Mindful Continuing Education

Clinical Intervention in Oncology Social Work

1. An oncology social worker is meeting a newly diagnosed patient who feels helpless and overwhelmed by complex treatment decisions. According to the principles outlined for oncology social work interventions, what should most strongly guide the social worker's initial clinical approach?

A. Prioritize long-term psychotherapeutic work over time-limited, focused interventions regardless of current distress level
B. Focus primarily on teaching problem-focused coping skills and delay exploring emotions until treatment is completed
C. Limit the intervention to community resource referrals because medical issues are the physician's domain
D. Base interventions on a clear understanding of the patient's diagnosis and treatment plan as well as their social and emotional situation, while helping them feel more in control and cope with physical, emotional, and social problems

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2. In a case conference, an oncology social worker argues for including social work input in the medical treatment plan. Which description best reflects the concept of interdisciplinary care as presented in the course?

A. Each professional independently manages their own aspect of care and documents in separate records to maintain clear role boundaries
B. Each professional practices within their discipline while actively collaborating through communication and knowledge integration to create a shared understanding and comprehensive care plan
C. The physician determines the care plan and other disciplines are consulted only if the patient requests additional services
D. Nurses and physicians form the core team, and social workers are engaged only for discharge planning and financial issues

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3. A patient with metastatic cancer repeatedly attributes her illness to being a "punishment" for past relationship choices and becomes angry at her oncologist, whom she experiences as controlling and critical like a former caregiver. Which theoretical lens from psychodynamic practice best helps an oncology social worker understand this pattern?

A. Cognitive distortions that arise solely from current medical information and are unrelated to past experiences
B. Conscious problem-solving biases only, where inaccurate cost–benefit analyses drive all health-related decisions
C. Unconscious processes and transference, in which unresolved childhood conflicts and prior caregiving experiences are displaced onto current providers and give symbolic meaning to the cancer

D. Behavioral conditioning, in which medical staff inadvertently reinforce avoidance through scheduling patterns

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4. During assessment, a patient with cancer frequently uses humor, seeks support, and openly reflects on his emotions, while another patient engages in help-rejecting complaining and passive aggression toward staff. Based on the defense mechanism research summarized in the course, how should the oncology social worker conceptualize these patterns?

A. Defense mechanisms are not clinically relevant in oncology and should not influence the social worker's formulation or intervention plan
B. Both patients are using equally adaptive defenses, since any defense mechanism that reduces anxiety is considered positive in cancer care
C. The first patient's defenses are maladaptive because they avoid discussing death, while the second patient's defenses are adaptive because they discharge anger outward
D. The first patient is using high-adaptive defenses associated with better physical and emotional functioning and acceptance of social support, whereas the second is using action defenses linked to more maladaptive functioning and lower survival probability

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5. An adolescent and young adult (AYA) with newly diagnosed cancer reports frustration about delaying college and feeling different from peers. Using Erikson's psychosocial development theory, which focus would best guide the oncology social worker's intervention?

A. Exploring challenges with identity formation and emerging intimacy, and how cancer disrupts tasks such as developing independence, pursuing education/work, and forming romantic relationships
B. Clarifying issues of trust versus mistrust in infancy to determine whether early feeding patterns created current anxiety about chemotherapy
C. Concentrating on generativity versus stagnation by encouraging the patient to focus on mentoring younger children with cancer
D. Focusing primarily on integrity versus despair, helping the patient complete a full life review to evaluate regret about past decisions

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6. A patient with a history of inconsistent caregiving in childhood has few current supports, mistrusts the medical team, and declines offers for help despite high distress. How does attachment theory, as applied in the course, inform the oncology social worker's understanding?

A. Secure attachment styles generally lead to chronic high distress and avoidance of social support, so the patient's behavior indicates secure functioning
B. Insecure attachment is associated with chronic high distress, limited social support, reluctance to seek help, and difficulty problem-solving, suggesting a need for tailored support to build trust and adaptive coping
C. Attachment patterns are fixed in infancy and have no demonstrated impact on how adults adapt to cancer diagnoses
D. Reluctance to accept help is best explained by cognitive distortions about treatment rather than early relational patterns

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7. An oncology social worker is assessing a patient who lacks stable housing, has limited food access, and is also asking for help finding meaningful volunteer work. Guided by Maslow's hierarchy of needs, what should be the social worker's primary clinical priority?

A. Focus on enhancing self-esteem through affirmations before addressing safety or physiological concerns
B. Begin with self-actualization by helping the patient find purposeful volunteer work, trusting that basic needs will resolve over time
C. Address basic physiological and safety needs such as food and housing first, while holding future conversations about meaning and self-actualization as secondary goals
D. Concentrate exclusively on love and belonging by starting a support group referral, regardless of material insecurity

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8. A patient reports distress related to losing his job after treatment and systemic barriers to disability benefits. Using the person-in-environment framework described in the course, what combination of perspectives would best guide the social worker's comprehensive assessment?

A. Spiritual assessment alone, assuming that religious beliefs fully explain his employment and disability challenges
B. Micro level alone, restricting assessment to the patient's intrapsychic conflicts and ignoring family and policy contexts
C. Macro level only, focusing exclusively on national cancer policies and not on the patient's personal coping or relationships
D. Micro–mezzo–macro plus biopsychosocial–spiritual perspectives, examining the patient's individual functioning, family and community supports, and broader policy and health care systems impacting his situation

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9. Parents of two school-aged children are navigating a new cancer diagnosis in one parent. Using family life cycle theory, what developmental consideration is most relevant for the oncology social worker's formulation?

A. The family is in the 'launching' stage, so the main task is promoting the children's physical separation from the home regardless of the cancer context
B. The family is in the 'families with school-aged children' stage, where children are becoming more independent and boundaries are expanding to include schools and other institutions, so cancer may strain role changes and role acceptance
C. The family is in the 'aging family members' stage, so the focus should be on grandparent–grandchild relationships and elder care planning
D. Developmental stages are irrelevant once cancer is diagnosed and should not influence assessment or intervention

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10. A patient with breast cancer reports automatic thoughts such as, "I'm a burden; my family would be better off without me," and presents with depression and anxiety. Which core element of cognitive behavioral therapy (CBT), as outlined in the course, should the oncology social worker

prioritize?

A. Encouraging the patient to ventilate feelings freely without linking them to cognitions or behaviors
B. Avoiding discussion of thoughts entirely and focusing solely on behavioral activation without examining underlying beliefs
C. Identifying and challenging maladaptive automatic thoughts and core beliefs, and helping the patient reframe them to support more adaptive emotions and behaviors in coping with illness
D. Replacing psychoeducation with unstructured supportive listening that does not target thought patterns

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11. A caregiver of a patient with advanced cancer feels overwhelmed and describes multiple concrete challenges (medication schedules, transportation, coordinating appointments). The oncology social worker chooses problem-solving therapy. Which intervention sequence best reflects this modality?

A. Focusing on uncovering childhood origins of the caregiver's stress and interpreting unconscious conflicts
B. Cultivating a positive problem orientation, then systematically defining the problem, setting goals, generating alternatives, selecting a solution, implementing the plan, and evaluating the outcome
C. Teaching cognitive defusion and values clarification without structured problem analysis or planning
D. Using free association and dream interpretation to explore symbolic meanings of caregiving tasks

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12. A patient with metastatic disease says, "I can't control whether the cancer progresses, but I don't want fear to run my life. I want to focus on what really matters to me." Which therapeutic approach from the course best matches this stance and could be most appropriate?

A. Acceptance and Commitment Therapy (ACT), which promotes psychological flexibility by accepting what is beyond personal control while committing to value-guided actions that make life meaningful
B. Traditional psychoanalysis, which focuses primarily on reconstructing early childhood memories over many years
C. Exposure-based trauma therapy, which centers on repeatedly reliving traumatic cancer experiences in detail
D. Systematic desensitization, which is limited to phobic responses and not to broader life meaning concerns

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13. A patient frequently experiences intense surges of fear before scans, becomes irritable with family, and later feels ashamed of these reactions. The oncology social worker decides to use DBT skills. Which focus is most consistent with the DBT approach described in the course?

A. Exploring defense mechanisms retrospectively without offering concrete coping skills for the present

B. Challenging and replacing all negative thoughts with positive affirmations while discouraging expression of anger
C. Teaching mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness while validating the patient's emotions and encouraging dialectical thinking that two truths can coexist
D. Focusing solely on exposure to feared stimuli without addressing relationships or emotional labeling

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14. A long-term survivor says, "Ever since cancer, all I see when I think of myself is that I'm a 'cancer patient' who failed my body." The oncology social worker uses narrative therapy. Which technique, as outlined in the course, would most directly help this client separate identity from illness?

A. Avoiding story work and focusing entirely on symptom checklists and brief advice-giving
B. Encouraging the client to accept the label 'cancer patient' as their primary identity to foster realism
C. Externalizing the problem by helping the client see cancer and its effects as something outside their core self, and collaboratively reconstructing a more affirming life story connected to their values and strengths
D. Directing the client to let family members write their story so they can adopt others' perspectives

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15. During a support group, a participant shares their story while a close friend is present as an outside witness. After hearing the story, the friend is interviewed about what stood out and how it affected them, and then the patient reflects on hearing this feedback. According to the course, what narrative therapy practice does this describe?

A. A definitional ceremony using an outside witnessing position to affirm preferred identity stories
B. A family systems genogram interview to map multigenerational patterns of illness
C. A crisis debriefing protocol focused on ABC (affect, behavior, cognition)
D. A motivational interviewing decisional balance exercise about behavior change

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16. An oncology clinic is revising policies to ensure it is trauma-informed. Which system-level set of principles from the course should they prioritize to align with trauma-informed care in cancer settings?

A. Safety, trustworthiness, choice, collaboration, and empowerment in all organizational practices
B. Efficiency, productivity, compliance, standardization, and hierarchy of authority
C. Prognostic disclosure, informed consent, performance monitoring, and billing optimization
D. Risk avoidance, legal protection, restricted information sharing, and rapid discharge planning

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17. A patient newly informed of disease progression appears disorganized, cannot make basic decisions, and reports feeling completely overwhelmed. Using crisis theory and intervention principles presented in the course, what should the oncology social worker prioritize in the first session?

A. Rapid rapport building and a brief, focused assessment to restore cognitive functioning and support immediate problem-focused planning in a time-limited, present-centered way
B. Intensive life history taking and long-term psychodynamic exploration of early losses
C. Encouraging the patient to delay all decisions until emotions subside without offering structure
D. Referring the patient out immediately because crisis work is incompatible with oncology social work

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18. A couple coping with early-stage cancer reports communication problems and decreased intimacy after treatment side effects. Based on the course's discussion of couples therapy in oncology, which focus would be most appropriate?

A. Encouraging each partner to manage their distress individually without structured couple-based work
B. Exclusively focusing on caregiving tasks and avoiding discussion of sexuality to prevent discomfort
C. Time-limited, educational interventions that strengthen coping skills, communication, responsiveness to each other's needs, support provision, and problem-solving, including around sexual and emotional intimacy
D. Delaying any couple-focused intervention until cancer recurs or progresses to an advanced stage

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19. An oncology social worker meets a patient who is ambivalent about joining a support group, saying, "Part of me wants connection, but part of me doesn't think it will help." Using motivational interviewing as described in the course, which response best reflects the recommended clinical stance?

A. Collaboratively exploring the patient's own reasons for and against joining, reflecting their ambivalence with empathy, and highlighting any 'change talk' to support autonomy and self-efficacy
B. Firmly advising the patient that refusal reflects denial and insisting that they attend the group
C. Providing a lecture on research evidence for groups without asking about the patient's perspective
D. Avoiding further discussion of groups to respect ambivalence and leaving decisions entirely unexamined

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20. A patient asks, "Why did this happen to me?" and struggles to reconcile her belief that the world is just with the randomness of her cancer. According to the meaning-making model discussed in the course, what process is she engaging in?

A. Using high-adaptive defenses like humor that are unrelated to meaning systems
B. Applying purely problem-focused coping without any reference to beliefs or values
C. Attempting to reduce the discrepancy between her global meaning system (beliefs, values, goals) and the appraised meaning of the cancer event through meaning-making efforts
D. Engaging in avoidance of meaning because searching for meaning increases distress by definition

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21. A patient near end of life worries about becoming dependent, losing dignity, and burdening family. Using the dignity model from the course, which domains should the oncology social worker explicitly consider when planning interventions?

A. Illness-related concerns (such as functional and cognitive decline), the dignity-conserving repertoire (like autonomy, pride, role preservation, and legacy), and the social dignity inventory (including privacy, social support, respect, and fear of being a burden)
B. Only existential concerns about spirituality, because physical and social issues are medical matters
C. Exclusively the patient's symptom report, since dignity is defined solely by pain scores
D. Primarily financial status, assuming material resources fully determine a sense of dignity

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22. A woman with early-stage, highly treatable cancer reports profound grief about body changes and life disruption, but her friends repeatedly say, "You have the good cancer; you'll be fine." Which grief construct from the course best captures her experience?

A. Closed awareness, where she is unaware of her prognosis but others are fully informed
B. Disenfranchised grief, in which her losses are not socially recognized or validated, leading to minimized or unsupported mourning
C. Ambiguous loss of a physically absent but psychologically present loved one
D. Continuing bonds, which involves ongoing connection to a deceased person

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23. A patient's spouse describes feeling that her husband with advanced brain cancer is "here but not here" because of cognitive changes and personality shift. Which concept from the course best helps the oncology social worker name and validate this experience?

A. Anticipatory grief, in which all loss is clearly defined and closure is imminent
B. Physically ambiguous loss, in which the person is physically absent but psychologically present
C. Psychologically ambiguous loss, where a person is physically present but psychologically absent
D. Continuing bonds, which refers to connections after a person has died rather than during illness

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24. An oncologist explains the staging and treatment of a patient's disease. Later, the oncology social worker meets with the same patient to provide psychoeducation. According to the course, what distinguishes psychoeducation from medical education in this context?

A. Psychoeducation is limited to written handouts without any discussion of coping or meaning
B. Psychoeducation focuses solely on reviewing pathology reports and laboratory numbers in detail
C. Psychoeducation replaces emotional support with structured didactic teaching about hospital policies
D. Psychoeducation helps patients and families understand the condition's course, expected outcome, treatment, and psychosocial components, allowing emotional and cognitive processing of its meaning in their lives

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25. During a serious illness conversation, the oncology social worker is meeting alone with a patient expected to live less than a year. The patient asks, "What does this mean for my future?" Based on Ariadne Labs' guidance in the course, what is an appropriate way for the social worker to discuss prognosis without giving a specific time frame?

A. Refuse to discuss the future at all, explaining that prognosis can only be addressed by a physician using exact timelines
B. Offer anticipatory guidance that acknowledges uncertainty, expresses hope the patient will feel well as long as possible, and prepares them for the likelihood of becoming sicker and less able to do usual activities
C. Provide a precise life expectancy in months based on personal opinion to satisfy the patient's curiosity
D. Reassure the patient that they will likely remain stable indefinitely to maintain optimism

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26. A healthy middle-aged adult names a trusted friend as surrogate decision-maker and completes a living will specifying preferences for life-sustaining treatments. Within Izumi and Fromme's advance care planning continuum described in the course, how is this best understood?

A. As early-phase advance care planning in which a surrogate decision-maker is identified and advance directives (health care power of attorney and living will) are completed while the person is still well
B. As an intervention that should be reserved until all curative treatment options have been exhausted
C. As unnecessary because advance care planning only applies to very old or terminally ill adults
D. As the same process as completing a POLST, which is appropriate for any adult regardless of illness status

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27. A hospitalized patient with advanced cancer has never completed advance directives and is now too confused to make decisions. What guidance from the course best describes how the health care team should proceed?

A. Automatically designate the bedside nurse as surrogate decision-maker irrespective of legal requirements
B. Follow state laws to identify who can make medical decisions on the patient's behalf, attempt to locate family or friends, and, if needed, have a physician represent the patient's best interests

C. Assume that full aggressive treatment is always preferred and avoid seeking surrogate input
D. Delay all decisions until the patient regains capacity, even if urgent choices about life-sustaining treatment are needed

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28. A patient from a cultural background that views illness as affecting the whole social and spiritual world feels that her oncologist talks only about organ pathology and chemotherapy. Misunderstandings and mistrust have grown. According to the course, how can the oncology social worker most effectively intervene?

A. Encourage the oncologist to limit explanations to technical language so the patient will take the disease more seriously
B. Advise the patient to defer entirely to the oncologist's view and stop discussing cultural beliefs to reduce conflict
C. Serve as a 'translator' by recognizing differing cultural constructions of illness and disease, interpreting each side's frustrations, and facilitating communication so that both the patient's holistic view and the provider's biomedical focus are acknowledged in care planning
D. Focus solely on the family's dynamics and avoid addressing interactions with the medical team

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29. In a psychosocial oncology program using the Collaborative Care Model, which role for the oncology social worker as care manager is most consistent with the description in the course?

A. Limiting work to financial paperwork and transportation coordination without addressing mental health symptoms
B. Delivering all psychotherapy independently while avoiding structured collaboration to preserve confidentiality
C. Providing psychoeducation and brief behavioral interventions for mental health needs, using patient-reported outcomes to guide stepped care, and facilitating communication and regular case review among team members
D. Serving solely as a liaison to community agencies, with no involvement in measurement-based care

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30. An oncology social worker is planning a new support group for patients receiving chemotherapy who report feeling unprepared and anxious about side effects. Which group format, as defined in the course, would best match a structured, time-limited group focused on learning coping skills and treatment-related information?

A. A psychoeducational group that emphasizes learning and skill development through organized content and activities with less focus on deep personal disclosure
B. An experiential group centered on art, movement, or adventure activities to access subconscious emotions without structured information
C. A psychotherapeutic group that is ongoing and primarily focused on exploring painful emotions too difficult to share with family
D. An unstructured drop-in group with no predefined goals or topics where education is discouraged

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