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How Interdisciplinary Teamwork Contributes to Psychosocial Cancer Support

KEY WORDS
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Background: The organization of psychosocial care is rather complex, and its provision diverse. Access is affected by the acceptance and attitude of patients and professional caregivers toward psychosocial care. **Objectives:** The aims of this study were to examine when patients with cancer experience quality psychosocial care and to identify circumstances in collaboration that contribute to patient-perceived positive psychosocial care. **Methods:** This study used a qualitative design in which semistructured interviews were conducted with patients, hospital workers, and primary health professionals. **Results:** Psychosocial care is often requested but also refused by patients with cancer. Based on this discrepancy, a distinction is made between psychosocial support and psychosocial interventions. Psychosocial support aims to reduce the chaos in patients' lives caused by cancer and is not shunned by patients. Psychosocial interventions comprise the formal care offered in response to psychosocial problems. Numerous patients are reluctant to use psychosocial interventions, which are often provided by psychologists. **Conclusion:** Psychosocial care aims to assist patients in bearing the difficulties of cancer and its treatment. Patients prefer informal support, given often in conjunction with physical care. **Implications for Practice:** This study confirms the important role of nurses in promoting psychosocial care. Patients perceive much support from nurses, although nurses are not considered to be professional psychosocial caregivers. Being perceived as approachable and trustworthy offers nurses a significant opportunity to bring more intense psychosocial interventions within reach of cancer patients.

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Psychosocial distress in response to a cancer diagnosis and treatment is well documented. Depression, anxiety, adjustment disorders, fear, anger, sadness, feelings of loss of control, worries about the cost of healthcare, loss of income and employment, and changes in one's role in the family are some well-known problems of patients with cancer.[1–5] The prevalence of clinical psychological disorders and social problems varies by the type of cancer and is estimated between 29% and 43%.[1]

The importance of meeting the psychosocial needs of patients with cancer is recognized.[1,6] Multiple studies link psychosocial care with increased well-being and quality of life of patients with cancer.[6–8] However, research shows that barriers can limit the use of psychosocial support services by patients who need it.[9,10] Some patients may fear being stigmatized as being "mentally ill." Fear of stigmatization sometimes persists because of a lack of knowledge about the content of psychosocial care and some physicians' unwillingness to accept it for their patients.[9] The attitude of physicians toward psychosocial care strongly affects access to it. Physicians act as gatekeepers: they largely determine which patients are referred to a psychologist or social worker at the time of diagnosis, and they are in a position to convince patients of the usefulness of a psychosocial consult. Mainly older physicians are more reluctant to involve psychosocial workers.[11] Psychosocial care is not always an evident part of hospital care because of the present (medical) hierarchy, a lack of interest in providing psychosocial care, insufficient respect for the academic disciplines involved in psychosocial care, difficulties in sharing responsibilities, and communication problems.[12]

In Belgium, the organization of psychosocial care is complex, and its provision variable. An evaluation indicates that psychosocial care depends on the type of cancer and the hospital where a patient is admitted.[13] For example, support is more readily available and hence more common for patients with breast cancer in university hospital settings. In contrast, psychologists and nurse consultants are less available to patients with rare cancers or for individuals with cancer in follow-up.[13] Nevertheless, the number of psychosocial caregivers in oncologic settings can be large and has been increasing since the Belgian government launched the national cancer plan in 2008.[14] This plan provides extra financial resources to support patients with cancer. For example, nurse consultants, psychologists, and social workers are funded to participate in the oncological care programs of hospitals. Their number is related to the number of patients who are discussed in multidisciplinary team meetings where patients' diagnosis and therapy are determined. Also, education programs in psycho-oncology and communication are being developed.[15] As a result of the extension of psychosocial care, many professionals have become involved in the support of patients with cancer.

Several studies have concluded that interdisciplinary collaboration contributes to better care than fragmented care.[16–19] What constitutes good collaboration between the members of an interdisciplinary team is complex. Studies highlight conditions that apply to interdisciplinary teamwork, but these are rarely specific for psychosocial care.[20–22] In the study of Palos et al,[23] a team approach was developed to improve psychosocial cancer care and outcomes. Changing the perception about psychosocial services as supportive services is one of their core challenges. They attempt to create the mindset that psychosocial services are an integral part of clinical care. Maintaining communication, shared goal setting, recognizing each team member's role, and leadership to facilitate the project are crucial concepts in their interdisciplinary approach.

During the last decade, the topic of psychosocial screening of individuals with cancer has increasingly been researched.[24–26] Much attention is paid to the implementation of distress screening programs in practice.[27–29] Implementation strategies describe how to introduce screening to adult patients with cancer, by whom this is best done, and how referrals can be made in the case of unmet needs. However, these processes insufficiently address how collaboration can be developed and maintained effectively once psychosocial needs are identified.

This study explored psychosocial care as well as collaboration in psychosocial care. To understand the processes involved in collaboration, the concept of psychosocial care has to be clear. Patients' perspectives and their experiences with high-quality psychosocial care serve as a standard to determine high-quality interdisciplinary collaboration. Therefore, this study examined patient and healthcare worker perspectives in order to explore what kind of collaboration is needed to result in effective psychosocial care. Our first aim was to examine when patients with cancer experience high-quality psychosocial care, and our second aim was to identify which circumstances in collaboration contribute to positive patient-perceived psychosocial care.

■ Methods

A qualitative approach, using the techniques of grounded theory, allowed us to investigate experiences with offering and receiving psychosocial support and to explore the characteristics of effective teamwork.[30] Grounded theory uses an inductive approach; data are analyzed without preformed hypotheses, and the relevant concepts are derived from the data in a process of rigorous analysis. Interviews are transcribed verbatim and coded in a manner consistent with open and axial coding.[31] Using comparative analysis, the process of data collection and data analysis alternated in a cyclic way in the construction of an inductively generated theoretical framework. The study was approved by the ethics committee of Ghent University Hospital.

Setting

The study was conducted in hospitals known to treat patients with cancer in an interdisciplinary oncology center. Two large university hospitals (>1000 beds) and 2 private hospitals (approximately 500 beds) in Belgium were selected.

Participants

Hospital healthcare workers who provided support to patients with cancer and primary healthcare workers (physician, community care nurse, palliative home nurse) whose patients had been hospitalized in 1 of the 4 participating hospitals were eligible to participate. One community care nurse and 2 physicians refused to participate because of lack of time. Thirteen patients with cancer and 31 healthcare workers participated in the study. The characteristics of the participating healthcare workers and patients are given in Tables 1 and 2, respectively.

Sampling

Purposive sampling was used to select healthcare workers and patients who were expected to offer rich information related to quality psychosocial care. The appropriateness of healthcare professionals being eligible to participate in the study was addressed by the contact person from the oncology centers in question. This contact person, assigned by the ethics committee of each hospital, suggested which healthcare worker could meet the sampling criteria and offered the contact data to the researchers. Healthcare workers (including nurses, social workers, psychologists, and physicians) who played an important role in the support of patients with cancer (or who were assumed to offer this support) were recruited from teams that were characterized by intense collaboration. To meet the criterion of intense collaboration, healthcare team members' subjective experiences of fruitful collaboration and communication were reviewed, as well as the frequency of (in)formal interdisciplinary psychosocial meetings of healthcare workers to discuss patient cases and participants' attendance at these meetings. In selecting healthcare workers, diversity regarding work experience was taken into account. Newly employed healthcare workers and healthcare workers with longer work experience were both included (range, 2-39 years). A purposive selection was made to represent all major psychosocial disciplines that participated in the interdisciplinary oncology center of the hospital. In disciplines that included more than 1 healthcare worker and when selection criteria of purposive sampling were difficult to meet, inclusion was determined by the availability of healthcare workers to be interviewed.

As the analysis proceeded, the developing concepts guided the selection of healthcare professional participants. Relevant sampling characteristics included the degree to which interdisciplinary collaboration was organized, the degree of interdisciplinary patient information exchange, and the degree in which healthcare professional participants considered the provision of psychosocial care as part of their current job (either formal and informal psychosocial care). The degree in which potential healthcare professional participants met the sampling criteria was discussed between the researcher and all potential healthcare workers prior to selection. This check took place in a small interview by telephone when the study was presented to the healthcare professional participant. Some invited healthcare workers suggested other participants who suited the predefined sampling characteristics. Thus, healthcare professional participants' inclusion was determined on the experiential information of healthcare workers about providing psychosocial care as validated in the interviews. During the process of analysis, the interest in sampling criteria differed depending on the questions to be revealed and the information needed. Participants were searched who could offer rich information to explore relevant and actual topics in depth.

Table 1 • Patients Diagnoses (n=13)

Type of Cancer	
Breast cancer	46.2 (6)
Hematologic malignancy	15.4 (2)
Lung cancer	23.1 (3)
Abdominal malignancy	15.4 (2)

Results are presented in percentages (%); the numbers of subjects are mentioned in parentheses (n).

Patients were also recruited from those settings in which multidisciplinary collaboration in principle existed. To be included, patients needed to have encountered several healthcare workers during their treatment. Purposive sampling required persons who had experienced the (non)provision of psychosocial care and the occurrence of collaboration. Patients of differing age, sex, social class, disease, and disease progression (from newly diagnosed to end of treatment) were recruited. The contact person in each hospital was instructed to obtain diversity in their selection of patients. In practice, nurse consultants and psychologists often suggested appropriate patients with cancer who were eligible to participate. Next, these patients were contacted by the researcher to participate in the study. All participants were interviewed only once. Almost all patients with cancer requested to be interviewed at their home and not in the hospital.

Data Collection

Patients were first approached by one of their healthcare workers to ask consent to communicate their names to the researcher. Eligible professionals were approached by the researchers to obtain consent for a semistructured interview. Patient interviews focused on experiences with psychosocial care, the attention paid by healthcare workers to nonmedical issues during their treatment, and what they consider quality psychosocial care. In the interviews with healthcare workers, their commitment to psychosocial care and the conditions for quality collaboration were discussed. As the process of data collection and data analysis evolved, the interview guide was adjusted to the emerging themes that required more exploration, and the interviewers' style generally became more structured. Two researchers, a nurse (M.D.) and a psychologist (M.V.), conducted the interviews. They both interviewed all categories of participants. Data collection took place between July 2011 and December 2012. The mean duration of the interviews with patients and healthcare workers was 58 and 60 minutes, respectively.

Data Analysis

Each interview was audio taped, transcribed verbatim, and coded using the software program NVivo 10.[32] All transcripts were read by 2 interviewers (M.D. and M.V.). Based on the

Table 2 • Characteristics of the Healthcare Workers (n=31)

Specialization	Breast Cancer	Breast Cancer/ Pelvic Oncology	Medical Oncology	Hematology	Palliative Care	Other
Specialist	6.5 (2)		6.5 (2)	6.5 (2)		
Nurse			6.5 (2)	9.7 (3)		
Palliative support team					6.5 (2)	
Nurse consultant	9.7 (3)					
Head nurse				3.2 (1)		
Psychologist	6.5 (2)	3.2 (1)		3.2 (1)		
Social nurse		3.2 (1)		3.2 (1)		
Pastoral worker						6.5 (2)
Physician						9.7 (3)
Community care nurse						6.5 (2)
Palliative home nurse						3.2 (1)

Results are presented in percentages (%); the numbers of subjects are mentioned in parentheses (n).

meaning that emerged from the data, interviews were first open coded in a manner consistent with Strauss and Corbin's[31] coding. The first 3 interviews were coded by both interviewers to attune the coding strategy. After 4 interviews, the interviewers each coded their interviews in a shared NVivo file. A third researcher (M.G.), with nursing as her discipline, read all transcripts, checked the coding, and participated in the analyses of the interviews that took place. Disagreements in coding and interpretations of each interview and the analysis thus far were discussed among these 3 researchers and rechecked against the data. The results of all discussions were documented in memos.

After the open coding of 17 interviews, codes were also related to each other, and interviews were axially coded. Inductively generated codes were reorganized in categories, and the resulting derived code tree was adjusted in accordance with the evolving results from new interviews. An analysis of the codes, coded transcripts, emerging concepts and their relations, and the insights from the group discussions was written up. A conceptual framework was derived from the code tree that reflected the insights that the analysis had generated. This framework described how psychosocial care was experienced by patients with cancer and what was needed in their relationship with healthcare workers in order for them to feel supported, as well as the ways in which healthcare workers offered support and how collaboration helped them to be supportive. Memos were used to refine the concepts of the framework. Further analytical processes revealed, refined, and clarified the final concepts. However, the data did not allow going so far as to construct an actual theory.

Researcher triangulation took place during the process of data analysis. Analyses were presented to 2 experts in psychosocial cancer care (W.S. and S.L.), who read parts of the transcript in order to reflect on the findings, to discuss the analyses, and to achieve consensus. The 2 experts (1 oncology nurse specialist and 1 psychologist who specialized in treating cancer patients) were familiar with qualitative research. Group discussions took place at 3 time points to improve the validity of the analyses: (1) when the first conceptual framework was developed (after interview 17), (2) when the majority of the interviews was conducted and analyzed, and (3) after the development of the final conceptual framework. At the end of each group discussion, consensus was reached as to a valid interpretation of the data by the executive researchers. Consensus, at that stage, could also mean that different interpretations would be maintained as long as data were not decisive.

■ Results

The first result section presents both patient participants' and healthcare workers' descriptions of psychosocial care and what they believed comprised quality psychosocial care for patients. Next, healthcare workers' perspectives of the experience of collaboration in psychosocial care are discussed. Patient participants did not really reflect on the process of interdisciplinary teamwork. They commented on its existence and its outcomes.

Part 1: What Comprises Quality Psychosocial Care?

DISTINCTION BETWEEN PSYCHOSOCIAL ''SUPPORT'' AND PSYCHOSOCIAL ''INTERVENTIONS''

In the interviews, patients often indicated needing attention for their psychological stress but not having accepted the offer of psychological care. Axial coding showed a conflicting attitude of accepting and refusing psychosocial care. Based on this ambiguity, a distinction can be made between psychosocial support and psychosocial interventions. Distinguishing psychosocial care into "psychosocial support" and "psychosocial interventions" gives meaning to the data and is in accordance with the patients' perspectives.

> Her (psychologist) value is not clear to me…. Our conversations are quite typical as people would expect from a psychologist. She nods, accepts everything unconditionally, and tries to be empathetic.

> Some patients react: "Consulting a psychologist, I'm not crazy!" We (oncologist) keep on seeing these reactions. …When we think that's really someone (who should

> consult a psychologist)… some patients answer: "I feel very comfortable talking with you, and I don't feel the need to go to a psychologist." However, we can't force this.

"Psychosocial support" aims at supporting the patients' efforts to deal with cancer and does not directly focus on problems but rather on the situation with which the patient has to cope. Hence, this support feels safe to patients (nonthreatening because emotions are not explored). This support implies that the involved healthcare workers bear the difficulties together with the patient, are aware of what the situation means to the patient, and are willing to accompany the patient through this experience. It requires the willingness of healthcare workers to (*a*) offer support for the tasks that patients with cancer have to face, in order to reduce the chaos caused by cancer in patients' lives; (*b*) assert that patients' feelings are normal; and (*c*) assist patients in enduring physical treatment. Healthcare workers tend to provide this informal care to the patient while in another role such as providing physical care or during a seemingly ordinary conversation. Many healthcare workers provide psychosocial support in difficult situations by giving the patient a feeling of being assisted. None of the patients shunned psychosocial support or complained that it was too extensive. Patients highly value a supporting approach and consider it to be something that should be part of the role of all healthcare workers.

> He (a person charged with patient transport) brought me to the operating room and that man tapped my shoulder and said, "I'll be back to bring you back. Everything will be alright." So those little things are really important at that moment…. While your life is in a runaway, in a merry-go-round that turns and you can't get off. So you must undergo those investigations, the chemo, the operation. And then someone occasionally jumps on that merry-go-round and says, "Just let it turn for a while, but everything will be alright."

A "psychosocial intervention" is theory based, a more intensive and systematic form of help. It is offered to a patient or family member in response to psychosocial deficiencies.

> The psychologist helps me psychologically. The breast care nurse also peps me up, but the heavy work, when I am emotionally distraught, is done by the psychologist. She has saved my life, psychologically speaking. It may sound dramatic, but it is like it is. She helped me mentally, and she still does. Her approach is also different (from that of the breast care nurse). When I am worried about medical things, for example, the breast care nurse reassures me on medical matters.

Many patients were reluctant to make use of psychosocial interventions, which are often provided by psychologists. For most patients, consulting a psychologist for psychosocial interventions meant admitting that there was something wrong or having a "psychological abnormality." Linking the psychologist to psychopathology often constituted a barrier to patients' acceptance of psychosocial interventions. Patients also feared the exploration of their feelings by the psychologist. They were afraid that this exploration (and the detection of what is wrong with them) would make it impossible to control their (negative) emotions and to "remain positive," while they consider remaining positive as their primary task. Patients considered psychosocial interventions valuable for fellow patients. Its availability created a sense of having a backup in case they were no longer able to deal on their own.

> The only thing she (psychologist) did was discuss my troubles. When I started to cry, I had the feeling that she thought that we had a good talk. However, that didn't help me, and I didn't want to tell her. I really didn't like that.

> I (patient with lung cancer) think they (healthcare workers) know that she shouldn't treat us that way (being too interested in our feelings and emotions, exploring our emotions). Otherwise, they make us (patients with cancer) more distraught than we already are.

WHEN DO PATIENTS WITH CANCER EXPERIENCE PSYCHOSOCIAL CARE AS POSITIVE?

Patients perceived psychosocial support as positive when the care provided fit their lived experience. Healthcare workers need to show awareness of the impact and the meaning of cancer on patients' life. Patients prefer an approach in which they feel treated like an individual, with respect for their identity and attention for more than just their medical history.

> The breast care nurse always puts a hand on my legs. It is those little things that make it. Those make you feel that you are a human person.

> The oncologic surgeon puts me in the box of the amputation, the radiologist in the box of the radiotherapy, the plastic surgeon in the box of the breast reconstruction. To me, that's all one process, and I wish to be treated within a cohesive framework.

Patients want to see their healthcare workers in particular as a person and not only as a professional. Self-disclosure by healthcare workers about their experiences and events in their personal life was described as especially deepening the relationship and comforting patients with cancer. Patients regularly reported being enchanted by unexpected (psychosocial) care or care they reported they "could not expect," such as the nurse on night duty sitting next to them to listen to their concerns. Healthcare workers being sensitive to patient needs and expressing it in small gestures created trust.

> When she (an outpatient nurse) noticed that I was hospitalized, she always came to visit me. Nobody told her she should do so, and she came anyway.

Patients who made use of "psychosocial interventions" reported feeling supported in controlling their emotions and in dealing with difficult situations they otherwise would not be able to cope with. Those patients who consulted a psychologist were often satisfied with the help they received. When the psychologist contributes to relief and helping patients to order their thoughts, patients continue consulting this person. The factors that influence patients' perceptions about good help are similar to those relating to psychosocial support. However, patients expect psychosocial interventions to be more professional and to lead to noticeable changes in their experiences with their problems.

> She (the psychologist) gives me more, it was more… She also starts with the fact of cancer; however, her approach is bigger and more personal. She deals with "Who am I," "How do I behave in this world," and those things. She really succeeds in helping me to put myself above the cancer in order to live with cancer.

> I received much support from her (psychologist). However, her support was different… Physicians give good information; they give that information in a way that makes it your problem. On the contrary, psychologists will do that in a different way, more smooth.

WHEN DO HEALTH CARE WORKERS PROVIDE QUALITY PSYCHOSOCIAL CARE IN A TEAM?

Although patients expect support from all healthcare workers, they can accept that physicians sometimes delegate the execution of this task to other team members without the patients losing their appreciation for the physician as a "good" physician. However, psychosocial care can be delegated only under the condition that there is still a commitment to respect their feelings by the physician. Nurses, for example, can take over the psychosocial support from the physician after a cancer diagnosis under the condition that the physician still acknowledges the impact of the bad news on the patient during his/her consultation and acts in accordance with it. Above all, patients prefer psychosocial care to be present in the care delivered by each healthcare worker.

When psychosocial care for a patient is transferred from one healthcare worker to another, patients consider the transfer of trust crucial for the success of referrals. If a known referring healthcare worker indicates his/her trust in a new healthcare worker, the relationship between the patient and the new healthcare worker starts at a more advanced point as the new healthcare worker does not have to first show himself/herself to be trustworthy. The expressed belief of the referring healthcare worker that he/she considers the new healthcare worker a suitable person to meet the needs of the patient often establishes trust in the new worker. This is only the case if the patient does not see the referral as a way of avoiding responsibility and letting the patient down.

> The psychologist told me: "Our culture is not to lie to patients, and particularly the professor (the physician who treats the patient) aims to impart the truth of the situation. If anyone is honest, it's the professor." So I rely on the professor, although I trust the psychologist in particular.

Part 2: The Context of Collaboration in Psychosocial Care

Psychosocial interventions and psychosocial support are shared areas among all disciplines and can sometimes cause collaboration conflicts. Overlapping tasks frequently result in the uncertainty that professional territories may be invaded, although the territory of healthcare workers when it comes to providing psychosocial care is not restricted by other team members who might also be providing psychosocial support. The wide scope of psychosocial care and the different approaches of each discipline justify complementary care from the whole team. In their psychosocial support, patients want all healthcare workers involved. Several contributing circumstances are identified that characterize successful collaboration in providing quality psychosocial care: flexibility in the team, knowing and respecting colleagues' perspectives, and shared experiences in collaboration.

TEAM FLEXIBILITY

The respondents' practice of collaboration in psychosocial care comprises few explicit rules. There is no fixed or regulated assignment of tasks to specific disciplines. Often, there is also no mutual agreement between healthcare workers when psychosocial support does not suffice. and hence psychosocial interventions would be indicated. When collaboration conflicts are experienced, healthcare workers seek more explicitly defined task descriptions and restrictions to solve these problems. However, formalization of responsibilities may not increase success. On the contrary, the openness and flexibility of team members to adjust task divisions clearly characterize good interdisciplinary teamwork.

> Collaboration works well when territories are not protected or are nonthreatening. Team members cannot think, "This is more important and that is less important" or "this is mine,"…I think that is very important, and the more clear task divisions are, the safer it is for people to perform these tasks, without being rigid in the collaboration.

Although constructive collaborations necessitate few rules, healthcare workers offer colleagues the opportunity to search for the best approach to providing psychosocial care for a patient, whether it concerns psychosocial interventions, psychosocial support, or both. The nature of a problem, personal strengths and limitations, colleagues' expertise, and the "fit" between patient and healthcare worker all affect the provision of quality psychosocial care. Intensively collaborating teams emphasize how one's competencies can complement those of the others. Vulnerabilities and limitations of specific personnel are revealed without this leading to open or covert disapproval. Territories are not protected because there is little need to make claims as the intervention of colleagues is not perceived as threatening. These collaborators accept, respect, and compensate the strengths and limitations of other team members in the interest of providing quality psychosocial care as a team.

KNOWING AND RESPECTING MULTIPLE PERSPECTIVES

When the psychosocial expertise of a healthcare worker is not sufficient, healthcare workers report that patients are referred to more skilled colleagues. Referrals are reported as essential to provide continuity in psychosocial care and to address patients' psychosocial needs. Some healthcare workers have to rely on these referrals as they have no direct access to those patients in the course of their clinical pathway. Hence, when collaboration is limited, competencies and expertise remain isolated. A referral allows the referred-to healthcare worker to access the patient and to bring the specialized care needed within reach of the patient. Also being consulted by other team members and giving them advice allow for disseminating expertise in order to meet patients' needs indirectly. Therefore, the healthcare workers emphasize the importance of being clear about the other healthcare workers' competencies. The interviewed healthcare workers stress the necessity of learning to understand different healthcare workers' perspectives and approaches. The interviews show that acknowledgement of each team member's specific role in helping and supporting patients with cancer strongly affects interdisciplinary collaboration. Each healthcare worker's contribution is assessed and considered in order to refer appropriately to a suitable colleague. Collaboration becomes quite difficult when the value of certain team members' efforts is underestimated.

> There is a professor of whom I (psychologist) thought: that closes the door for multidisciplinary work. A woman had difficulties taking her hormone therapy. And the doctor is getting angry at her and says, "That's all between your ears, go to the psychologist." Actually, he is saying to the patient, "You are problematic, so you have to go the psychologist."

The interviews also show that constructive collaborations are characterized by healthcare workers taking the various approaches into account in their work and by recognizing that team members need collaboration to fulfill their job. Being able to define what is considered important by other healthcare workers enables a complementary collaboration. Respect for the differing focus of each discipline is a basic necessity for interdisciplinary collaboration. Being able to subordinate one's own view creates opportunities for a patient-centered collaboration. Healthcare workers' awareness of the different approaches allows adjustment of one's own perspective. However, taking distinct approaches into perspective is felt demanding because gained insights have to be taken into account in one's own care. Healthcare workers in well-functioning teams clearly assess the information their colleagues need to perform their component of psychosocial support. The colleagues in their turn must share their experiences with the patient with the team so that all advice is considered.

> We (nurses) have pretty often had the discussion of therapeutic tenacity on the part of the doctors. Even though the outcome of a patient is hopeless, they still give chemotherapy in order to try one last time. While the nurses, who are almost continuously at the bedside of the patient, have a different opinion, they sometimes feel that the patient wants to stop his therapy. Actually, the patient holds on for the family. Or the family insists on speeding up the dying process, while the physicians don't want to.

The distinction between psychosocial support and psychosocial interventions that we make in our analysis is clearly reflected in constructive collaborations. Healthcare workers show how to recognize the wide scope of psychosocial care and report the need for a variety of specializations. In such cases, the breadth of competencies needed to provide adequate psychosocial care increases partnership and mutual support and shared care. The more experienced healthcare workers are, the more they tend to acknowledge the range and diversity of psychosocial care and their limitations in providing it. Sharing care in a satisfactory way improves collaboration and decreases the need to protect one's territory.

> The more skilled I became (palliative support nurse), the more I felt: "These cases are quite specific, in fact psychological. So I said to myself, a psychologist would have a great value in our team. And so it grew… The way you work together clearly affects the opportunity to offer high-quality care. Care becomes less restricted when you are able to collaborate or to consult each other. In the beginning, I did it all by myself without being aware of it… Shared care weighs less heavily and has a better chance of success.

SHARED EXPERIENCES

Healthcare workers underline the importance of shared experiences in interdisciplinary collaboration. Having previously dealt together with complex patient cases offers the opportunity to know someone's way of working and to transfer knowledge to colleagues. Working together in a team reveals the perspective, the position, and the focus of other disciplines. Healthcare workers are more convinced about the appropriateness of a referral, and it is easier to consult a colleague in an intensive work relationship. Moreover, collaborating clarifies the role and competencies of these healthcare workers. Through collaboration, common goals are set, patient aims can be achieved, experiences are shared between healthcare workers, and complementarity is ensured to provide quality psychosocial patient care. Having shared work experiences also includes collaborating less intensely in case of former collaboration conflicts.

> Getting to know each other starts with successful patient cases, patient cases that necessitated a lot of support and required strong collaboration, patient cases in which support had to be well defined and worked out well, having the feeling to fit together well and to know: "Actually, we have completed this case in the right way." From that moment, you know what you can mean for each other. In the beginning, it is not always clear; you always have to find out.

■ Discussion

The results of this study convey how patients experience psychosocial care and how they want to be supported by healthcare workers. Patients have a strong need to be treated and respected as a person. Patients expect healthcare workers to understand what cancer and its treatment mean for them. They feel entitled to a willingness on the part of healthcare workers to support them in difficult situations. Patients confirm that each one of the healthcare workers has a place, as they do not feel overloaded when psychosocial care is offered in this way. Their experience shows that it is unnecessary for healthcare workers to protect a psychosocial territory for themselves or to perceive colleagues' care as a threat for one's own psychosocial caregiving.

To understand patients' perceptions and evaluations of interdisciplinary psychosocial care, it is important to distinguish between psychosocial support and psychosocial interventions. In their stories and explanations of their experience, this distinction plays an important role. Patients perceive psychosocial support to be safe because their emotions are not explored and do not become the focus of attention. It does not threaten to expose vulnerabilities that a patient cannot face or acknowledge. However, for some patients, support will be insufficient, and more professional help will be needed. Indeed, because of the radical, life-threatening character of cancer and its treatment, some patients experience deeper psychological problems.[1] This explains a potential need for more intense psychosocial interventions. However, patients in 1 study reported being reluctant to call on a psychologist because they feared that their positive attitude during cancer treatment, which they considered important to their survival, would be threatened if they worked with a psychologist.[33] This finding is in accordance with our results: patients fear that reflecting on their emotions may undermine their ability to control their emotions. Psychosocial interventions focusing intensely on patients' emotions are thought by patients to interfere with their perceived need to remain positive.

This study shows that quality psychosocial care clearly affects cancer patients' feelings of well-being. Quality psychosocial care supports patients to bear the difficult situation of cancer and to deal strong feelings such as fear, anger, and uncertainty. The feeling of being assisted and bing recognized as a person in particular (instead as a patient with cancer) helps standing cancer and the treatment. Currently, Belgian oncology centers are responding to patients' psychosocial care needs with a multidisciplinary approach. Some interventions are rather new, such as coaching of patients with cancer by nurse consultants or the large increase in number of oncopsychologists and their therapeutic offer. Healthcare workers who had not interacted with each other in the past reported having learned to do so or were even forced to collaborate more intensely. An example of more intensive collaboration was the introduction of psychosocial team meetings in several hospitals to deepen psychosocial patient problems next to the general multidisciplinary team meeting, which has a rather medical focus. The results of our study show that collaboration is well developed in the participating institutions; however, some teams can still progress as evidenced by the healthcare workers reporting that their work is not valued or is not appealed by colleagues. Patients' beliefs about quality psychosocial care stress the importance of constructive interdisciplinary collaborations. Psychosocial support and psychosocial interventions are valued in distinct ways as both do not appeal to all patients. Therefore, healthcare worker collaboration improves the changes that the patients will receive the psychosocial care they need and is acceptable to them.

Based on the findings of this study, interdisciplinary collaboration shall be fruitful and supportive when team members are respected, the others' knowledge and competences are valued, and the patient is put first instead of healthcare workers or academic disciplines. Nurses play an important role in the provision of quality psychosocial cancer care. First, all patients with cancer encounter nurses (as opposed to, eg, psychologists, social workers, etc). Supporting all these patients in bearing up under the difficult situation of cancer and its treatment is just part of good nursing care. Moreover, it is assumed by the patients in this study. Nurses are also nonthreatening healthcare workers in the view of patients. Not having to deal with patients' emotions as their core business thus makes them more approachable than those healthcare workers who provide psychosocial interventions. Patients who have experienced a sincere interest in their individuality and feelings rely on such healthcare workers to take good care of them. Consequently, providing quality psychosocial support generates trust in patients. From that moment on, some patients more easily accept referrals for explicit psychosocial interventions. Being accessible as a nurse and being trusted by patients offer the opportunity to bring needed psychosocial care within reach of the patient. Finally, nurses can also reduce barriers toward psychosocial interventions by emphasizing the normality of feelings of psychosocial need. Healthcare workers can address the strong emotions due to the difficult situation. Psychosocial interventions can be presented as useful in supporting patients in dealing with their emotions, an art in which psychologists are well grounded. Psychosocial interventions that help patients sort out their chaotic feelings can provide the experience that talking to a psychologist can really help. Patients' stereotypes about psychologists penetrating their deepest emotions to reveal weaknesses should be corrected. As Dilworth et al[9] recommend, informing patients about what psychosocial services involve and what services are available, what these interventions may be able to offer, and how these might complement the support that they already have in place may lead to greater acceptance by patients.

Studies show that many patients with cancer do not perceive their emotional distress as a real problem for which help needs to be sought.[34–38] Patients with cancer often try to deal with their emotional distress by activating their own coping mechanisms. For example, Steele and Fitch[38] found patients with cancer who do not want to be helped with some needs. Their study shows that "independent," "proud," and/or "positive thinkers" prefer to rely on themselves. Approximately a third of the patients with cancer express a need for psychosocial interventions.[39–43] The study of van Scheppingen et al[44] reports that 51% of the distressed screened patients with cancer express no need for psychosocial services. Our results do not show that patients with cancer sometimes refuse psychosocial care, while our distinction between psychosocial support and psychosocial interventions can explain why some forms of psychosocial care are rejected. As the literature shows,[43,45–48] patients with cancer clearly recognize an unmet need for psychosocial support. Contrary to support, psychosocial interventions are not indicated, needed, or accepted by all patients with cancer, which is in line with those studies showing some patients who have no need for psychosocial treatment.[34,38,44,45] The review of Brebach et al[49] shows that nearly half of all patients with cancer do not accept psychosocial interventions, and for those who do accept, adherence is very high. Also similar to our findings, patients are more likely to accept psychosocial care from nurses than from other healthcare workers. Stigma as a barrier to the acceptance of mental health services is less present in the care of a nurse than in consulting a psychologist.

The study of Kam et al[45] focuses on the referral of patients with cancer to psychosocial care services. The results show that many patients with cancer do not receive adequate psychosocial care because of missed referrals. One explanation is that some healthcare workers experience a referral as unpleasant. Healthcare workers may have difficulty acknowledging an inability to solve the patient's problem themselves when referring to a colleague. We suppose referrals are threatening sometimes because they reveal someone's limitations, which shows the necessity of a safe working environment in order to enable good interdisciplinary collaboration. Dilworth et al[9] describe a lack of referrals as a barrier to quality psychosocial support. An absence of professional dialogue, working in isolation, late referrals, and the marginalization of psychosocial issues in care are reported barriers in their study.

Our study identifies mediating factors that affect quality psychosocial patient care in the interdisciplinary context of an oncology setting. However, every setting differs and is also subject to change. An unambiguous answer about which factors contribute to collaboration and the provision of quality psychosocial care cannot be given. Of major consideration is to organize care in such a way that it is attuned to the patient's experiences and expectations while receiving cancer treatment, the members of the team, the work situation, and the whole context. This is also in line with Andreasson et al,[50] Williams et al,[51] Baker et al,[52] who emphasize tailoring care processes to the unique and emerging context of each work situation that can explain the current professional practice and reasons for resisting new practice.

Limitations

A number of limitations should be noted when interpreting the validity of these results. In some interviews, the researchers noted healthcare workers chose their words carefully when collaboration was difficult within the team. It is both difficult and potentially threatening to express oneself negatively regarding colleagues. Some healthcare workers requested turning off the dictaphone during sensitive passages, and sometimes supplementary information was provided at the end of the interview after the recording had stopped. However, the meaning of the participants' language was taken into account in the data analysis, and confidentiality was ensured to encourage participants to speak freely in order to increase the reliability of the interviews.

Social desirability plays a role in the reliability of the data. In a study that investigates the collaboration in psychosocial cancer care, participants will be more likely to recognize and to confirm its importance to the researchers. It is, for instance, not desirable to minimize psychosocial care for patients with cancer or to neglect the importance of working within a team. Social desirability was reduced to a minimum by further questioning about general answers and asking respondents to illustrate statements with examples from the healthcare workers' own practice or experience. The values expressed by healthcare workers in the interviews did not always match the behavior that healthcare workers show in practice or the values that drive their actions. Discrepancies were also reflected in several conflicting interview quotes from a number of healthcare workers describing the same facts in the analysis. Social desirability might have been further reduced with more observations reflecting real practices from the interviewed stakeholders' perceptions.

Finally, our results are based on healthcare workers' stories and will be affected by their needs and views on how care and collaboration should be. Healthcare workers' thoughts and opinions do not necessarily reflect the most correct or constructive perspectives. For this reason, the perceptions of patients are included, in order to represent their ideas on good patient care.

■ Conclusion

High-quality psychosocial cancer care aims to help patients bear the difficult situation of cancer and its treatment. Much more is involved than providing professional interventions for psychological problems. Quality psychosocial care involves healthcare workers who understand the patients' experiences and realize what they have to go through. Patients prefer informal support, given on the occasion of and often in relation to physical care. This support is less threatening than more intensive psychosocial interventions from healthcare workers, which focus explicitly on patients' emotions. In case more specialized care is needed, patients need to be reassured that their feelings are normal and that psychosocial interventions assist in coping with their emotions. However, lowering the barriers to psychosocial interventions will not be successful for all patients with cancer. Transferring trust to a referred psychosocial caregiver is an important strategy to convince patients of the benefit of consulting other psychosocial specialists.

Positive collaboration requires that complementarities are recognized by the members of the team. Collaboration requires that healthcare workers are able to offer their services at the right time and refrain from taking the lead when not beneficial for the patient. From this perspective, competencies can be shown, and the specific disciplinary expertise is brought into the reach of the team and consequently to the patient. This enlarges the scope of psychosocial care in accordance with patients' needs. When the provision of psychosocial care between healthcare workers is flexible, interdisciplinary collaboration is facilitated. This is to be done not only by the determination of disciplinary expertise and its limitations, but also by the assessment of the existing relationship between healthcare workers and the patient. Centering the patient in the interdisciplinary context of psychosocial oncology is exactly what is expected in good collaborations.

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