with peers.

Pediatric psycho-oncology, which focuses on the emotional and behavioral aspects associated with childhood cancer, is a rapidly developing area. It is considered a fundamental specialty in the care of children with cancer, given the importance of providing them with physical and therapeutic care, as well as effective psychological and social support (Datta et al., 2019).

Psycho-oncology emerged in the mid-1970s in the United States as a field of scientific knowledge and professional practices centered on the psychological aspects of cancer. According to Jimmie Holland (2018), one of its founders, it includes the emotional responses of patients and caregivers at all stages of disease and treatment, as well as the psychological, social, and behavioral factors that contribute to morbidity and mortality. The goal is to understand how these factors influence the risk, detection, and survival of the disease by focusing on cancer patients, their families, and the professionals involved in the treatment process.

In pediatric psycho-oncology, the goal of the guidelines and tools is to support children and their families during the crisis caused by the disease (Wiener et al., 2020). Thus, psychologists working in this field can base their work on actions ranging from assessments to interventions directly related to children's behavior and emotional state. Psychosocial support for cancer patients and their families has been integrated into Brazilian healthcare, particularly since Ordinance No. 3,535 (1998) of the Ministry of Health legalized the inclusion of psychologists in multidisciplinary teams responsible for caring for adult and pediatric cancer patients.

Thus, psychologists have become an integral part of pediatric oncology teams. These professionals provide technical support and care to children and adolescents during the diagnostic investigation and treatment phases, as well as during social reintegration, survival, and end-of-life care. They also work with family members and healthcare teams whenever necessary (Wiener et al., 2020).

Neiva (2010) emphasizes that psychological and social factors often diminish a person's well-being during the course of an illness. Therefore, implementing psychological and psychosocial interventions can foster coping strategies and help patients overcome the adversities present in this context. These strategies are frequently used in pediatric psychology to help patients and their families give meaning to their experiences and cope with stressors related to illness, hospitalization, and medical procedures required for treatment (Coutinho & Costa Junior, 2018).

This study aimed to analyze psychologists' perceptions of the contexts in which psychosocial interventions are implemented and the outcomes they achieve in pediatric oncology. This is an excerpt from a larger study investigating the psychosocial strategies of 30 psychologists from different countries caring for children and adolescents with cancer in hospitals. The psychologists responded to an online, self-administered questionnaire. The work reported herein focuses on the results of semi-structured interviews conducted with five Brazilian psychologists to further investigate their professional practices as members of oncology teams.

Method

This qualitative, descriptive, and exploratory study was conducted in person and online with five psychologists working with children and adolescents with cancer at four public hospitals in the state of São Paulo. The professionals' ages ranged from 27 to 32, with an average age of 29. They had completed their undergraduate psychology degrees between 3 and 8 years ago. The inclusion criteria were as follows: a) possessing a psychology degree; b) working as a psychologist in a general or oncology hospital in an outpatient and/or inpatient setting, or an oncology treatment center; and c) providing care to children undergoing cancer treatment for at least one year.

After the Research Ethics Committee of the Federal Rural University of Rio de Janeiro (UFRRJ) approved the research project under protocol 23083.038850/2019-21, data collection began using a semi-structured interview guide. The guide consisted of 12 open-ended questions designed to encourage the psychologists to share their experiences and professional practices with hospitalized children and adolescents undergoing cancer treatment. The questions covered topics such as their perceptions of treatment outcomes, the involvement of other adults, and the obstacles and benefits of working in pediatric oncology.

The interviews were scheduled according to the availability of each participating professional. Two took place in person, and three were conducted via Skype video call. At the beginning of each meeting, the psychologists were informed of the research objectives, procedures, and ethical considerations. They then signed an informed consent form expressing their agreement to participate in the study. Their statements were audio-recorded, and the content was transcribed. To ensure anonymity, the participants were identified by fictitious names.

The responses obtained in the interviews were categorized based on Bardin's (2016) content analysis method, which uses strategies to systematically and objectively analyze what was communicated. The method comprises three fundamental phases: pre-analysis, material exploration, and data processing, which involves categorizing, analyzing, and interpreting the responses.

Results and discussion

The psychologists' reports were organized into four categories based on their experiences and perceptions in pediatric oncology. The categories are: 1) working with families, 2) working on a multidisciplinary team, 3) evaluating the results of psychosocial interventions, and 4) the challenges and benefits of working in this field.

Working with families

In pediatric care, it is emphasized that involving significant persons in the child's care, usually the mother and/or father, is important. In addition to being good sources of information about the patient's characteristics and needs, adults often serve as attachment figures, providing greater security and comfort during hospitalization and invasive procedures (Coutinho et al., 2020). Furthermore, joint hospitalization is guaranteed in many countries, including Brazil. Psychologists can take advantage of the presence of family members in the hospital to provide educational and preventive care. This helps minimize the adverse effects of illness and hospital care on the child's emotional state and development (Crepaldi, 1999).

In this regard, the interviewed psychologists stated that they include caregivers at various stages of their pediatric oncology practices for different reasons, which are revealed by the subcategories described below.

a) Family caregiver as informant. Parents or other caregivers are asked to participate in psychological care sessions so that relevant information can be obtained to support interventions with the child. They are also encouraged to clarify the needs and demands of the patient and family. In Moana's words:

> In the outpatient clinic, I usually do the following: During the first appointment, I call the caregiver and the child [...] I ask the parents about their work demands on me, their expectations of me as a psychologist, and their desires for their child's treatment. This allows me to understand their perspective and what they consider to be demands. [...] Sometimes I tell the parents that they are the spokespersons for their children's feelings.

Due to their limited cognitive maturity and insufficient communication skills regarding their treatment and history, children depend on their caregivers to provide information that will help the psychologist understand their functioning before and after the illness, as well as to know their family structure and dynamics (Wiener et al., 2021).

b) Family caregiver as ally. The goal is to guide family members regarding the child's behaviors, emotional state, and needs associated with the illness. The caregiver acts as a role model and equips family members to collaborate throughout the medical treatment and psychological care process. This category was highlighted in Pocahontas's statement: “[...] regarding how to help us with the child, whether behaviorally or emotionally, I guide the caregiver on what they can do at certain times and ask them to observe me so they can repeat what I did.”

Since parents generally spend the most time with their children, it is the psychologist's responsibility to educate them on how to help their children cope with cancer. This will reduce their distress levels and encourage behaviors that facilitate treatment in the hospital and at home later on (Rodgers et al., 2018). Furthermore, it is important to consider that raising and caring for a sick child can leave parents insecure about their ability to handle new situations. In this sense, while obtaining their collaboration, the psychologist can help them recognize their strengths and become more confident in their parenting role (Inhestern et al., 2016).

c) Family caregiver as a support center. Family members collaborate with the child on an activity to help them understand certain information or manage potential emotional reactions. Rosa's statement illustrates this category: “[...] When parents want to talk to the child about something, they ask to do so with me nearby, either to clarify the child's doubts or in case the child freaks out or bursts into tears upon hearing.”

During cancer treatment, the patient-caregiver dyad may feel overwhelmed by the large amount of information and stimuli they receive about the disease, its treatment, and the child's clinical condition and prognosis. This can make parents/guardians insecure, causing them to question how to care for or respond to the emotional needs of a sick child. In this sense, a psychologist can help parents understand and manage their children's emotional and cognitive experiences at different stages of cancer treatment (Brand et al., 2017).

d) Family caregiver as the target of intervention. Family members become the focus of psychological care when they express a need for emotional support in dealing with difficulties related to their child's illness and treatment. As Rosa states: “Sometimes the child is perfect, without complaints, but the parents are anxious and depressed, so I call them in for consultations.”

Indeed, caregivers can experience intense psychological distress during the child's treatment or even after its completion. Fear of losing their child or of the disease worsening or returning can lead caregivers to experience emotional difficulties requiring direct psychological attention to preserve their mental health and improve their quality of life (Coutinho & Costa Junior, 2018; Kohlsdorf & Costa Junior, 2012; Nascimento & Santos, 2021).

Work within the multidisciplinary team

The interviewed psychologists reported that they interacted with other members of the healthcare team for various reasons, allowing for the development of four thematic subcategories. Horlait et al. (2019) emphasize the potential for psychologists to collaborate with professionals from other fields to improve the quality of care provided to children.

a) Psychologists as promoters of team interactions. They access healthcare team members to obtain information about the child or their treatment. In these interactions, they also provide relevant information about care or assessment results. This category was observed in Elza's statement, for example:

> I think we should always know what the other person is working on, at least to the extent of exchanging ideas or sharing what's being done. We need to know the patient's clinical situation, what stage of treatment they're in, and how their medical follow-up is going. Sometimes the OT [occupational therapist] is already seeing the child and suggesting activities that interest them, so you can exchange ideas or opinions about that patient as well.

b) Psychologist as an interconsultant. They provide theoretical and methodological knowledge based on psychological science to other professionals, helping them better understand and manage psychosocial variables associated with their care. According to Elza:

> [...] Sometimes it's a patient, for example, who has significant dental needs, but also has an emotional issue, and you share your opinion on the case, your impression, in fact, of the case with your colleagues.

c) Psychologist as a mediator in the interaction between the team and the patient/family. When asked to assist in communication with the child and/or their family, the psychologist seeks to collaborate directly with the healthcare team. This category includes cases of resistance to a therapeutic procedure, as reported by Rosa:

> [...] when the child isn't cooperating with a procedure or task, which happens a lot, the professional will say... ‘Ah (X), come here. (X) doesn't want to do the treatment anymore,’ then I will go with them, approach the child and the family, and try to understand what's happening and what's behind that choice [...]. [...] and I serve as a mediator with the team, representing the child and family; I'm here for them.

d) Psychologist as support when breaking bad news. Psychologists can help deliver bad news and collaborate from the initial preparation to the subsequent psychological support. This category involves communicating diagnoses, prognoses, test results, and end-of-life care. In the words of two of the interviewees: “Always there to shed light or put out a fire, when they're about to deliver bad news, like ‘there's nothing more to do,’ or communicate about the illness” (Dori); “With doctors, when they're delivering bad news or when a bombshell explodes during communication, they ask us to be present. In palliative care, they warn us in advance to help them address it” (Moana).

These data show that the interviewed psychologists actively participated in patient care routines, working directly with other members of the oncology team in a variety of ways. Therefore, their involvement was not limited to occasional contact with other professionals when requesting an opinion from the psychology department. In line with the agent integration model described by Peduzzi (2001), they sought greater opportunities for interdisciplinary work through constant and consistent interprofessional exchanges. Horlait et al. (2019) criticize purely multidisciplinary work and reinforce the need for integration among health professionals' actions. They also highlight the role of psychologists in identifying psychosocial aspects linked to treatment plan decisions.

However, according to the five interviewees, psychologists' roles in oncology teams could be more effective if there were broader and more realistic knowledge about this profession's work in hospitals, as Veit and Barros (2008) also suggest. In the words of two of the interviewees:

> [...] I think the team doesn't have much of an idea of what the psychologist can do to contribute in that scenario [...] so I think this ground is still a bit raw, it's still being built. Some professionals have a clear idea, but not many. It's also our responsibility to show what we do. (Elza)
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> Look, it's still very limited. What I've been trying to do consistently is psychoeducate the team about what the “talk lady” does. I hate that term, you know? I'm a psychologist, and my work involves more than just conversation. They used to call me that a lot: “Go over there and talk to so-and-so.” One day, I gave up and gave a mini-lesson on “[...] it's not just conversation; it's care [...], like they all do there” (Dori).

Veit and Barros (2008) emphasize that daily interactions focused on interdisciplinarity are necessary to clarify the understanding of psychological intervention in oncology. To change this scenario, psychologists must invest in institutional routines, highlight their roles and contributions, and deconstruct the perception of psychologists as “firefighters” or just “talkers.”

Despite the limited knowledge of psychological practice, the psychologists reported feeling welcomed and, generally speaking, recognized for their work within their respective teams. However, Elza reported a lack of receptiveness from some of the professionals she worked with. In her words: “[...] Sometimes they're receptive, and sometimes they're not. Sometimes you give your opinion and it's not well received—especially when it's criticism of how the team handled the situation.” Moana emphasized the need to value and facilitate this connection with other specialists. “I think there's a lot of discussion in psychology. They often seek us out. [...] but, sometimes, we have to empower the team to do this.”

Assis and Figueiredo (2020) point out that hospital psychology is a relatively new area of professional practice that is still developing and seeking to become more established. Psychologists have entered an institutional context that was previously exclusive to other health professionals and that has broad social recognition and well-defined professional roles. Furthermore, psychologists must establish their professional identity in a workplace that requires significant adjustments to their daily work. First, they must clarify their role within the service so that, through daily practice and with greater confidence, they can demonstrate their desired role and contributions to patient and family well-being and advancement.

Evaluation of the results of psychosocial interventions

Developing psychosocial interventions requires professionals to verify if they have promoted emotional, behavioral, and/or cognitive changes in patients and their social environments. Professionals must also determine if these interventions are relevant and well-adapted to hospital settings. Data extracted from interviews revealed psychologists' perceptions of how they evaluated the results of their interventions with children and adolescents undergoing cancer treatment. Four subcategories were developed within this thematic axis, corresponding to the different methods of measuring the results of their practices:

a) Emotional and behavioral changes in the child. Several children began exhibiting more collaborative behaviors during medical procedures and improved mood as a result of the intervention, according to two psychologists: “[...] she [the child] is more relaxed, calmer, and more at ease” (Elza); “[...] she [the child] is already demonstrating more collaborative or functional behavior” (Pocahontas).

b) Feedback received. Feedback is received from healthcare professionals, family caregivers, and/or children regarding the positive effects of psychosocial interventions on patients' behavior and emotional state. For example:

> I think that the parents' speech is very important in this regard, especially with younger children. It helps us understand how they are doing and how they are coping. For example, many times a child is anxious when they have to go to the operating room. I can't always go up there to see how they are doing, so the parents' and children's reports are important (Elza).

c) Results of psychometric instruments. Psychometric scales are used to assess the child's behavioral and emotional states before and after the intervention. In the words of the interviewees: “Since I use the emotion diary, I can notice if the child's mood improves throughout the day. I use it as my thermometer” (Dori); and “When it's a patient I already know and have been following up with for a while, I usually use a previously used scale to quantitatively assess the extent of mood improvement” (Pocahontas).

d) Decreased demand. A decrease in demand is understood as an indication that a child is improving when requests for interventions become less frequent. This category was present in Dori's statement: “Another way is when the team or family calls me less frequently. You can tell things are better there.”

The interviewees' reports indicated that the psychologists' work was generally well-received and recognized by other members of the healthcare team and by patients' families. Understanding the nature and contributions of psychosocial interventions for children and adolescents undergoing treatment for illnesses is important for achieving collaborative work and expanding and consolidating the psychologist's role in hospitals. However, the prioritization of subjective evaluations of work performed based on reports from others was noted, without obtaining results supported by more objective instruments. These instruments tend to be highly valued in the medical field and facilitate the maintenance or expansion of activities proposed by the psychology service.

When psychologists join the child/adolescent care team, they must assert their role and demonstrate the effectiveness of their work. To this end, measurement instruments are useful. In a literature review conducted by Scialla et al. (2018) on psychosocial assessment methods used in pediatric oncology, the authors identified several strategies that can be used to assess the mood and behavioral aspects of both children and their families.

Challenges and benefits of professional practice in pediatric oncology

Psychologists working in hospital settings often face many challenges in their work. Pediatric oncology is no exception. Based on the accounts of the interviewees, it was clear that they all faced some kind of difficulty in their daily work. Five subcategories relating to these difficulties were developed: difficulties dealing with children and responsible adults; difficulties imposed by the hospital routine; and difficulties resulting from emotional limitations when faced with pain and terminal illness.

a) Lack of parental cooperation. Some parents prioritized medical care and failed to recognize the need for psychological care for children. As Rosa recounted:

> My biggest challenge is when parents don't attend the appointments. Some think, “Oh, just go there and talk! Or, “There's no problem now. We had a good week, so everything's fine.” Then they don't bring their child. This is very distressing. Unlike medical appointments, our appointments aren't mandatory.

It is important to help parents understand that emotional, social, behavioral, and cognitive factors related to cancer treatment must be adequately addressed to achieve patient engagement and disease control, rather than focusing solely on organic factors (Gupta & Bhatia, 2017). Considering what they commonly learn in our culture, parents tend to prioritize relieving physical symptoms and aim for a cure. Thus, psychoeducational interventions can provide information and help parents identify the psychosocial aspects involved in the illness process. It is necessary to demystify treatment as purely biomedical and value a comprehensive understanding (Rodgers et al., 2018).

b) Interference from routine hospital procedures. It's challenging to adapt psychological care to the needs of other specialties, which are often a priority. There is also the issue of how treatment affects the child's behavior and alertness. They may not be physically fit enough to work with a psychologist. As Dori states, “My biggest challenge is when I need access to the child, but they are undergoing a procedure or are with another professional.”

Ordinance No. 140 (2014) establishes that the care of any cancer patient must be carried out in a multidisciplinary manner, which allows for a variety of healthcare professionals to provide care to children. Once inserted into this context, professionals must adjust their medical routines and adapt their practices and schedules to perform their duties successfully. Given the professional diversity in the field, psychologists must be creative and devise ways to work with the healthcare team in an integrated manner.

c) Children at the end of life. Personal difficulties, such as emotional and/or management challenges, are reported when dealing with children in end-of-life care. This occurs when there is no longer any treatment that can cure the disease, and death becomes imminent. Regarding this type of care, Moana stated:

> [...] It's a delicate matter when we talk to that child. It's not a challenge, but it requires great care. Sometimes I wonder if it's better or not. In other words, I don't know if my work will fit into that child's time frame. Will they be ready to listen?

When all possibilities for a cure or disease control have been exhausted and the child enters palliative or end-of-life care, professionals, including psychologists, may have more difficulty following up on these cases. Accepting that a child whom we had hoped would have a long life is approaching their greatest antagonist, death, can be emotionally draining. Silva et al. (2015) emphasize that members of the healthcare team may have difficulty working with a child with cancer during this time because they fear that the child's fragility will lead to greater emotional involvement. In this context, psychologists can be seen as the professionals best suited to address issues related to finitude and dying. However, psychologists are not always personally or professionally prepared to address these issues, especially when working with very young patients. Psychologists must prepare to handle these situations, which are common in hospitals and oncology settings. They must also pay attention to their own mental health and seek help if necessary.

d) Children with treatment sequelae or specific disorders. Some children have greater behavioral and communication difficulties due to pre-existing conditions and the effects of medical procedures. This requires psychologists to develop new skills to manage these situations. For example:

> [...] It's also difficult with children who have tracheostomies in terms of communication. As a psychologist, you want to communicate, but sometimes you can't do so in the traditional way. The same is true for neurological patients with sequelae. It's difficult to know what the patient understands and to what extent they mean yes or no (Moana).
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> Another difficult thing is working with autistic children. It's especially hard when they're in the hospital. I hardly leave the room. I go in during the procedure and instruct the team on how to manage the child and crises (Dori).

Tumors that originate in the central nervous system may require surgical procedures to collect samples for biopsy and tumor removal. If the tumor is located in a sensitive part of the brain, these procedures can cause damage to the child's cognitive, motor, and executive functions (Krull et al., 2018).

Psychologists working with autistic children with cancer must seek tools and ways to work with these patients so that their quality of life is not compromised in the short or long term because their cognitive and behavioral processing differs from that of other children without the disorder. In a literature review on working with hospitalized autistic children, Johnson and Rodriguez (2013) emphasize the importance of teaching different coping strategies to both the child and their caregiver during medical procedures. They also stress the need for further research in this area to promote engagement and reduce non-facilitating behaviors.

e) Children resistant to psychosocial intervention. Some children resist psychological care by exhibiting oppositional behavior or challenging the professional, which poses a greater challenge to the work. The statements of Elza and Moana illustrate this category.

> Sometimes you have difficulty bonding with the child. They are more resistant because, in the hospital context, one of the difficulties is that you are offering a service. The person can choose to accept it or not. (Elza)
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> [...] Well, it's very personal, but I believe that children whose parents don't set many limits for them end up being a little more challenging. [...] I wouldn't say they have ODD [Oppositional Defiant Disorder], but they are more stubborn. They are aggressive to the point of challenging you. It's personal, but I have difficulty working with them in that sense (Moana).

Do Valle and Ramalho (2008) emphasize that a lack of clear boundaries on the part of parents regarding their sick child's suffering can lead the child to exhibit non-facilitating behaviors during treatment and even fail to develop sufficient emotional regulation skills. Furthermore, illness and hospitalization can make a child more defensive due to the numerous painful procedures they undergo and the handling of their body by various professionals. Therefore, psychologists must understand a child's refusal of psychological care as a right to be respected, while demonstrating a willingness to provide care in the future.

The psychologists' reports regarding the perceived benefits of working in pediatric psycho-oncology were organized into three subcategories, as described below:

a) Contributing to the well-being of children and their families. The psychologists assessed that they were able to improve the quality of life of children and their families through their work, as exemplified by Moana's statement:

> [...] It's a job where I'm here for the children. I dedicate myself to them, not to other institutional issues. It's also a privilege to be a psychologist and a pediatric psycho-oncologist. [...] I discovered a lot about myself with them [children and adolescents] through this role of great trust for the family and them.

b) Receive recognition for their work. The psychologists felt professionally recognized by family members, patients, and the healthcare team, as Dori states:

> The recognition from family members really catches my attention. It's gratifying. They send little messages, and when they're not in the ward, they come to the hospital and call me to meet them at the entrance. It's all very beautiful.

c) Strengthening one's spirituality. Psychologists expressed their belief that they could exercise their spirituality and religiosity while caring for children with cancer. This belief is evident in the following statements: “I feel at peace with my religiosity and spirituality, you know? When I'm with them, I feel close to God” (Dori); “[...] There's a spiritual benefit. Here, I can truly practice my spirituality. It makes me see life differently. It's not just about considering the sacred; it's also about seeing things differently” (Moana).

Despite the difficulties and adversities they experienced in their daily work, the psychologists felt satisfied with their work's positive effects on the lives of children and their families, as well as the social recognition they and their professional category received. Bendassolli (2012) emphasizes the importance of professional recognition because it enables psychologists to highlight their role within the multidisciplinary team and helps them develop their personal and professional identities as agents of care promotion.

These perceived gains outweighed the value attributed to psychological intervention and also resulted in spiritual well-being for the interviewees. Koenig (2015) emphasizes that spirituality and religiosity are linked to satisfaction and psychological well-being, which are paramount for constructing meaning in life. Values such as compassion, charity, and solidarity may be related to the religiosity or spirituality of employees and manifest in their practices in a hospital environment.

Final considerations

The interviewees' accounts offered insight into their understanding of psychosocial interventions for children with cancer and how other adults are involved in this context. The interviewees emphasized the importance of involving parents as informants and allies while observing and addressing the emotional impact of the illness on them. Although multidisciplinary teamwork was seen as essential, the need to educate other professionals about the role and potential collaboration of psychological services was also highlighted.

Psychologists and professionals from other specialties most commonly interacted when there was a need to encourage a child to cooperate with their treatment. In these cases, the psychologist intervened, serving as a mediator between the child and the team.

Although this is the hospital psychologist's responsibility, it often occurs without prior discussion or a more educational and preventive approach. One of the interviewees stated that psychologists largely acted as “firefighters” because they were asked to “solve” problems urgently without discussing them with the requesters. If properly guided, the requesters could have handled the situation appropriately.

Perhaps the reason psychologists are still seen as “behavioral problem solvers” is because of the limited knowledge about the scope of their work. They are commonly assigned tasks such as controlling crying or aggressive behavior. The lack of information about psychologists' roles in patient care may lead teams to call on them to meet demands beyond their expertise or that teams could handle themselves. However, as the participants demonstrated, it is believed that this situation will gradually change through exchanges in daily work, with greater openness to increasingly interdisciplinary work.

The interviewees highlighted the importance of their activities for the well-being of children and their families. They also acknowledged the recognition of their work by various actors involved (professionals, parents, and children). Nevertheless, the interviewees mentioned several challenges they face, particularly resistance from the child or team members and personal difficulties when dealing with the child's worsening clinical condition and death. This last point underscores the need to emphasize discussing this topic in psychology professional training.

In this sense, it is important to emphasize that studies like this one have the potential to inform training courses in the field of childhood cancer. Such courses could better prepare psychologists to perform interventions that prevent or mitigate the negative effects of childhood cancer and its resulting hospitalizations. They could also strengthen the protective elements of child and adolescent development. The work of these professionals is expected to contribute to the humanization of hospital care.

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