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Dolna 17, Warsaw,
Poland 00-773
+48 226 0 227 03
editorial_office@rsglobal.pl

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ROLE OF MEDICAL STAFF IN THE ONCOLOGY DEPARTMENT IN THE PSYCHOLOGICAL CARE OF CHILDREN AND ADOLESCENTS WITH CANCER

Guellil Mohammed Réda
Department of Humanities and Social Sciences, Université Ibn Khaldoun Tiaret, Algeria
ORCID ID: 0009-0007-8303-2620

Ainad Tabet Ismail
Department of Humanities and Social Sciences, Université Ibn Khaldoun Tiaret, Algeria
ORCID ID: 0009-0004-6542-4303

ABSTRACT

This study aimed to identify Role of medical staff in the oncology department in the psychological care of children and adolescents with cancer, as well as to know the position taken by medicine in the treatment of psychological aspects of cancer in children. This is an exploratory qualitative study and was conducted at the Pediatric Oncology Department of Oran. Clinical interviews were used, because it is a methodological tool that allows direct and personal contact with a source of information from a versatile conversation to obtain clear answers to our question. The observation grid was also used as a research tool which lists a set of criteria. The results of this study confirmed the validity of the previously proposed hypothesis and indicate that the participation of medical staff in the psychological support of children with cancer during treatment is crucial for the quality of care provided to these children.

KEYWORDS

Medical Staff, Psychological Care, Children With Cancer, Psychological Aspects, Psychological Support

CITATION

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1. Introduction

The experience of cancer and its treatment still represents a difficult and destabilizing ordeal for patients and their loved ones; despite medical progress, it causes numerous and complex psychological, relational, family and ethical difficulties(Oppenheim, 2010).

Patients and their loved ones rightly demand not only to be treated with the best medical and nursing skills, but also for the treatment not to destabilize them in the various aspects of their lives: Professional and social, financial, family and psychological. They do not want to be considered as only carriers of a disease to be treated but want to remain themselves to preserve their self-esteem they also want ethical dilemmas to be perceived and resolved.

This modest piece of research looks at the involvement of medical staff in the psychological support of children with cancer. This category of patients requires not only palliative care, but comprehensive care, and the interventions of medical staff must not be limited to technical gestures and prescribed roles, but go beyond that; This is another dimension of care, centred on relational care, psychological support, a relationship of help, trust and empathy; an intimate relationship.

Medical staff have a very specific role within the hospital. They have skills that enable them to welcome patients and their families, inform them, provide care and ensure the patient's future. All carers must do their utmost to instil confidence in patients. To do this, they must listen, talk, reassure and help. In providing care, the carer takes charge of the human being, i.e. the body, but also the mind. The term "carer/patient relationship" refers to "all the psychological conditions that are established between the carer and the patient". According to the encyclopaedic dictionary of nursing care, the term carer/cared-for relationship refers to "a bond existing between two people of different status, the cared-for person and the healthcare professional. This relationship requires three attitudes: personal commitment on the part of the carer, objectivity and availability on the part of the carer" (Potier, 2002).

During our various practical studies, the situations that really touched us where the problems of psychological suffering, pain and anxiety in children with cancer and the various obstacles that can influence their support and overall care.

The work that you are about to discover is the source of an initial questioning following which we put forward a problematic and we will propose a research hypothesis. It is a practical study that I supervised in the production of the end-of-study dissertation with the trainees Miss. Benichou F. Z and Miss. Nabi F, to obtain the diploma of Public Health Nurse. On the basis of this study, we would like to find out more about the phenomenon of psychological support for children with cancer in hospital, particularly in the paediatric oncology department;

A theoretical part is devoted to defining the key concepts of the research, the practical part is devoted to the survey to obtain the views of medical and paramedical staff in the field on the subject addressed; then the analysis and interpretation of the results, verification of the hypothesis and finally a conclusion and suggestions to try to help improve the situation.

We therefore decided to tackle this theme and, before beginning our investigation, we thought it appropriate to set out a few objectives beforehand in order to achieve them at the end of our research:

1- Define childhood cancer.
2- Identify the physiological, psychological and social consequences of childhood cancer.
3- Determine the role of medical staff in the psychological care of children with cancer.
4- To define the means of helping these children through all the stages of their illnesses.

2. Research problem

Illness is a distressing experience at any age, but particularly so for children. It affects many aspects of a person's life.

The experience of cancer and its treatment is a difficult and destabilising ordeal for patients and their families, giving rise to many complex psychological, relational, family and ethical difficulties(Oppenheim, 2012).

The emotional experience is extremely violent because the impact of cancer on the body cracks the self-image. Cancer, whether it progresses to the worst stage or even goes into remission, jeopardises the reference points that the psyche has built up over time. The future collapses, the past is gone and the present is unthinkable. Depressive anxieties and fears are bound to emerge, because cancer is an experience of psychological collapse in which the very question of existence arises (Laval, 2003)

During the course of a cancer treatment, a sick child is sometimes unable to think. The experience of the disease, its psychological repercussions and the effects of treatment can have more or less lasting repercussions on the emotional, physical and psychological levels, and this is not always easy.

Patients and their families rightly ask not only to be treated with the highest medical and nursing competence, but also to ensure that the treatment does not destabilise them in the various aspects of their professional, social, financial, family and psychological lives(Oppenheim, 2012). They do not want to be considered as merely carriers of an illness to be treated, but want to remain themselves, to preserve their identities and their self-esteem.

The duty of all medical staff is to take into account not only the illness, but also the sick child, in all his human and subjective dimension. They deserve our special attention if we are to avoid certain complications and relapses, and if we are to achieve recovery and remission without psychological after-effects. Sick children need help and support, particularly from those around them: family, friends, colleagues and the medical team. Illness is best experienced with support.

In this case, the medical staff would have a role of listening, supporting and comforting, which motivated us to choose the theme " **Role of medical staff in the oncology department in the psychological care of children and adolescents with cancer** ".

From our research and the situations we have experienced in the paediatric ward, we have observed that there are difficulties in re-establishing a helping relationship between the medical staff and the child with cancer during the latter's treatment, which is in the best interests of these patients. It is for this reason that we undertook this work in an attempt to answer our central research question as follows:

"How is the participation of medical staff in the Oncology Department in psychological support useful, necessary, or even essential for quality care of children and adolescents with cancer?"

3. Research objectives

- Define the role of medical staff in the Oncology Department regarding the psychological care of children with cancer
- To find out what position medicine adopts to deal with the psychological aspects of cancer in adolescents.
- Understand the elements that make up the situation of these children (a particularly difficult and dangerous situation), and objective experiences (physical, psychological, relational, family, social...).
- Define ways of helping these teenagers through this ordeal, without losing confidence in their qualities, to preserve their ability to become adults.

I/ Review of Literature

1- Definition of cancer in children and adolescents.

According to WHO (2013) Cancer is a disease originating in our cells, characterised by abnormal and disordered cell proliferation. Broadly speaking, we can divide childhood cancer into three groups. Firstly, solid tumours affecting the bones, organs and tissues of the body. Here we find benign tumours where the cells remain localised in one part of the body; when they spread and affect neighbouring tissues, we speak of malignant tumours. The second group is lymphomas, cancers of the lymphatic system, and finally leukaemia, which are cancers of the blood and bone marrow(Isch, 2015). We speak of metastases when cancer cells migrate to other parts of the body.

Cancer is a rare disease in adolescents and young adults, since cancers diagnosed between the ages of 15 and 24 account for only 6% of all cancers. Nevertheless, it is the third leading cause of death in this age group after accidents and suicide(Dauchy, 2010).

There are a number of symptoms associated with the onset of this disease. They appear between a few days and several months depending on the type of cancer and its origin. These symptoms include paleness, fatigue, bone pain, visual impairment, difficulty walking, vomiting and falls, and are generally confused with those associated with benign illnesses. If these symptoms persist, further tests should be carried out. Childhood cancer differs from adult cancer in its characteristics. It is therefore impossible to compare them.

The development of knowledge that cancer pathology depends on many interacting factors (Ben Soussan, 2009):

- Biological factors (neuro-hormonal-genetic, etc.)
- Event-related factors (exposure to microbial and chemical agents, etc.)
- Social and cultural factors (lifestyle, eating habits, etc.)
- Psychological factors (attitudes to preventive behaviours, addictive behaviour, etc.)

2- Having cancer in adolescence: psychological aspects

The psychological issues specific to adolescents with cancer are based on two main problems which are mutually reinforcing. The first is that the onset of cancer during the pubertal period runs counter to the demands and questions about adapting to the disease and its treatment. In some cases, for adolescents, these can become the preferred arena for playing out and expressing pubertal conflicts(Dauchy, 2010).

3- The consequences of cancer in children and adolescents

3-1- Physiological consequences

According to (Oberlin et al, 2008) Treatment will have physiological consequences for the child. Nausea, abdominal pain, vomiting, infections, hair loss and eating disorders often occur during this phase, with subsequent psychological and osseous consequences((Isch, 2015).

3-2- Psychologically

A real change of life takes place for the patient, but also for his family. The child's psychological state will be disturbed.

From the onset of cancer, there are five successive stages: the announcement of the disease, the start of treatment, the period between treatments, the end of treatment and the next stage.

After the announcement, questions are asked, followed by psychological reactions corresponding to different phases: denial, revolt, bargaining, sadness and a recovery phase. The subject's own experience plays an important role in these reactions.

Danion-Grilliat, S et al in their book entitled "taking charge of and supporting a child with cancer at all stages of the disease" state that following physiological changes due to treatment, the subject's body image will be modified(Grilliat & al, 2008). This damage to the image will be more or less significant depending on the changes to the body. In addition, various disorders are noted during this period. Firstly, anxiety disorders, present in 50% of children following the announcement of the disease and manifested by difficulty falling asleep. It is more marked in children under 12, but diminishes as the disease progresses. Depression, which is also present in this type of disease, is very marked in children aged over. Symptoms associated with this disorder include instability, thoughts of death, loss of appetite, irritability, difficulty concentrating and behavioural changes. It appears following treatments, interventions, during a recurrence, but also when the individual is at the end of their bone life (Isch, 2015). Finally, maladaptive reactions are observed, such as crying when the illness is mentioned, difficulties in making contact with those around them and regressive behaviour. This is known as adjustment disorder.

In short, the experience of cancer has repercussions on a child's psycho-affective development. Overall, cancer affects feelings, representations and cognition (Herbinet., 2002).

3-3- Social support

When the disease first appears, families are overwhelmed by the suffering of their loved one and by the reorganisation required to cope with the changes imposed by the disease. Their support also involves a partnership with social workers. The aim is to provide both practical solutions and a listening ear(Laval, 2003).

Oppenheim, (2003) states "Growing up with cancer" The hospitalisation of children in sterile rooms leads them to be isolated and cut off from the world, resulting in a decline in social ties(Oppenhiens, 2005). As a result of the bodily changes, the child is presented with an unfamiliar body. The way in which their body is viewed by those around them, by their friends and by others, accentuates this feeling of suffering and provokes reactions which, as Jean Pierre Chevance (2002) points out, "reinforce the feeling of strangeness". Depression becomes increasingly prevalent as a result of this exclusion and break with the world. Their points of reference and habits are shattered, leading them to question their relationship with their body, because as Merleau-Ponty (1976) states, "it is through our body that we perceive the world. This body lives, acts, feels and sees. It is in relationship with the world". In fact, the body is where experiences and emotions pass through. In addition, children will question their sense of identity. This is defined as an internal feeling of unity, coherence, belonging, value and autonomy. It is constructed both in relation to oneself, but above all in relation to others, referring to the feeling of individuality and singularity. Leaving hospital is a difficult time for children, as they have to find new points of reference and find their place in society (Isch, 2015).

4- Diagnostic

The signs leading to the diagnosis of a tumour in this age group are not specific and vary greatly depending on the type of location: pain, appearance of a mass or pathological adenopathy, neurological symptoms, etc.

In an English study carried out in a cohort of patients aged between 15 and 24, the median delay between diagnosis and the first symptoms was estimated at between 15 and 25 weeks for bone tumours and 26 weeks for soft tissue tumours. There are many reasons for these long delays. They are partly due to a lack of knowledge about these diseases on the part of patients and doctors themselves. In some cases, the delay is also partly linked to patients' denial of the initial clinical signs, leading to a delay in consulting a doctor (Dauchy, 2010).

5- Care and support for children and adolescents with cancer at all stages of the disease

5-1- Psychological problems

The occurrence of cancer in an adolescent poses specific problems on the medical level but also psychological, academic, social or even family. At this period of life, marked by a delicate transition from childhood to adulthood, the treatment of cancer requires recognition and consideration of all of these different needs in order to best help the adolescent and their loved ones to get through this experience (Sarah & Razavi, 2010).

The duty of all medical staff is to take into account not only the illness, but also the child who is ill and then cured, in all its human and subjective dimensions.

5-1-1- Announcing the diagnosis

The announcement of the diagnosis is an important moment, which must always be accompanied. The diagnosis and the whole course of the cancerous disease are extremely difficult for a child and his or her family to endure, due to the life-threatening nature of the cancer and the severity of the treatment. Because of its intense emotional impact, the diagnosis always takes time to be announced. The difficulty parents have in understanding what they have been told is rooted in their emotional upheaval.

5-1-2- Psychological distress

In the definition of Massie and Holland (Chen, Chang, & Yeh, 2000), emotional distress is considered a normal response to the diagnosis of cancer. The announcement of the disease represents a catastrophic event, it is therefore normal for the individual to present anxious or depressive symptoms. For these authors, the symptoms of distress generally fade 7 to 10 days after the diagnosis, but may remain present in some patients and justify the intervention of a professional. The National Comprehensive Cancer Network (Carlson & Bultz, 2003) defines psychological distress as "an unpleasant emotional experience that affects the ability to " cope" effectively with cancer and its treatments, and which falls along a continuum of feelings “Normal” levels of vulnerability, sadness, fears, up to difficulties that can become disabling, such as anxiety, depression, social isolation or spiritual crisis.” (Sarah & Razavi, 2010).

5-1-3- The onset of the disease

Life changes in a matter of minutes. The child will create new points of reference based on the information he or she is given.

The diagnosis of cancer, as with any serious illness, provokes intense feelings of guilt in children and their parents. The search for the cause, for the why, is always intense.

Anxiety, a feeling of dread and catastrophe, inhibition and sometimes even stupefaction accompany the child's entry into the disease and the unknown and dangerous world of physical damage, pain, heavy treatment and hospitalisation.

Some children regress to dependent behaviour and apparent disinterest, others to opposition.

The course of the disease depends very much on the parents' ability to cope with the disease, to support the child without denying the disease or engaging in early morning.

First and foremost, those around the child must help the child to master his or her emotional and fantastical experiences.

The disruption to body image is major in children with cancer.

The reality of their body is affected, as is the image they have of it. If the dysfunction of their body is incomprehensible to them, they lose interest in it or develop a frightening imagination. The disruption to body image is greater depending on the extent of the physical changes they undergo (e.g. alopecia, weight gain due to corticosteroids).

5-1-4- Risk factors for psychological distress in adolescents

Some difficulties are considered by adolescents to be particularly painful and a source of distress. This is the case of nausea, mucositis and pain related to treatments or diagnostic procedures; changes in body image and school absences. In the study by Enskär and colleagues, waiting (for treatment, for information, for seeing a member of the medical team, etc.) was considered by adolescents facing cancer to be one of the most difficult problems they had to face. Dependence on parents was also considered a major problem by these adolescents (Enskär, Carlsson, Golsäter, & Hamrin, 1997).

6- The field of Psycho-oncology:

The field of Psycho-oncology is vast, like that of oncology to which it is closely associated. Psycho-oncology has two major concerns: On the one hand, the effects of cancer on the psychology and emotions of patients, their families, their caregivers in the other, the skills and social factors that influence the risks of cancer and their prevention. She is concerned with everything that cancer affects for all the medical and social situations in which it finds itself through the consequences of the disease and the treatments. Its aim is to help patients and also their families (if the latter is destabilized, patients may lose a valuable point of support) to get through this ordeal in the best possible conditions and to limit as much as possible the negative psychological aftereffects. They are also interested in caregivers who individually and collectively have their own fragility, which can cause misunderstandings and conflicts with the patient or within a team and be a cause of wear and tear (Oppenheim, 2012).

6-1- Objectives of psycho-oncology interventions.

The objectives of psycho-oncological interventions in a carefully structured in this way. These units require human resources (psychologists and psychiatrists) and financial resources.

Several stages can be individualized in the structuring of psycho-oncology care integrating a prevention dimension and consideration of the patient in their environment.

Primary prevention: prevent the development of psychological and/or psychopathology symptoms through early detection.

Secondary prevention: treat early psychological and psychopathological disorders associated with cancer following early and systematic detection.

Tertiary prevention: continue monitoring to avoid complications.

Information and support: inform and support non-professional mental health workers in the medical or surgical team to increase their ability to assess, detect and treat psychological and psychopathological disorders (Sarah & Razavi, 2010).

6-2- Levels of care in psycho-oncology services:

Characteristics of the main levels of care for cancer patients and their relatives.

We can thus schematize different levels of care, each level having the skills of the previous level in terms of assessment and intervention.

An important corollary of this structuring of care is the possibility of recording the activity of the stakeholders, which aims beyond administrative requirements to constitute a liaison tool between the stakeholders (psycho-oncology, support care, oncology teams) and to facilitate the representation of the activity of the psycho-oncology units and services by the other care stakeholders (Sarah & Razavi, 2010).

Table 1. Objectives of interventions in psycho-oncology

	Action	**Skills**	**Speakers**
Level 1	Health Professional	Identifying distress and needs	Basic communication skills to assess, inform and support
Level 2	Psychologistes	Support and Accompaniment	Basic techniques such as listening, counselling, helping with problem solving
Level 3	Clinical psychologists trained in psychotherapy and psycho-oncology	Diagnosis and management of the main psychological disorders	Specialized psychotherapeutic techniques for individuals, couples, families and groups
Level 4	Psychiatrists trained in psycho-oncology	Diagnosis and management of all forms of psychopathological disorders	Same if trained in psychotherapy and psychopharmacological treatments.

7- Doctor-patient communication and therapeutic decision-making

Several authors have issued recommendations regarding the communication strategies to be promoted in the context of... Following this work, it is possible to define a certain number of steps promoting patient participation in decision-making. These steps can be summed up in 3 main phases: an evaluation side: this phase has 3 main objectives. Firstly, it must allow doctors to have a more precise idea of the patient's wishes regarding the transmission of information and participation in treatment. Second, it must allow him to assess the patient's concerns and expectations. Finally, it must allow doctors to have an idea of the patient's emotional state.

The literature of doctor-patient communication has shown that assessment strategies facilitate the patient's expression of their concerns.

Which includes sharing knowledge about risks and benefits. It also involves the issue of uncertainty that is involved. The doctor's goal is to convey clear and precise information while maintaining the patient's trust in his doctor and hope regarding the benefits of the treatment.

The negotiation side: It is important in this context that the patient feels comfortable with the doctor so that they can ask questions and benefit from sufficient time to make their decision(Bacqué, 2006).

Conclusion

It is important to detect psychiatric and/or adjustment disorders because they compromise psychological and social rehabilitation. They have a negative impact on the quality of life of the cancer patient, psychological well-being being an important component of the concept of quality of life (Razavi & Delvaux, 1998). Newport and Nemeroff emphasize the serious consequences that untreated depression can have: In addition to reducing quality of life, it is associated with decreased compliance with medical care, longer hospitalizations, and a higher risk of mortality. Although this concept of psychological distress remains poorly defined in some aspects, particularly in its psychopathological meaning, it nevertheless appears to be a relevant indicator for describing the emotional difficulty of a patient or a group, and helping to determine risk or vulnerability factors of a population (Newport & Nemeroff, 1998).

II/ Practical approach

1- Methodological phase

1-1- Type of study:

This is an exploratory, qualitative study which aims to justify and determine the need for medical staff to be involved in the psychological support of children with cancer and to describe the relationship they develop with them and their parents in the paediatric oncology department of the CLCC Oran.

1-2- Location of the study:

We chose to conduct our study in the paediatric oncology department of the ORAN CLCC, a place where medical staff have the most contact with children with cancer.

1-3- Study population:

1-3-1- Target population:

The study population consisted of all the medical staff of the paediatric oncology department of the CLCC of ORAN.

1-3-2- Sample:

The sample consisted of :

Ten (10) children with cancer: aged between 5-16 years.

Ten (10) mothers: they are the entourage of the children with cancer. They are the link between the sick child and the nurse.

Paramedical care staff: a total of 14 people, including

- Public health nurses: six (06)
- Nursery nurses: two (02)
- Care assistants: six (06)

Of the six nurses, we only had the opportunity to speak with the nurses because they work on call and we did not have the opportunity to meet all of them.

1-4- Inclusion criteria :

The nursery nurses and care assistants were deliberately included because their roles on the ward are closely linked to nursing care; we felt that their assessments of our theme were beneficial.

1-5- Data collection methods

1-5-1- Data collection instruments

1-5-2- Interviews

This is a methodological tool that allows direct and personal contact with an information resource based on a multi-faceted conversation in order to obtain direct and clear answers to our question.

-It allows active listening and the use of several approaches to the same question.

1-5-3- Observation grid

We chose the observation grid because it is a research tool that lists a set of criteria whose presence or absence we noted.

It is characterised by its reliability and its direct observation in the field, which makes it possible to gather real information taken directly from the field. It is used to draw up and evaluate the quality of actual supportive care for children with cancer and their parents.

1-6- Development of instruments:

We conducted interviews with the mothers of her children with cancer. In addition, we combined the grid with observation questions and based our observations on targeted criteria concerning the quality of the relationship between medical staff and their children with cancer, such as reception, education, support, assistance during care, etc.

2- Empirical phase

2-1- Results

2-1-1- Analysis of the interview with the mothers

We are going to analyse the questions proposed in the interview addressed to the mothers of children with cancer hospitalised in the paediatric oncology department of the CLCC of Oran and their answers according to the following method: Question / Answer / Analysis.

Question N° 01 : How many times has your child been hospitalised on this ward and why?

Table 2. Numbers of hospitalisations

Numbers of hospitalisations	Numbers	Percentage
1st time	01	10%
2nd time and more	09	90%
Total	10	100%

- Analysis : For the majority of the sick children, the number of hospitalizations is for the second time and more, because of their cures and the excessive relapses.

Question N° 02 : How did you find the reception in the department ?

Table 3. Nature of reception

Type of reception	Numbers	Percentage
Good	10	100%
Médiocre	00	00%
Bad	00	00%
Absent	00	00%
Total	10	100%

- Analysis: All of the mothers interviewed said that the nursing staff in the paediatric oncology department of the CLCC in Oran were very welcoming, for the following reasons:

-Understanding / -Patience / -Flexible behaviour / -Smiling.

Question N° 03 : Who welcomes you on admission ?

Table 4. Person in charge of reception

Reception staff	Numbers	Percentage
Head of department	00	00%
Treating doctor	10	100%
Nurse	00	00%
Security Guard	00	00%
Total	10	100%

- Analysis: All the mothers confirmed that it was the Treating doctor who took charge of their reception at the day hospital, and then referred them to the specific unit where they found the paramedical team, who looked after each of them in their entirety, unconditionally, with respect and without value judgement.

Question N° 04: Do you know anything about the pathology for which your child is hospitalised?

Table 5. Diagnoses of hospitalization

Answers	**Numbers**	**Percentage**
Yes	09	90%
No	01	10%
Total	10	100%

-Analysis: The overwhelming majority of mothers questioned know their children's diagnosis.

Question N° 05 : After the treatment sessions (chemotherapy/radiotherapy), how does your child generally feel?

Table 6. The condition of the sick child

Sick Child feelings	Numbers	Percentage
Calm	00	00%
Physically tired	10	100%
Depressive	01	10%
Lack of support	09	90%

- Analysis : Mothers declare that their children are most of the time bothered by the side effects of the treatments by becoming uncooperative and this has an effect on their morale.

Question N° 06 : Do medical staff prevent incidents and side effects of treatments ?

Table 7. Prevention of treatment side effect

Responses	Numbers	Percentage
Yes	10	100%
No	00	00%
Total	10	100%

- Analysis : The teen mothers confirm that the medical staff always take precautions to prevent the undesirable effects of chemotherapy/ radiotherapy.

Question N° 07 : Does the nurse meet your child's needs ?

Table 8. Meeting Needs

Responses	Numbers	Percentage
Yes	09	90%
No	01	10%
Total	10	100%

- Analysis : Almost all the mothers interviewed saw that the nursing staff looked after their children, except in cases where the role fell to the nurse.

Question N° 08 : Are there places and means of distraction for your children during hospitalisation?

Table 9. Means of distraction

Means of distraction	Numbers	Percentage
Yes	10	100%
No	00	00%
Total	10	100%

- Analysis: All the mothers interviewed felt that the wards had the means of distraction that their children no longer felt were lacking, and that their stay in hospital was completely normal: a games room, a garden where the nurses help their children to play on the swing during the hours of treatment, a study room where they can continue their studies.

Question N° 09 : Are you able to reassure your children on your own at the time of care ?

Table 10. Reassurance

Answers	Numbers	Percentage
Yes	05	50%
No	05	50%
Total	10	100%

- Analysis: Half of the mothers questioned felt that they were unable to reassure their little ones on their own because they have an immature psyche, a serious, fatal, complicated and despairing pathology for the child and for the parents themselves, where they are unable to talk to them.

Question N° 10 : Is the nurse present at the time of your child's anxiety ?

Table 11. Presence of nurses

Answers	**Effective**	**Percentage**
Present	08	80%
Absent	02	20%
Total	10	100%

- Analysis : The majority of mothers say that the nurse is always present and it is he who helps the children to forget their pain, their anxieties and release their fears.

Question N° 11 : What do you think of the therapeutic education you received ?

Table 12. Quality of education

Quality of education	**Effective**	**Percentage**
Impertinent	00	00%
Not Very pertinent	03	30%
Pertinent	07	70%
Total	10	100%

- Analysis : Most of the mothers questioned said that the therapeutic education they had received was relevant.

Question N° 12 : Do you prefer a nurse to take care of your child ? Why or Why not?

Table 13.

Answers	**Effective**	**Percentage**
Yes	00	00%
No	10	100%
Total	10	100%

- Analysis : Mothers confirm that they do not have a problem with the nurses they are going to take care of their children because the good accompaniment, the attitude and the involvement of the nurse always leave their impressions from the first stay in hospital.

Question N° 13 : How satisfied are you with the quality of care provided by the nurses ?

Table 14. Levels of satisfaction

Availability of nurses	Effective	Percentage
Dissatisfied	00	00%
Moderately satisfied	03	30%
Satisfied	07	70%
Total	10	100%

Analysis: The mothers interviewed confirmed that the nurses were always available to meet their children's needs, and thanks to them their children were adapting to this change of life and accepting the hospital environment.

2-1-2- Analysis of observations grids

Table 15. Quality of care

Criteria	Standards	Observation in the Field
Reception	-The nurse greets the sick child and his parents with a smile, and guides them appropriately.	When sick children and their parents arrive on the ward, the attending doctor takes responsibility for receiving them and directing them to the unit specific to their condition, where the nurse receives them as a matter of priority.
Data collection	-The data is collected by the doctor and the nurse, with a specific objective relating to the onset, course and management of the disease.	The nurse and doctor gather information from the sick child about the reason for hospitalisation, the precise symptoms, the experience of the situation, the child's lifestyle and identify the child's needs and resources.
Education	- Listen to the requests of children and their parents and answer questions within the limits of their competence -Giving honest explanations while optimising the child's future.	We noticed that the nurse always tries to reassure the patient, explain the chronology of the care pathway and explain the benefits of the various examinations.
Accompaniment / support	-Listening to children with cancer and letting them express themselves. -From the outset of the illness, to provide an environment conducive to the adaptation and autonomy of children with cancer and their families. -Encourage children with cancer to develop their ability to solve problems arising from their illness.	We can see that the nurse makes the patient feel secure, giving them a sense of direction so that they can master their new environment and overcome their feeling of insecurity. In addition, from the moment they are admitted, nurses create a bond of trust with sick children by helping them to talk about their suffering and their illness.
Helping others during care	-Facilitating fluid, open communication between the child, his or her relatives and all members of the multidisciplinary team. -Carry out the treatment by explaining it in terms that are easy to understand, and establish a relationship of trust between the nurse, the child and his or her parents, taking care not to overstep the boundary of intimacy. -Establish a meaningful therapeutic relationship with the child with cancer and his or her family, while exercising clinical surveillance.	Most of the nurses distract and talk to the child at the time of care, to reduce the child's sensation of pain, and also explain the care process to the child's parents. The nursing team co-ordinates and co-operates with each other. The absence of isolation rooms for children who are depressed or dying, or who speak or act aggressively, creates a tense atmosphere that threatens the care of other sick children.

3- Discussion

In the observation grid, we analysed several criteria: reception, data collection, education, support and the helping relationship during care. Sick children are seen by the doctor treating them and by the doctor who refers them to the unit specifically for their condition, where the nurse sees them within an approximate waiting period, as the reception is often considered to be the starting point of any relationship and influences the rest of the relationship between individuals. We have noted that thanks to the interview established with the parents of sick children, to get to know the sick person better, the doctor and nurse will be able to evaluate the care strategy to adopt the autonomy of sick children so as to optimise their care in the paediatric oncology department and participate in the patient's adherence to the care project.

The literature on doctor/patient communication has shown that the evaluation strategies that make it easier for patients to express their concerns and expectations are open evaluation strategies (Maguire, 1996). These strategies enable patients to address different registers of concerns and to discuss their own agenda with their doctor(Bacqué, 2006). The transmission of information includes sharing knowledge about the risks and benefits of the proposed treatments. Ideally, the doctor's aim is to pass on clear, precise information, including the uncertainties inherent in any medical treatment, while maintaining the patient's trust in their doctor and hope in the benefits of the treatment (Bacqué, 2006). As far as the patient's safety, support and comfort are concerned, a suitable setting must be set aside to preserve their privacy. The paramedical staff respect the suffering of the child and his or her family by behaving in a manner and using detailed language, reassuring them and placing their trust in the care team. In addition, we found that the sick child gives permission for therapeutic procedures or investigations to be carried out on him or her after having been informed in a clear and intelligible way of the procedures, aims and consequences of these procedures or investigations. As we have seen, nurses also participate with psychologists in the psychological support of their sick children, since they are always in contact with them. They help them mobilise their suffering, encourage them to verbalise their emotions, and support them in their reflections so that they can find their own solutions. In fact, we found that more than half of the medical staff (paramedical) are public health nurses, while the rest are nursery nurses and care assistants, which makes it difficult to provide appropriate care for children with cancer, because nurses are trained to care for all categories of patients with different types of pathology, unlike nursery nurses, whose training is based on caring for children, and care assistants, whose training is based on hygiene and comforting patients.

4- Summary of the general analysis

Cancer is a biological phenomenon which it is important to understand to the point of trying to understand its nature in its human dimension, i.e. taking into account both the body and the mind. This will require the doctor to ask himself the question of the relevance of his medical service, but also that of the appropriateness of his human service (Dr Jean- Patrick Chauvin, 2013).(Gustave, 2013) According to our work, which we developed in order to show the usefulness of the participation of medical (and paramedical) staff in supporting children with cancer in the paediatric oncology department of CLCC Oran, and after collecting and analysing the data, we were able to confirm that medical and paramedical staff play an exceptional role in the physical and psychological relief of patients by proving their ability to care for their patients and also by participating in the usefulness of their own roles and finding pleasure in exercising their professions. According to Dr Jean-Patrick Chauvin (2013), this is medical care, a form of support that goes right down to the very meaning of the illness, right down to the identification, with the patient, of the actions that he or she will have to put into practice in his or her life (Fischer, 2013). In this support, the demand for the senses will radically change the doctor-patient relationship. It has given the doctor the role of co-accoucher of the meaning of the illness event and advisor on good human health, helping his patient to determine his own path to recovery.

In this support, the doctor will help the patient to understand a little more about himself, in order to lead him step by step towards a possible personal cure(Fischer, 2013) a never-ending process of entering into intimacy with oneself, with one's own suffering, one's own history and one's own solutions, in order to be able to enter into intimacy with would add that the mothers of children with cancer described the support provided by her staff to their children in the paediatric oncology department as good. From our interviews with the mothers, we found that parents generally try to help their children with cancer as best they can, bringing to the fore the question of their ability to perceive their child's needs and difficulties. It is on the basis of this perception, among other things, that parents can assess their child's situation and offer or seek help. This perception remains a fundamental element in defining the way in which parents approach their child's condition. Finally, we were also able to confirm that all the medical and paramedical staff would like to have isolation rooms in the department to be able to provide high-quality nursing care for children with cancer. From this summary approach and the foregoing, we were able to confirm our hypothesis previously established as follows. The participation of medical staff in the psychological support of children with cancer during treatment seems to be a determining factor in quality care.

5- Recommendations for the Organization of Care

At the end of this summary, and to conclude this study, we would like to add some more general recommendations for improving the psycho-oncological care of adolescents and young adults with cancer and their mothers(Sarah & Razavi, 2010)

5-1- Towards a structured organization of psycho-oncology care

- Offering appropriate psychological care. Allowing psychologists and healthcare teams to take on this responsibility themselves.
- The relay and cooperation of several actors (psychologists from different hospitals, psychologists at home) seem necessary to guarantee continuity of care, which is sorely lacking at present, where each institution tends to operate in isolation, without liaison work.
- Find psychologists and psychiatrists working outside of hospitals and specializing in psychological support for cancer patients.
- The quality of life of caregivers is also potentially affected because relationship difficulties occur more frequently in these patients experiencing psychological difficulties(Kurtz, Kurt, & al, 1995)
- It therefore becomes essential to develop an organization of psycho-oncology care which does not only intervene in a "rescue" mode when the disorders are established and pose significant problems in medical or surgical care; Which is an integral part of the multidisciplinary team surrounding a patient and their family; which works with a network and in collaboration with all the stakeholders involved in the psychological care of patients; which makes it possible to make the detection and treatment of psychological and psychopathological disorders systematic(Sarah & Razavi, 2010)

5-2- Towards a true integration of the social and family dimensions of adolescent and young adult patients.

- Recognition of the patient's social and family dimensions from the onset of the illness is essential not only to increase the support capabilities of their natural environment, but also to respect all the components of their identity, beyond the illness, whose onset cannot justify the interruption of all other perspectives.

6- Conclusions

For an adolescent, the onset of cancer means being able to cope with two unprecedented events: the disease and adolescence (Dauchy, 2010). In this context, it is important that the multidisciplinary team supporting the child is able to take into account, on the one hand, the needs associated with the disease and treatment. Secondly, the psychological issues raised by adolescence, and thirdly, the interactions that the adolescent has with his or her environment. Adolescents must therefore be able to receive psychological support throughout the cancer ordeal, and even after the treatment has ended, so that they can cope as best they can with the psychological challenges of childhood despite the illness. Care in all its dimensions: medical, psychological and social. Increasing attention is paid to the child's therapeutic environment. The aim is to help adolescents remain themselves, like any other teenager their age(Oppenheim, 2012). Illness and treatment should not give them a special status. The aim of this attention is to enable them to maintain an active attitude and a sense of identity, value and place in society and among their peers, which limits the negative effects of the inevitable passive position caused by the illness and treatment.

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