Induced abortion and consciousness objection: an explorative analysis of gynecologists' narratives

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Abstract

In Italy gynecologists can claim consciousness objection when requested to provide abortion; as described by the latest data analysis, 70% of them decide to not provide this kind of medical procedure. Psychological and sociological research studies about abortion are usually related to the construct of "abortion stigma" and they are mostly focused on women's experiences rather than on providers' ones. The present study tries to understand the subjective perspective of physicians in relation to abortion and to consciousness objection to better understand the emotional dynamics taking part in their workplace and job's emotional experience. Structured interviews were administered to 19 gynecologists and trainees in Gynecology to explore their feelings connected to their work with a focus on voluntary interruption of pregnancy and the choice of being or not an objector. Since it is an exploratory study, we decided to employ Emotional Text Analysis to analyze the entire textual corpus of interviews to explore their affective symbolization. Statistical multidimensional analyses were conducted to detect thematic domains (clusters) and latent factors organizing the contraposition between them, considered as a mirror of emotional dynamics part of the context. We found out five clusters, referring to different emotional dimensions: the representation of undesired pregnancy as something unmanageable; the role of consciousness objection in defining physicians' professional identities; the role of manhood power on women's pregnancy; the emotional detachment needed to deal with abortion and the representation of consciousness objection as an instrument of power. All the results are discussed based on the previous literature.

Keywords: *Abortion; Consciousness Objection; Healthcare professionals; Staff's narratives; Emotional text analysis*

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Introduction

Induced abortion is a procedure aimed at ending a pregnancy. The right to have a safe abortion is worldwide recognized, as well as the principle of freedom in family planning (see of International Conference on Population and Development, 1994). Since the use of family planning methods may prevent the prevalence of unplanned pregnancies, we call upon all national Governments to reduce the need for abortion by providing universal access to family planning information and services. As highlighted by the map "The World Abortion Laws" realized by the Centre for Reproductive Health, most European countries have depenalized abortion. The centre for reproductive health has also defined five categories to describe laws regulating abortion: Prohibited Altogether (24 countries, 91 million (6%) of women, no abortion for no reason); To Save a Woman's Life (41 countries, 358 million (22%) of women); To Preserve Health (48 countries, 186 million (12%) of women); Broad Social or Economic Grounds (13 countries, 386 million (24%) of women) and On Request (75 countries, 576 million (36%) of women). Italy is part of the latest group described. Twenty-one of these countries introduced the opportunity of expressing "conscientious objection", a legal instrument which allows physicians and all the other health professional involved to refuse the provision of treatment. This opportunity is linked to religious, moral or philosophical beliefs. It impacts on each country in a specific way: in Slovak Republic consciousness objection is quite prevalent while is gaining importance in England; in Portugal 80% of gynecologists refuse to carry out induced abortions and in Austria, there are entire regions lacking in abortion providers; in Italy nearly 70% of gynecologists is a conscientious objector. As introduced by Law 194, the law regulating abortion's matter in Italy, conscious objection is a legal self declaration which allows physician to not provide abortion. As the Convention on the Elimination of All Forms of Discrimination against Women affirmed, conscientious objection should not limit the access to healthcare assistance. However, it has to be acknowledged that induced abortion is a practice that may challenge physicians' feelings thus favoring their choice not to provide abortion to their patients. Many works have studied emotional and psychological consequences of abortion for women who went through this medical procedure, while a few considered effects on providers (Hanschmidt et al., 2016). Most studies are strictly focused on the concept of "abortion stigma", as conceptualized by Kumar (2013). The author defines "abortion stigma as a negative attribute ascribed to women who seek to terminate pregnancy that marks them, internally or externally, as inferior to ideas of womanhood" (Kumar et al., 2009). She also highlights that abortion providers, in framing discourse, "are often referred as abortionist or murderers by other providers" hypothesizing that this representation could enhance conscientious objection. The author also presents hypothesis about how abortion stigma might impact on women's health: silence, denial, shame, guilt, fear, isolation and loss of social status are some of the consequences described. Feelings of guilt, shame, negative beliefs about self-image and negative feelings take part to internalized stigma explication (Cockrill et al., 2016). Some authors report that also partners, family and friends of women who had an abortion could experience a "courtesy stigma": male partners of women who decided to interrupt a

pregnancy found that they often experience emotions similar to women's ones: ambivalence, guilt, sadness, anxiety, and powerlessness (Shostak et al., 2005). As reported by Norris, "The stigmatization women experience may not be rooted in the act of aborting a foetus; stigma may instead be associated with having conceived an unwanted pregnancy, of which abortion is a marker". Abortion could thus be considered as something which brands women having an undesired pregnancy and consequently eluding the representation of the binomial women=mother (De Beauvoir, 1949; Russo, 1976). Norris et al. (2016) points out three other dimensions which could participate to the concept of abortion stigma: the attribution of personhood to the foetus, also supported by technological changes which gave access to instrument like ultrasounds and fetal photography; the relationship between law and access to healthcare assistance; the narrative of abortion as a dirty, illicit and harmful practice. Some studies also referred to abortion providers: feelings of marginalization were found among them, as reported by Martin (Martin et al., 2014). Lipp (Lipp, 2011) analyzed how abortion stigma is perceived by nurses and many others underlined that abortion is considered a "dirty work - a socially necessary task or occupation generally regarded by others as physically disgusting, socially degrading, and/or morally dubious", linking abortion issue to the construct defined by Hughes. (Martin et al., 2017; O' Donnell et al., 2011; Chiappetta-Swanson, 2005; Hughes, 1951). In Italy this issue was recently explored by De Zordo (De Zordo, 2016) who conducted a qualitative study from which emerges the representation of abortion as a "dirty work" or "the Gynecology Cinderella". The author also highlights the "inhuman" condition with characterizes many hospitals in Italy, since women having IVG are often admitted with women waiting for the birthing room or for ultrasound imaging and points out hat in hospitals where the chief physician is an objector, it is difficult to find non-objector staff: therefore, a professional development aspect would also intervene. It seems that physicians providing abortion experience ambivalence in their work (Roe, 1989). Some authors explored narratives of abortion providers highlighting experiences tend to polarize through the dichotomy pro-choice/ pro-life (Martin et al., 2017), while some others (Dworking, 1993) highlighted the aspects of sacrality.

Method

Aim of the study

The present study aims to deeper understand the emotional dimensions, regulating the relationship between individuals and their context, that contribute to the physician's experience facing abortion and consciousness objection issues, also considering the possible ambivalence, as it emerges from literature. Emotional dimensions are strictly related to the construct of "affective symbolizations": indeed the affective symbolization of objects within a context (Carli & Paniccia, 2002; Fedele et al, 2020) represents the link between individual models and cultural systems of social coexistence. Cultural models do not specifically deal with common sense, in terms of cognitive evaluations, beliefs or stereotypes; rather they include the affective meanings which people attribute to reality or social

events, and symbolic processes which regulate interpersonal relationships (Langher et al. 2017).

Participants

The group of participants consisted of nineteen professionals working in public hospitals (years of professional practice μ=13,6) in Italy selected thought snowball sampling Specifically, seven were structured gynecologists while twelve were trainees in Gynecology; four of them were men while fifthteen were women; six of them declared to be conscious objector while thirteen of them declared that they did provide abortion at the hospital. Interviews were conducted individually and took place after obtaining written consent. In order to respect Covid-19 security procedures all the interviews were conducted online. The employment of meeting online services allowed us to reach professionals coming from different contexts in Italy: seven of them came from the northern part of the peninsula, ten of them from the central region and two of them from the south of Italy. The audio of each interview was recorded on consensus; all data identifying participants were removed from transcripts in order to guarantee anonymity. All the interviews took place when professionals were free from medical work activities. The study received approval from the Ethics Committee of the Department of Dynamic and Clinical Psychology, and Health Studies, Sapienza (Protocol number: 0000516).

Figure 1. Participants gender distribution; the (n.) represents the number of objectors within the group

	Males	Females
Gynecologist	2 (2)	5 (0)
Trainees	2 (1)	10 (3)
Total	4 (3)	15 (3)

Materials

A structured interview, elaborated ad hoc for this study, was administered to participants in order to explore their affective symbolizations regarding their professional experience, with a specific link to abortion and conscientious objection. Existing literature was employed as a guide to define all the questions, which were specifically designed for this study, since we consider previous literature as telling about some aspects of the affective symbolizations characterizing this context. The interview consisted of eight open-answer questions covering four aspects emerging from literature: the concept of women's bodily integrity (Boston Women's Health Book Collective, 1976) ; the social role of the woman and her social representation as “naturally mother”(Kumar et al., 2009); the concept of what’s life and when it does start; the concept of sacrality of life (Dworking, 1993). Considering the sensitivity of the issue, at the start of the interview participants were explicitly invited to answer freely, in a non-judgmental frame of listening.

Data Analysis

Research Framework

Emotional Text Analysis (ETA) is a textual analysis methodology aimed to explore and comprehend the affective symbolizations characterizing an organization or more generally, a community group (Carli & Paniccia, 2002). This method has already been employed to explore healthcare settings, such as a fertility clinic (Fedele et al., 2020) or fertility issues (Langher et al., 2019; Langher et al., 2020).

This methodology is supported by a strong psychoanalytic frame: we refer to Matte Blanco's remark of the structurization of unconscious, which is thought to function as mode of thinking of the mind (Matte Blanco, 1975; Salvatore et al, 2021). This mode of thinking is characterized by a symmetrical logic, unlike Aristotelian logic, which guides conscious thinking. In this view language is thought to be a continuous compromise between these two ways of modes. Referring to Fornari's theory of language (Fornari, 1976) and to the "double reference" principle in particular, we consider language as the precipitate of lexical-cognitive processes (conscious mode) and symbolical-affective ones (unconscious mode), according to the hypothesis that human beings attribute emotional significance to everything they experience. In line with the free-association technique defined by Freud, the deconstruction of these syntaxial relations between words can open to the comprehension of emotional meanings. ETA aims to uncover how language expresses emotions—in other words, how language indicates affective symbolization (Carli & Paniccia 2002). This method deconstructs the typical linguistic links within the speeches in order to detect the spontaneous chains of associations between words. Besides, to grasp unconscious meanings the concept of polysemy is relevant in terms of emotional meanings attributable to a word, when it is extracted from the linguistic context. Throughout the concept of polysemy defined by Carli et al (2016) (the emotionally meaning referring to a word), authors define two categories of words: dense words, characterized by high emotional value (high polysemy) leaving out the context (i.e. "failure" or "ambition"), and non-dense words (low polysemy) which can either be words without significant content (i.e. auxiliary verbs, conjunctions, articles) or ambiguous words with a contra-dictionary emotional meaning (e.e. to go, instead). As defined by authors we considered dense only polysemic words, and we collected dense words respecting the following principles: Key principle: words related to the topic; Verbs (except modal verbs); Nouns; Adjectives; Adverbs (that are qualifying in some way, that are not in interlayer use, that are not part of the connective tissue of the text). This concept is fundamental in the following process of cluster interpretation, since authors aim to disambiguate dense words throughout a process of linguistic context analysis.

All the interviews were transcribed in a unique corpus of text. The software T-Lab (Lancia, 2004) allows to divide the text in units of meaning which are then analyzed using multiple correspondences analysis.

On that basis ETA does not consider individual interviews since they're analyzed as a unique text. T-Lab, after the result of a statistical analysis, provides clusters of dense words positioned in a factorial space. The analysis of clusters allows the researcher to

comprehend relevant emotional aspects of the context: for instance, a cluster could be telling about how the members of a group consider out-group people, if they have feelings of fear or if they are curious about them, or both. Clusters are not separated identities, they do have a strong relationship between each other, both statistical and emotional. Through the analysis of these relationships, i.e. latent factors, it is possible to understand the way physicians represent themselves in relation to abortion and consciousness objection issues. In our study we tried to comprehend how physicians symbolize their professional role in connection with the topics proposed in the interview.

Results

Through the statistical analyses we obtained a corpus including 18,755 occurrences. The percentage of distinct words (V=4,651) out of the total occurrences (types/tokens) is 24%, while the percentage of hapax legomena (H=2,705) (i.e., words that occur only once within the text) is equal to 58%.

Medical language is a specific and technical language, this might be the explanation of these values. Despite this kind of statistical analysis required to have type/token percentage under 20% and percentage of hapax legomena lower than 50%, we proceed with the analyses taking into account the special features of the language concerned. Using the thematic analysis of elementary context we obtained five clusters organized in four latent factors (table 1). All lemmas were translated from Italian for the purpose of this article.

Table 1. Clusters with most characteristic lemmas (Keywords) and percentage of the overall percentage units.

Cluster 1 (22,7%) Pregnancy as an indigestible problem		Cluster 2 (16, 4%) The processual choice of becoming an objector		Cluster 3 (23,8%) The phantom of a powerful manhood		Cluster 4 (22,5%) The desertic hospital		Cluster 5 (14,6%) The symbolic instrument of life	
Lemma	χ2	Lemma	χ2	Lemma	χ2	Lemma	χ2	Lemma	χ2
To find	168,60	Objector	182,72	To place	103,45	Service	279,27	Life	87,05
Pregnancy	113,72	Physician	95,61	Child	74,62	Surgery	134,59	Choice	76,15
Voluntary termin	47,39	Religious	85,26	To take	68,94	Hospital	115,01	Objection	67,58
Carry on	25,80	Collegue	83,49	Son	62,43	Voluntary termina	89,67	Consciousness	54,23
To arrive	22,40	Reason	52,45	Father	62,13	Surgical	88,21	Prenatal	34,54
Social	20,07	To become	41,28	Pregnant	53,03	Healthcare	52,39	Freedom	30,60
To happen	19,82	Different	40,37	Together	48,13	Medication	50,18	To solve	29,32
Problem	18,73	Gynecologue	33,62	To pay	37,29	To function	47,04	Fair	26,81
To interrupt	18,43	Right	30,67	To write	34,51	Dayhospital	45,87	To protect	23,58
Situation	16,14	Topic	23,62	To use	31,56	To search	42,93	Willingness	23,02
Person	14,87	Senior	20,52	Decision	28,68	System	39,26	Person	21,77
Esclusively	14,64	Trainee	17,11	Mother	22,54	Trainee	37,35	Important	21,36
Interview	14,62	Job	17,08	Sex	22,37	Centre	36,37	Thought	19,66
Judgment	13,04	Convinction	16,72	Dick	21,82	To garantee	31,88	Moral	19,23
To include	12,68	Teacher	14,85	Insurance	20,34	Method	29,23	Power	17,30

Thematic domains

Cluster 1. Pregnancy as an indigestible problem

The first cluster starts with the verb "to find" (trovare): in Italian this verb has a double meaning, since it could mean "to obtain something you are looking for" or "to find yourself" somewhere you were not expecting to be. In the cluster we also find the verb "to happen" (capitare) which made us wonder this cluster might be telling about a random "happening". The noun "pregnancy" (gravidanza) and "voluntary pregnancy interruption" (IVG) are the object of this emotional status; the noun "problem" (problema), highlights that these events are experienced by physicians as problematic, unresolved dimensions, metaphorically we described this condition of unresolvedness as "indigestibility". The recurrency of the undesired pregnancy seems to be indigestible, not solvable, emotionally unhandleable. Moreover, the etymon of problem refers to "something that comes forward, which prevents, an obstacle". These elements reveal operators' difficulty in confronting an issue such as that of the pregnancy interruption and the unwanted foetus, evocative of a womanhood which is distant from the ideal of woman as naturally mother.

Cluster 2. The processual choice of becoming an objector

The cluster 2 includes 16,4% of the elementary context units. The nouns "objector" (obiettore) and "physician" (medico), followed by "to become" (diventare) and "reason why" (motivo) remind to the process of choice, which seems to be a processual, dynamic procedure (Objector; Physician; To become, Reason why): participants reported that many gynecologists "become objectors", highlighting in progress aspects. Moreover, processuality is emphasized by the word "reason why" which means "anything which drives, urges to do. An impulse." "Religion" (religione) seems to be regarded as a valid "reason" (motivo), a "right" (diritto) that someone has for taking this choice; on the other hand the presence of the word "different" (diverso) is telling about the fact that there are some other reasons for which physician may decide to express their conscientiousness objection. Hence these other motifs are not strongly felt as the religious-ethical ones, they do not occur within the thematic domain, but they probably have a connection to the "convenience objection", a linguistic form which often echoes through the course of the interviews.

Cluster 3. The phantom of a powerful manhood

Cluster three contains 23,8% of the whole elementary context units. In this cluster most of nouns refers to masculinity where terms such as "kid" (bambino), "father" (padre) and "son" (figlio) are not balanced with "pure" feminine nouns. Womanhood only appears with the term "pregnant" (incinta), a noun which is strongly linked to the idea of etero-couple male-female. This thematic domain reflects a relationship hierarchically organized based on power: the verbs all express a bond based on power or contemplating subordination where someone does something on someone else (to place; to take; to write; to pay; to use) (mettere, prendere, scrivere,

usare): to place reminds of the gesture of putting something somewhere, while writing etymologically echoes the act of engraving a tablet of clay. Summarizing, this cluster is telling about the patriarchal power on women, where men can do something on women, such are making them pregnant, and where women can do something to men, acting on men's chance to become a father by the employ pregnancy interruption, symbolically and practically represented as an act of power and self-affirmation.

Cluster 4. The desertic hospital

The fourth thematic domain is representative of 22,5% of the overall elementary context units and it is telling of the ward of pregnancy interruption. It starts with the noun "service" (servizio), followed by "surgery" (intervento) and "hospital" (ospedale): no human being seems to be part of it. Within the cluster there are nor operators nor women, but only the place, the hospital, an empty space. Everything conveys emotional detachment (surgery; surgical; medication; dayhospital) (chirurgico, sanitario, farmaco, dayhospital) which is surely part of the medical culture but that here appears in an extreme configuration. Only one verb shows up at the end of the cluster: to search has a particular etymology "circare" which in latin refers to the action of "going around, almost in a circle". We can hypothesize that operators may circumvent the issue, by reporting only cognitive, pragmatic aspects of their work, but it also evokes the image of people wandering in an abandoned space.

Cluster 5. The symbolic instrument of life: consciousness objection

Cluster 5 contains 14,6% of the overall elementary context units. It starts with "life" (vita) followed by the lemmas "choice" (scelta), "objection" (obiezione), "consciousness" (coscienza): the consciousness objection seems to be an instrument to preserve life as sustained by the verb "to choose", which etymologically means "to separate what's better from what is worse and to elect the better part". Life seems to be the eligible choice. The cluster also contains ethical dimensions (freedom; right;) (libertà, giusto) in accordance with a level of ideological celebration of the inherent value of life. This celebration would not find any explanation if not into the symbolic container of this cluster: abortion. Following this path, we suppose that this thematic domain is configured as a strong defence from death's anguish.

Latent factors

Four latent factors have been detected from correspondence analysis, which highlight the main semantic opposition, based on the spatial disposition of clusters within the factorial space.

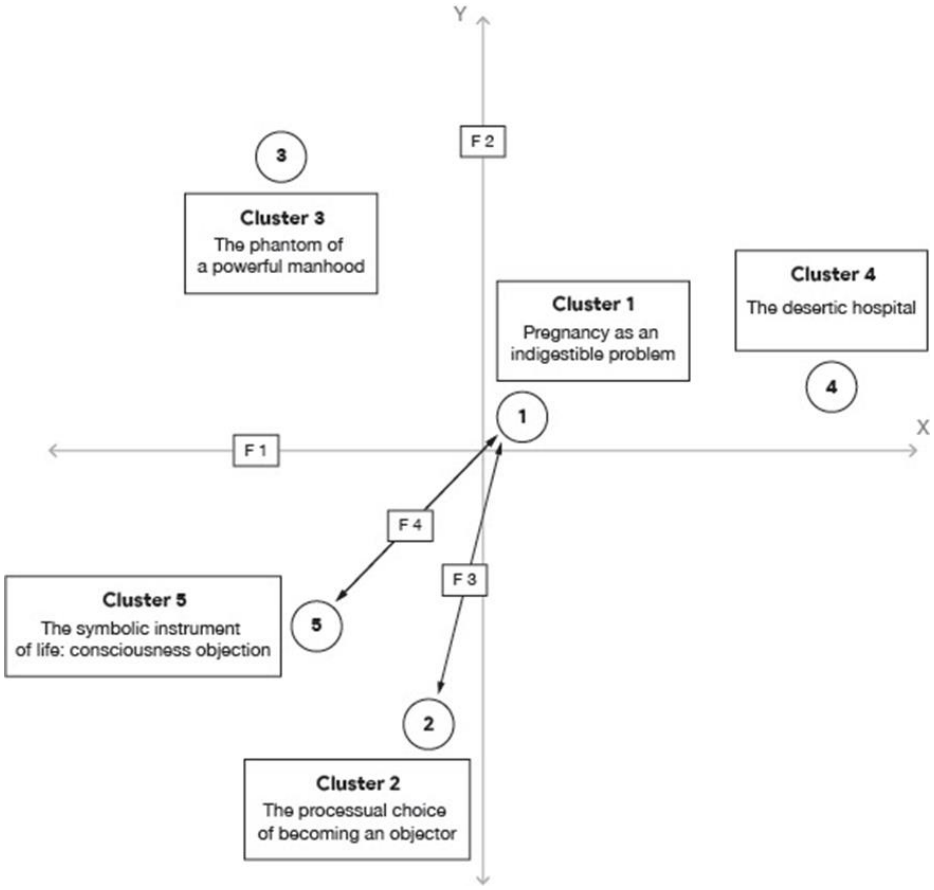
The table beyond shows the association between clusters and factors, expressed by relative contributions (squared cosines), indicating the quality of representation of each cluster on the different latent dimensions. The four latent factors explain the entire data variance (R^2= 100%).

Figure 1 shows the factorial space organizing the relationship between clusters and factors, here we provide a map of emotional symbolizations shared by professionals interviewed.

Table 2. Association between Clusters and Factors (Relative Contributions)

Cluster	Fattore 1	Fattore 2	Fattore 3	Fattore 4
Cluster 1	0.0027	-0.0558	0.6151	-0.2929
Cluster 2	-0.1174	-0.6408	-0.5504	-0.3519
Cluster 3	-0.5155	0.6453	-0.2245	-0.0184
Cluster 4	0.8972	0.1760	-0.1374	0.1607
Cluster 5	-0.4215	-0.4595	0.1613	0.6510

Figure 2. Factorial space.



The Anguish (F1)

The first factor (36,2% of the total variance) differentiates Cluster 3 (The phantom of powerful manhood) and cluster 5 (The symbolic instrument of life) from cluster 4 (The desertic hospital). This factor seems to express the physicians' emotional experience solicited by the abortion: a profound anguish,

against which they react celebrating the strength of life, and which brings to a behavioral detachment from the service of pregnancy interruption, thus making the hospital an empty space, in an emotional way.

The Incompetent Omnipotence (F2)

The second factor (27,3% of the total variance) differentiates Cluster 2 (The processual choice of becoming an objector) and Cluster 5 (The symbolic instrument of life) from Cluster 3 (The phantom of powerful manhood). It describes power dynamics internal to the context. Since our society is strongly bounded to the concept of "life as sacred gift", the defense of this gift means being symbolically powerful, "doing the right thing". Consciousness objection is thus symbolized as an instrument of power, which assures to those who defend life a feeling of powerfulness. On the other hand, providing abortion determines the occurrence of feelings of impotence and frustration.

The Unwanted Pregnancy (F3)

The third factor (21,7% of the total variance) differentiates Cluster 2 from Cluster 1 and describes the symbolic configuration of hospital users. Users are experienced as "unwanted pregnancy" who propose an "overturning" of the social representation of women as "surely desiring motherhood". Whenever it is possible to stay in contact with this configuration (the unwanted pregnancy) of womanhood it is also possible to guarantee abortion services; whenever facing this configuration of womanhood is too troubling, then it becomes impossible for physicians to provide abortion.

Foetus-Woman or Prenatal-Woman? (F4)

The fourth and last factor (14,8% of the total variance) is characterized by the opposition between Cluster 1 and Cluster 5 and describes the two bodies that a woman can carry inside her: "foetus" or "prenatal". Historically the term "foetus" was in use inside the anatomical-medical field of research: the foetus was dead and it was useful for the growth of medical knowledge. The other body is the "prenatal", which is evocative of an "almost born baby", more generally of a living baby. Since many linguistic evidences underline the symbolic fusionality between the mother and the foetus, which is for example defined as "pars viscerum matris", it is possible that the couple get the same emotional value. This representation evokes two possible figures of the mother: a mother carrying death inside her, in opposition to a mother carrying life, giving life, a generative mother. In conclusion we can affirm that this latent factor tells about the two essential categories of existence: life and death, and the fear they can strike.

Discussion

Abortion issue generates a profound sense of anguish, since it seems to be perceived as dangerous for the self. It has a close relationship with aspects related to death, as it emerges from factor 4. An object-relation perspective can be useful to understand this emotional dynamic since the term "object relation" is referred to describe the internal images or mental representations of the self and others (intended as symbolic objects) which have the power to influence both the individual's affective states and overt behavioral re-

actions (Goldstein, 2001). It seems that physicians experience an inner splitting: by one side they respond to anguish with a celebration of life, characterized by aspects of idealization, sense of triumph and omnipotence mirroring the extreme anti-abortionist position, on the other one they feel haunted, persecuted, in danger.

These feelings reflect abortion providers' narratives, which often report feelings of impotence and weakness. The presence of this strong inner anguish determines that being in touch with women asking for abortion elicits pain and negative feelings: the hospital appears dehumanized and deprived of any kind of emotional contact.

The symbolization of the woman who chooses to interrupt a pregnancy is one of the key aspects of the study: referring to the archetypes proposed by Neumann (Neumann, 1955) and considering the results emerging from factor 4 (Foetus-Woman or Prenatal-Woman) it seems that she might be evocative of a woman bringing death inside her, a symbolical configuration which reminds us of the "Terrible mother" described by Neumann. This result is in line with the gender studies cited in the introduction (Kumar et al., 2009; Cockrill et al., 2016): a woman who decides to interrupt a pregnancy represents the opposite of what a woman should naturally be, a mother. Thus abortion, foetus and women not desiring pregnancy evoke death, and consequently, anguish.

Being unable to tolerate the presence of such a symbolical woman, consciousness objection becomes the instrument of preservation of the self since it allows the preservation of life, and all the values related to the concept of "sacrality of life". Preserving life, which in this context means to not provide abortion, expropriates women of their bodily integrity, and evokes the dimensions of control and power. The popular feminist manifesto "Our bodies, ourselves" is representative of this issue, since aspects of control and bodily self-determination have been historically bound to the abortion issue. On the other hand, we would like to focus on the solitude of the abortion providers, wedged between the responsibility towards the women asking for abortion and the Hippocratic oath binding them to strenuously preserve life. Overall, this study has some limitations: starting from the low number of participants (n=19) which does not allow us to generalize results and the presence of two physicians who were working in hospitals guided by catholic organizations, and who were consequently not allowed to provide abortion. Moreover the sample was strongly auto-selected because of the method of sampling and the voluntary based participation to the study; this last event could have reduced the sample variability in terms of culture. The gender variables were also not homogeneously distributed, as happened for the kind of professional experience (structured and trainees): this could be an explanation of the missed strong presence of a variable within a particular cluster. As already mentioned in "Results" section, the percentage of hapax (58%) and the type/toke percentage (24%) we obtained are higher than the ones defined by guidelines. Moreover, since this inquiry is a qualitative study, further quantitative studies are needed in order to confirm the interpretations we proposed. Some tools could be created in order to operationalize the emotional dimension emerging from this study. Additionally, the small number of participants did not allow to highlight any kind of difference based on the gender or the age of providers; it could be interesting to study the change of emotional dimension in connection to these

variables. Despite these limitations, the present study provides results which can be considered as preliminary for the understanding of subjective experience of providers who are part of this context: in fact case studies can represent a potential richness for clinical practice consequently to their high sensitivity and their potential innovatively: the more a study helps researchers in understanding a context, the more it can guide clinical intervention in taking care of the emotional and the organizational issues of health providers (Langher, 2017).

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