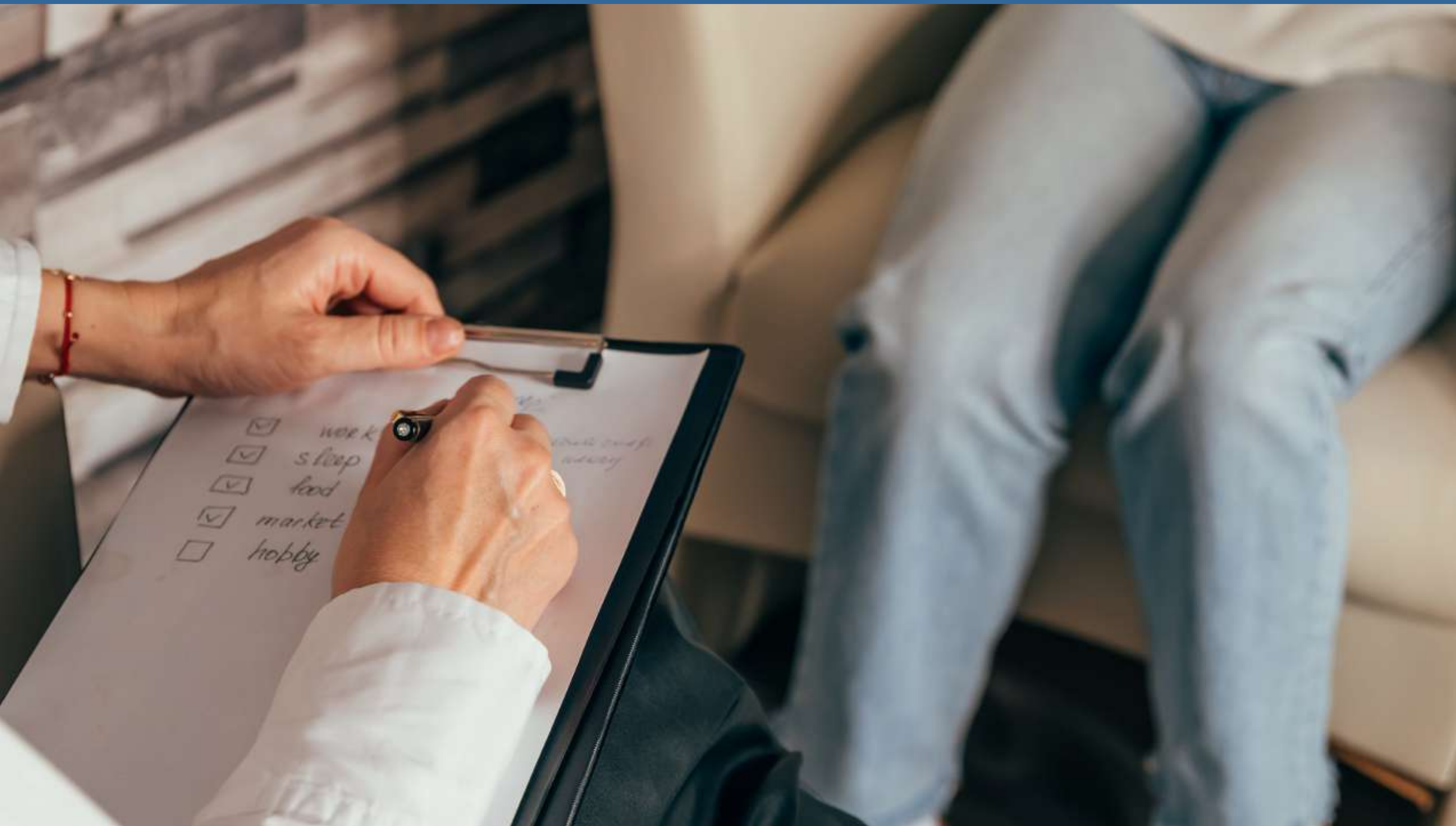
Mindful
Continuing Education

Assessing Psychosocial Needs in Oncology



Section 1: Introduction

References: 1, 4, 7, 12, 17, 19, 33, 34, 43, 51, 59

According to the U.S. Centers for Disease Control and Prevention (CDC) (2025), more than 1.8 million people were diagnosed with cancer in the U.S., and over 610,000 people died from the disease in 2022 (the most recent data available). Since 2022, estimates of these statistics in the annual Cancer Facts and Figures reports published by the American Cancer Society show a steady increase in the number of people who will be diagnosed with cancer, as well as those who will die from the disease. In 2024, it was estimated for the first time in U.S. history that the number of people diagnosed with cancer was expected to exceed 2 million. The increase in these numbers is attributed to the ongoing rise in population, including those who are aging (American Cancer Society, 2025; Collins, 2024).

In 2025, the American Cancer Society's Cancer Facts and Figures report again estimated that just over 2 million people in the U.S. would be diagnosed with cancer, and close to 620,000 people would die from the disease. This report also estimated that 40 in 100 men and 39 in 100 women in the U.S. will develop cancer in their lifetime (Siegel et al., 2025). Another version of the American Cancer Society's Cancer Facts and Figures report, which focuses on cancer treatment and survivorship specifically, estimated that there are over 18 million cancer survivors in the U.S. as of January 2025, which means that about 1 out of every 18 Americans has a history of cancer. The number of cancer survivors is expected to exceed 22 million people by 2035. The increase in cancer survivors is also attributed to a growing and aging population, as well as advances in cancer screenings and treatments that have improved survival (Wagle et al., 2025).

In addition to the number of people who have been diagnosed with cancer, there are caregivers, family members, friends, neighbors, co-workers, and other people who are impacted by the disease based on their connection to the person living with the diagnosis. Though data was not found on the number of people affected by a cancer diagnosis, there is some data on informal cancer caregivers, who are family members and friends. Estimates from the National Alliance for Caregiving and the National Cancer Institute (as cited in Applebaum, 2018) indicate that the number of people caring for individuals with cancer in the U.S. ranges from approximately 3 million to over 6 million people. Considering these numbers, there are millions of people in the U.S. who are not only diagnosed with cancer but are caring for them and are a part of their support system.

While these numbers are considerable, the impact of a cancer diagnosis on a person's life can be substantial. People living with the disease and their loved ones often face many challenges in both the short and long term. There can be physical issues from the cancer itself and side effects from the treatments, both of which may change a person's ability to function day to day. Physical problems can include pain, neuropathy, fatigue, weakness, nausea, lymphedema, and cognitive issues (Cleveland Clinic, 2024). These physical issues can increase an individual's care needs, which in turn, places more responsibility on a cancer caregiver. There can also be psychosocial concerns, which are the "mental, emotional, social, and spiritual effects of a disease" (National Cancer Institute, n.d., para. 1). Psychosocial problems can include anxiety, depression, changes in relationships and roles, financial stressors, and existential distress (Adler & Page, 2017). Both patients and their loved ones typically have their own psychosocial experience of cancer, making these concerns a significant part of their lives as well.

To focus more on psychosocial issues, studies have shown that about half to two-thirds of cancer patients experience considerable psychosocial distress during the course of their illness (Zingler et al., 2025). The National Cancer Institute (2025) defines psychosocial distress as:

> *“A multifactorial unpleasant experience of a psychological (i.e., cognitive, behavioral, emotional), social, spiritual, and/or physical nature that may interfere with one's ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis” (para. 9).*

As noted in the definition, psychosocial distress is a normal response to a cancer diagnosis. Patients often experience distress around the time of their diagnosis, but as time goes on, they typically adapt and find a new equilibrium as they adjust to living with cancer. However, some people experience distress throughout their treatment. Additionally, patients who are not living with metastatic disease may experience distress again after treatment, when they are in the survivorship phase of their illness. During this time, people are usually trying to cope with the fear of recurrence, lack of control, and are trying to figure out who they are now, as well as what they want their future to look like. If a recurrence occurs, patients often experience distress during that time and typically adapt to living with the illness again (Caba et al., 2024). If a patient is living with metastatic cancer, in addition to experiencing distress at the time of their diagnosis, they may also experience it throughout treatment, at times of disease progression, and when they have transitioned to solely receiving palliative or hospice care. As the definition notes, psychosocial distress can intensify and develop into a mental health condition, such as anxiety or depression, or cause people to feel that they are in crisis at different times in their illness.

With the increasing number of people impacted by cancer and the prevalence of cancer-related distress, oncology social workers continue to be an essential part of cancer care in assessing and addressing the psychosocial needs of patients and their loved ones. Since evaluating psychosocial issues throughout the disease trajectory is a critical skill for oncology social workers, this course will review different aspects of psychosocial assessment in oncology, including the following:

- Conducting a comprehensive initial evaluation of the patient, caregiver, and/or family's biopsychosocial and spiritual needs, as well as the ongoing assessment of these needs.
- Assessing patients for common mental health concerns, such as anxiety and depression.
- Assessing and fostering coping skills, resiliency, and adjustment to the disease for patients and their support systems.
- Evaluating patients, caregivers, and/or family members' understanding of the disease, including the diagnosis itself, treatment options, and outcomes, as well as their ability to adhere to the treatment plan.
- Assessing patient risk for abuse/neglect and referring for appropriate services.

Section 1 Key Term

Psychosocial distress - an unpleasant experience of psychological (i.e., cognitive, behavioral, emotional), social, spiritual, and/or physical issues that can impact a person’s ability to cope with different aspects of a cancer diagnosis. Distress extends throughout the continuum of care, from initial diagnosis to survivorship or end-of-life, encompassing a range of common feelings to problems that can become disabling (National Cancer Institute, 2025).

Section 1 Reflection Question

What types of psychosocial distress do you see most commonly in your practice?

Section 2: Comprehensive Biopsychosocial and Spiritual Assessment

References: 5, 6, 8, 10, 11, 12, 15, 21, 23, 24, 25, 26, 28, 29, 31, 32, 35, 36, 38, 40, 42, 45, 46, 47, 49, 54, 56, 57, 58

Biopsychosocial Model of Care

Dr. George Engel and Dr. John Romano proposed the biopsychosocial model of healthcare in the 1970s to expand on the traditional medical model (also known as the biomedical model), which primarily focuses on the biological causes of disease. The biopsychosocial model of care considers the interplay of multiple components of a person’s illness, including social, environmental, psychological, and behavioral factors, in conjunction with biological aspects (Browne, 2006, p. 24). According to Madeson (2024), the model was “an attempt to emphasize the importance of understanding human health in its fullest context rather than limiting it to a biological system alone” (para. 7). One of the advantages of the biopsychosocial model is that it “maintains that health and illness are caused by multiple factors and produce multiple effects” (Taylor, 2008, p. 7). It also maintains that mind and body cannot be separated when it comes to illness, as they both influence an individual's health (Taylor, 2008).

The biopsychosocial model has clinical implications that influence the care that healthcare professionals provide. The first implication is that the process of diagnosing an illness should consider how biological, psychological, and social factors interact, examining a broader picture of the patient and the various aspects of their life. The second implication is that treatment recommendations should consider these three sets of factors, taking into account a patient’s overall health, rather than focusing solely on one aspect of it. The third implication is in the patient-provider relationship. When patients have positive relationships with their healthcare providers, it can improve their use of services and efficacy of treatment. Having an interdisciplinary team of healthcare professionals is a best practice based on these implications (Taylor, 2008).

The biopsychosocial model and its clinical implications align with the way oncology care is delivered today. Oncology social workers often work as part of an interdisciplinary team that includes oncologists, surgeons, advanced practice professionals, nurses, patient navigators, pharmacists, dietitians, and other support services (depending on the cancer center). Healthcare providers from various disciplines collaborate to consider all aspects of a patient’s life, providing comprehensive care that assesses and addresses the physical, psychological, social, and spiritual factors that may impact their cancer experience.

The biopsychosocial model was introduced around the same time that psycho-oncology was formally recognized as a subspecialty of cancer care (Holland, 2002). According to Werner-Lin and Biank (2006), “psycho-oncology is the field of study and practice that addresses the unique psychological, social, and spiritual needs of individuals, families, and communities affected by cancer” (p. 507). The biopsychosocial model is inherently interconnected with oncology care, which, in turn, recognizes psycho-oncology as a critical part of cancer care.

Studies have shown that psychosocial distress negatively impacts well-being, quality of life, and clinical outcomes (Bergerot et al., 2024). Therefore, being able to conduct a comprehensive assessment of a patient's, caregiver's, and/or family member’s biopsychosocial and spiritual needs is a considerable component of addressing distress, as well as a critical skill for oncology social workers.

Before the Biopsychosocial and Spiritual Assessment

There are some steps that an oncology social worker can take before initiating the biopsychosocial and spiritual assessment process. Depending on various factors, such as time constraints and the amount of notice given before meeting with a patient, some of these steps may not be possible; however, they can support the assessment process if they can be done beforehand.

- **Consider the purpose of the assessment** - The oncology social worker can reflect on the reason for completing the evaluation before it begins. Some examples of reasons they may be completing an assessment include:
    - A direct referral by a member of their healthcare team for a specific reason, such as emotional support or assistance with a practical need.
    - The patient scored a certain number on a distress screen or other screening tool used in the clinic or inpatient setting. It can be helpful to review the screening tool before meeting with the patient to understand their responses.
    - An assessment may be required by the oncology social worker's work setting for certain patients, including those newly diagnosed, new hospital admissions, patients starting chemotherapy or radiation treatment, candidates for a bone marrow transplant, and/or patients with a recurrence or metastatic disease.
    - The patient receives a referral from their healthcare team for therapy or refers themself for this type of support.
- **Conduct a chart review** - If the oncology social worker has access to the patient's medical chart, it can be beneficial to complete a chart review

before meeting with the patient and/or their caregiver to gather some preliminary information.

- **Discuss with other members of the healthcare team** - There are various professionals involved in the patient's care, including doctors, advanced practice professionals, and nurses. It can be helpful to discuss the patient with other team members to gather information and their impressions, as this can help inform the biopsychosocial and spiritual assessment.
    - If the patient is being seen outside of the clinic, such as in a private practice, the oncology social worker can ask the patient for permission to collaborate with their medical team and request that they sign a release of information.
- **Prepare questions in advance** - If the referral is for a specific reason, such as addressing a patient's substance use, the oncology social worker can prepare to have a particular screening or assessment tool available to support their evaluation.
- **Inform the patient in advance if a caregiver will need to be present** - If the assessment is scheduled with the oncology social worker ahead of time, or if it will take place during another appointment (such as the first chemotherapy treatment) and the patient should have a caregiver with them, the oncology social worker or another member of the healthcare team can inform the patient of this requirement so that they can prepare accordingly.
- **Consider meeting with the patient and caregiver or family member individually and/or together** - Depending on the situation and reason for the referral, the oncology social worker may want to meet with the patient

and their caregiver or family member individually and/or together to complete the assessment.

- If the referral is specifically for caregiver support, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule allows healthcare providers to communicate with a patient’s family members, friends, and other individuals involved in their care. HIPAA states the following:

  > *“When a patient is present and has the capacity to make healthcare decisions, healthcare providers may communicate with a patient’s family members, friends, or other persons the patient has involved in his or her healthcare or payment for care, so long as the patient does not object (See 45 CFR 164.510(b)). The provider may ask the patient’s permission to share relevant information with family members or others, may tell the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object. A common example of the latter would be situations in which a family member or friend is invited by the patient and present in the treatment room with the patient and the provider when a disclosure is made” (U.S. Department of Health and Human Services, n.d., p. 2).*

Psychosocial Distress Screening

As noted above, a biopsychosocial and spiritual assessment may take place after a patient has completed a distress screen in the clinic or inpatient setting. The National Comprehensive Cancer Center (NCCN), American Society of Clinical Oncology (ASCO), and the American College of Surgeons Commission on Cancer

(CoC) have all advocated for psychosocial distress screening as an accreditation standard, which has resulted in almost universal distress screening in oncology care settings throughout the U.S. There are several validated tools to screen for distress, including the NCCN Distress Thermometer, the Patient-Reported Outcomes Measurement Information System (PROMIS), the Patient Health Questionnaire (PHQ-9), and the Generalized Anxiety Disorder 7-item Scale (GAD-7).

Each organization listed above has its own recommendations for management once distress has been identified. Still, best practices include the following:

- Using screening tools that can capture distress broadly
- Screening at multiple time points
- Reviewing results promptly
- Having a trained clinician, such as an oncology social worker, follow up on positive screens to complete an assessment.
- Documenting both the assessment and interventions (American Psychosocial Oncology Society, n.d.).

The following section will discuss the different components of a comprehensive biopsychosocial and spiritual assessment.

Conducting a Comprehensive Biopsychosocial and Spiritual Assessment

The oncology social worker’s first encounter with a patient, caregiver, or family member is an opportunity to identify the psychosocial concerns that are most important to them at the time of the initial meeting. Just as in any other area of practice, the oncology social worker should start where the person is and allow them to “set the pace, define the problem, and establish their own goals” (Caba et al., 2024, p. 114). For example, a patient with metastatic cancer may be referred by their oncologist to an oncology social worker for assistance with advance care planning, also known as advance directives. However, in meeting with the patient, the oncology social worker learns that the patient is most concerned about their financial situation and their ability to continue supporting their children, as well as how to inform them about their diagnosis. Because the patient identified these as their most pressing concerns at the moment, this is where the conversation begins. However, the social worker can keep the reason for the referral in mind and address it when appropriate, based on the patient's situation.

Starting where the patient, caregiver, or family member is provides the opportunity for the oncology social worker to begin building a relationship with them. They can listen to the concerns that are most important to them, provide validation, ask additional questions to show an interest in gaining a deeper understanding of their psychosocial situation, help them prioritize their concerns, and develop an intervention plan tailored to their needs.

Because the patient, caregiver, or family member may have specific concerns to address during an initial meeting with an oncology social worker, it may not be possible to complete a comprehensive biopsychosocial and spiritual assessment within a single session. The oncology social worker may need to gather necessary information to understand the person’s psychosocial situation over the course of several sessions, as well as through ongoing assessments throughout the disease trajectory. On the other hand, there may be an opportunity to meet with a patient, caregiver, or family member to complete a comprehensive assessment during a single visit. For example, a scheduled assessment is part of a patient’s evaluation for a bone marrow transplant, during which several psychosocial aspects are explored to help determine a patient’s candidacy for the procedure.

Just as the name implies, a biopsychosocial assessment should evaluate the biological, psychological, and social aspects of a person's life. It is also beneficial to incorporate spirituality into this assessment. Assessing these areas helps an oncology social worker gain a deeper understanding of a person's strengths, vulnerabilities, and needs, all of which play a role in how they may manage and cope with their cancer diagnosis.

Biological

The biological part of an assessment involves learning more about a patient's physical health and functioning before their cancer diagnosis. It also includes exploring how the patient has been doing physically since receiving their cancer diagnosis, as well as their understanding of the disease, treatment plan, and prognosis. The latter is covered in section 5 of this course.

Learning biological information not only helps an oncology social worker understand more about the patient's life before cancer and how it has changed since their diagnosis, but it may also provide insight into how they will manage (or are managing) their current illness. It also helps an oncology social worker understand a patient's experience with illness (if any) before their cancer diagnosis, if they have co-morbid medical conditions, and if they have been compliant with aspects of their care, such as appointments and taking medications.

The biological assessment includes asking questions about a patient's past and current medical problems, including their cancer diagnosis and other health conditions they have been diagnosed with, their family health history, medications, self-care practices, and lifestyle habits.

The oncology social worker can consider asking the patient the following questions or different versions of them:

Health History

- Can you tell me about your health before your cancer diagnosis?
- Have you ever been diagnosed with a medical condition other than cancer?
- Do you have a family history of any medical conditions, or is anyone in your family currently dealing with an illness?

Medication Use

- Did you take any medications before your cancer diagnosis?
- What medications are you taking now?
- Have you had any difficulty remembering to take your medications?
- Have you ever missed taking your medications for reasons other than forgetting?

Complementary Therapy Use

- Are you currently using any complementary therapies, such as herbs, supplements, or relaxation techniques?

Activities of Daily Living

- Can you physically take care of yourself, including tasks such as bathing and dressing?
- Do you need assistance with any tasks related to self-care and/or other daily activities, such as cooking and cleaning?

Functional Status

- Do you have any hearing, speech, or visual impairments?
- Do you use any medical equipment, such as a walker or wheelchair?

- Can you engage in any physical activity, such as walking or stretching?
- What are your current sleep habits like? (A. Colver, personal communication, July 2, 2021; Biopsychosocial assessment, 2025; Madeson, 2024)

If the patient is going to need some level of caregiving throughout their cancer experience, it is also important to learn about their caregiver's health, as it may impact their ability to provide care to the patient. The oncology social worker may not need to assess a caregiver's physical health as in-depth as they do with a patient, but having some information provides them with an understanding of the patient's caregiving situation and any challenges they may face. It also allows the oncology social worker to work with the patient and caregiver to initiate the conversation (if they have not already done so) about the support they may need during the cancer experience, and to begin thinking through their options for additional assistance.

The oncology social worker can consider asking the caregiver the following questions or different versions of them:

Health History

- Do you have any physical health conditions? If yes:
    - Are you experiencing any symptoms?
    - How does it/how do they impact your daily life?
    - How often do you need to receive your own care?
    - Are you having any difficulty meeting your own health needs?

Activities of Daily Living

- Can you physically take care of yourself and your household?

- Have any physical or mental health conditions affected your ability to care for your loved one thus far?

Caregiver’s Perception of Health and Functional Status of the Patient

- Can the patient complete their activities of daily living (such as showering and dressing) and independent activities of daily living (such as shopping and managing finances) without assistance?
    - If not, what things do you assist with?
- Can the patient administer their own medications?
- Other than a cancer diagnosis, does the patient have any other physical issues? Do they have any mental health diagnoses, emotional or behavioral problems, memory loss, or cognitive impairment? (Family Caregiver Alliance, n.d.)

Psychological

Since psychological well-being impacts physical and social health, it is important to understand this part of a patient’s history and their current experience (Madeson, 2024). Research on pre-existing mental illness and cancer care is noteworthy. According to Elliott et al. (2025),

> *“Although cancer incidence rates are similar in people with and without a mental illness, it has been consistently reported that people with a mental illness have poor cancer outcomes; specifically, they are significantly more likely to die from cancer and/or survive for a shorter period following diagnosis” (p. 2).*

One study looked at over 50,000 Medicare beneficiaries diagnosed with pancreatic cancer and found that roughly 1 in 12 people (or close to 10%) had a diagnosis of a mental illness before their cancer diagnosis. Most commonly, people were diagnosed with anxiety or depression, while others had bipolar and schizophrenic disorders. Those with anxiety and depression were less likely to undergo cancer surgery, and those with bipolar or schizophrenia had a higher risk of mortality, both from all causes or pancreatic cancer, compared to those without a history of mental illness (Paredes et al., 2021). Another study looked at breast cancer patients with pre-existing mental illness and found that patients with anxiety, mood disorders, schizophrenia, psychotic disorders, and neurodevelopmental disorders were less likely to receive guideline-based treatments, including chemotherapy or radiation therapy. They were also more likely to have a mastectomy (a more invasive procedure) instead of a lumpectomy (or breast-conserving surgery that is less invasive) (Elliott et al., 2025). This issue is not unique to breast cancer patients, though, as another narrative review found that guideline-based care was significantly lower across colorectal, lung, prostate, and bladder cancer patients with pre-existing mental illness (Wang et al., 2023).

If a patient has a history of a mental health condition, their symptoms may flare up or worsen when they are under the stress that a cancer diagnosis can bring. For example, symptoms of depression, such as low motivation and feeling hopeless, may decrease their treatment adherence. As another example, patients with severe mental illness may have cognitive impairment or limited communication skills, which could result in them not understanding their diagnosis and treatment options. There may also be treatment-related aspects that trigger a prior mental health condition, including claustrophobia or anxiety when wearing a mask for some radiation treatments, or trauma associated with earlier hospital stays (Elliott et al., 2025). With all these considerations, it is beneficial for an oncology social worker to be aware of a patient’s mental health history, enabling them to provide support and advocate for the patient as needed throughout their cancer experience (Taylor, 2024).

The psychological part of the assessment includes learning about the patient's mental health history before their cancer diagnosis, including prior diagnoses, therapy experiences, psychiatric medications, and hospitalizations. It also includes assessing for substance use. Additionally, it includes assessing for any mental health concerns since the patient was diagnosed with the disease (Biopsychosocial assessment, 2025). This topic is covered in section 3 of this course.

The oncology social worker can consider asking the patient the following questions or different versions of them:

Mental Health History

- Have you ever or are you currently being treated for any mental health needs? If yes:
    - What is your diagnosis?
    - What type of mental health provider were you seeing at the time of your diagnosis?
    - Are you currently seeing a mental health provider?
        - If so, how often do you see them?
        - If not, how long has it been since your last visit?
    - Have you ever received counseling services? Are you currently receiving them?
    - Have you ever attended any self-help or support groups?
        - If so, tell me about your experience?
        - If not, is that something you are interested in?

  - Have you taken medication in the past for a mental health need?
    - If yes, how long did you take this medication?
  - Are you currently taking medication for a mental health need?
    - If yes, how long have you been taking it? Do you have any side effects?
  - Have you ever been hospitalized for a psychiatric condition?
  - Have you ever experienced any trauma, violence, or abuse? (A. Colver, personal communication, July 2, 2021; Biopsychosocial assessment, 2025; Madeson, 2024)
- If appropriate, based on the conversation with the patient, the oncology social worker may also need to assess for suicidal thoughts, tendencies, and ideations (Madeson, 2024).
  - The Columbia-Suicide Severity Rating Scale (C-SSRS) can be used to screen for suicide risk (The Columbia Lighthouse Project, n.d.).

Coping

- What are some things you do to cope with the stress of your illness and treatment?
- Do you have any concerns about how your children and/or other family members are coping with your illness? (A. Colver, personal communication, July 2, 2021)

Cultural Considerations

- Sometimes people seek help from various sources, such as doctors, helpers, or healers. In the past, have you received any type of treatment, help, advice, or healing for different problems in your life?
- Has anything prevented you from getting the help you need? (American Psychiatric Association, 2013)

Substance Use

- Do you regularly use any substances, such as tobacco, alcohol, marijuana, or other drugs? (Biopsychosocial assessment, 2025)
    - Based on the answer to this question, you can ask more about the specific substance, including the type, past and/or current use, and frequency. Screening tools can also help gather this information, including:
        - Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) - this tool combines screening and brief assessment questions for commonly used substances (National Institute on Drug Abuse, 2023).
        - The Alcohol Use Disorders Identification Test (AUDIT) and the CAGE are practical alcohol screening tools.
        - The CAGE-AID is a tool to screen for drug use (Substance Abuse and Mental Health Services Administration, 2012).

Similarly to the biological aspect of an assessment, if a patient is going to need some level of caregiving throughout their cancer experience, it is important to learn about their caregiver's mental health, as it may also impact their ability to provide care to the patient. Research has shown that caregivers with high emotional distress can have a negative impact on the patient, as they may become more distressed or anxious as a result of their caregiver's emotional state and what they are experiencing (Northouse et al., 2012). Therefore, being aware of any psychological concerns on the part of the caregiver can help support both the patient and their caregiver.

The oncology social worker can consider asking the caregiver the following questions or different versions of them. However, they should be thoughtful about how this information is documented in the patient's chart:

- Do you have any mental health conditions? If yes:
    - Are you experiencing any symptoms?
    - How does it/how do they impact your daily life?
    - How often do you need to receive your own care?
    - Are you having any difficulty meeting your own mental health needs?
- What emotions are you experiencing related to your role as a caregiver?
- How are you coping with your loved one's illness and your caregiving responsibilities? (Family Caregiver Alliance, n.d.)

Social

The social aspect of the assessment involves learning about the patient's living situation, family, other relationships, education, occupation, and cultural background. These factors play a role in physical and mental health as well as social well-being, and can impact them positively or negatively (Madeson, 2024). These factors are especially important in cancer care, as the illness often impacts many, if not all, aspects of a person's life, including how they manage their disease as well as their outcome. For example, people with limited social support may become more isolated, which has been linked to adverse outcomes, higher mortality, and worse physical, mental, and emotional functioning (Rodriguez, 2025). As another example, people experiencing financial distress may not take their medication as prescribed to save on copayments, they may miss treatments to go to work, and their overall quality of life may be lower (National Cancer Institute, 2024). Therefore, mental health providers need to assess a patient's social situation to gain a deeper understanding of it and develop appropriate interventions.

The oncology social worker can consider asking the patient the following questions or different versions of them:

Support Network

- What is your marital status?
    - If married, how long have you been married?
    - If in a committed relationship, how long have you been together?
    - If separated or divorced, how long have you been separated? How long were you together?
    - If widowed, how long ago did your spouse or partner pass away? May I ask what happened?
- Any previous marriages?
- Do you have any children and/or grandchildren?
    - If yes, ask their names, ages, and where they live.
    - Are any child care arrangements needed?

- Are your parents living or deceased? Could you tell me more about them and your relationships with them?
- How many brothers and sisters do you have? Could you tell me more about them and your relationships with them?
- Who are other supportive persons in your life, such as extended family, friends, and work colleagues?
- Who will be/is your primary caregiver?
- Are you receiving support from any social services or cancer support agencies?

Living Arrangements

- Who lives in the home with you?
- What is your home environment like? (A. Colver, personal communication, July 2, 2021; Biopsychosocial assessment, 2025; Madeson, 2024)

Cultural Considerations

- Are there any types of support that are helpful to you that we have not discussed yet?
- What are your preferences for receiving care or services from someone other than a family member or friend?
- Is there anything we can do to provide you with the support or help you need?
- Are there any kinds of stressors that make things worse for you, such as family problems, or difficulties at work or school?
- What are the most important aspects of your background or identity?

- Are there any aspects of your background or identity that are helpful to you, or are causing you concern? (American Psychiatric Association, 2013)

Interests

- What do you enjoy doing in your free time?

Education, Employment, and Financial

- What is the highest level of education you have completed?
- Do you have any military service?
    - If so, are you registered with the VA for benefits?
- What is your employment status (for example, disabled, employed, retired, stay-at-home parent, student)?
    - If disabled, are you receiving disability benefits through your employer or Social Security? If not, have you applied for these benefits?
    - If employed, do you have access to short-term and long-term disability benefits? Are you eligible for family medical leave (FMLA)?
        - Have you applied for any of these benefits?
    - If retired, stay-at-home parent, or student, what is your source of income?
- What type of work do you/did you do?
- Do you have health insurance coverage and prescription drug coverage?
    - If so, what type?
    - If not, do you need assistance with exploring insurance options?

- Do you have any financial concerns? If so, can you tell me more about them?
- Are you currently receiving financial assistance from any program or organization?

Legal Concerns

- Do you have any legal concerns?

Advance Directives

- Have you completed your advance directive documents, including a healthcare power of attorney and living will?

Health Literacy

- Do you have difficulty understanding medical instructions or other written information you receive from your doctor or pharmacy?
- Do you struggle to complete medical forms independently?

Other Information/Concerns

- Is there any other information that you would like to share? (A. Colver, personal communication, July 2, 2021; Biopsychosocial assessment, 2025; Madeson, 2024)

It is also helpful to learn about the caregiver's social situation and the practical impact that caregiving is having on them. Caregivers can experience additional burdens and/or burnout if they have limited social support and are also dealing with other practical stressors, such as work or financial concerns (Cleveland Clinic, 2023a). Therefore, being aware of the caregiver's social situation can help support both the patient and their caregiver.

The oncology social worker can consider asking the caregiver the following questions or different versions of them:

Relationship with the Patient and Living Situation

- What is your relationship to the patient?
- How long have you been caring for them?
- Do you live in the same household?
    - If the caregiver lives separately from the patient and will be receiving care at their home:
        - What is your home environment like?
        - Who lives in the house with you?
- What have been the positive and negative aspects of caregiving when it comes to your relationship with the patient?

Cultural Considerations

- Do you feel obligated to provide care?
- What type of care arrangements are considered normal in your family? For example, if your loved one needed home health care services, would this be acceptable?
- What are your preferences for receiving care or services from someone other than a family member or friend?

Support Network

- What is your social support network like?
- Can you rely on your support network for help?

- Are other family members or friends involved in the patient’s care?
    - If so, do you agree or disagree with any care issues that have come up?
- Are you currently receiving any support from community resources/ programs/services?

Employment and Financial

- What is your employment status (for example, disabled, employed, retired, stay-at-home parent, student)?
- Do you face any work-related challenges due to your caregiving role?
- Do you have any financial stress because of your caregiving role? (Family Caregiver Alliance, n.d.)

Spiritual

According to Mattison et al. (2024), the spiritual aspect of a biopsychosocial-spiritual assessment is a “foundational component of oncology and palliative care” practice. However, it is often missed in the assessment process. It is important to consider that patients may have certain experiences with religion or spirituality that predate their cancer diagnosis, or it may be something that they decide to explore or continue to practice after their life-changing cancer diagnosis. Additionally, for some people, their religion and/or spirituality may help them cope with their illness and provide them with a sense of comfort or hope. In contrast, others may feel hurt, confused, or conflicted by religion and/or spirituality, and they may want to process these feelings after their diagnosis.

Before assessing this aspect of a person's life, it is essential to understand the differences between religion and spirituality. The following chart outlines each concept:

Religion	**Spirituality**
Institutionalized beliefs and codes of conduct	Individually defined, personal, inner experience
Possible affiliation with an organized community	Not always focused on a particular faith group
Belief in superhuman power	Focused on meaning, purpose, and wholeness beyond the body and mind, including the spirit
Outward expression of spirituality through actions that involve worship, rituals, and gatherings	Connectedness and relationship with the self and something larger, such as other people/community, energy, or the universe

(Mattison et al., 2024; National Center for Cultural Competence at Georgetown University, n.d.)

Next, it is important to understand the relevance of religion and/or spirituality in a person's life. As noted above, these concepts can be helpful coping mechanisms. Research has shown that they can also influence healthcare decisions that ultimately impact treatment and care. Additionally, some people who are facing a cancer diagnosis, including those that may be terminal, can have existential questions and concerns that they hope to process and possibly answer. Existential concerns are often related to the meaning of life, the purpose of suffering, and the uncertainty that accompanies it. Being able to assess a person's religion and spirituality can help provide a more comprehensive picture of their life and how these concepts may influence their cancer experience (Mattison et al., 2024).

The following are spiritually focused questions that oncology social workers can use to assess an individual's beliefs and experiences. They are encouraged to ask these questions as "a part of a narrative framework with a genuinely conveyed 'tell me more' attitude that allows patients to use whatever diverse terms they choose to tell their stories and enhances mutual understanding of the patient's worldview" (Mattison et al., 2024, p. 158).

- "Do you have any spiritual, religious, or philosophical beliefs that are important to you?
- Who or what comforts, encourages, or helps you have hope?
- What helps you when you are afraid or in pain?
- What are you still hoping to experience or get out of life?
- What do your beliefs say about trials, suffering, sickness, and hope?
- Tell me about any practices or rituals you do that are helpful right now" (Mattison et al., 2024, p. 158).

Oncology social workers can also use spiritual assessment tools to gain a deeper understanding of a patient's beliefs. They can use the questions in this tool during a semi-structured interview, focusing on the existential aspects of spirituality, including expression and values. The FICA Spiritual History tool has been extensively researched and demonstrated to be a useful clinical assessment tool (Borneman et al., 2010; Henry & Gilley, 2024). Compared to the questions listed above, the FICA more directly asks whether a person considers themselves spiritual or religious, what beliefs give them meaning, and if those beliefs also help them cope. It also inquires about the importance of spirituality or religion in a person's life, including how these beliefs play a role in regaining their health. There are questions about being part of a spiritual or religious community, and if so, whether it is supportive and, in what ways. In the area of community, it also asks a person if there is a group of people that they really love or that are important to them. Lastly, there is a direct question about how the person would like their healthcare providers to address any identified issues in their care (Borneman et al., 2010).

When assessing the religious or spiritual beliefs of caregivers or family members, a spiritual assessment tool specific to this population was not identified in a literature search. However, one study demonstrated that the Spiritual Perspective Scale was validated in cancer caregivers (La et al., 2020). A oncology social worker can use the questions in this tool during a semi-structured interview, focusing on the existential aspects of spirituality, including expression and values. The scale was designed to measure the level of agreement with statements about spiritual beliefs (ranging from "strongly disagree" to "strongly agree") and the frequency of engaging in spiritual activities (ranging from "not at all" to "once a day"), all to help professionals understand an individual's spiritual perspective (Delaney, 2005).

Some of the questions listed above can also be used when speaking with caregivers or family members to gain insight into their beliefs. Oncology social workers could also explore how their beliefs have influenced their role as a caregiver, and what is important to them when it comes to support for themselves and their loved one, not only from a spiritual perspective, but also when it comes to other aspects of care, such as the physical, psychological, and social.

Ongoing Assessment of Biopsychosocial and Spiritual Needs

After the oncology social worker has completed the assessment process, they can work together with the patient, caregiver, or family member to identify their strengths as well as any issues they may face throughout the cancer experience. The oncology social worker will develop a psychosocial care plan based on the assessment. Then, they can engage in ongoing assessment by asking follow-up questions over time to gather additional information about how the biological, psychological, social, and spiritual aspects are affecting the cancer experience. Based on this information, they can make adjustments to the psychosocial care plan to accommodate the progress of the initially identified needs, as well as to address any new needs that may arise.

Section 2 Key Terms

<u>Biopsychosocial model of care</u> - considers the interplay of multiple aspects of a person's illness, including social, environmental, psychological, and behavioral factors, in conjunction with biological factors (Browne, 2006, p. 24).

<u>Interdisciplinary healthcare team</u> - a group of professionals with diverse training and expertise who collaborate on patient care and work towards shared goals.

<u>Distress screening</u> - a process in cancer care that uses validated tools to identify psychological, emotional, social, and practical problems that may impact a patient's well-being throughout their cancer experience.

Section 2 Reflection Questions

1. What is your experience completing biopsychosocial and spiritual assessments for patients, caregivers, and or family members?
2. What have you found to be helpful to the assessment process? What have you found challenging with completing assessments in your role?

Section 3: Assessing for Anxiety and Depression

References: 12, 14, 33, 46

According to Naser et al. (2021, as cited in Caba et al., 2024), approximately 30% of cancer patients have symptoms of anxiety, and about 25% experience symptoms of depression. As noted in the section above, oncology social workers need to assess for any pre-existing mental health conditions that a patient may have had before their cancer diagnosis, as well as mental health symptoms, such as those that are related to anxiety and depression, after being diagnosed with the disease. As outlined above, mental health conditions can have a significant impact on the cancer experience; therefore, it is crucial to assess and address any mental health needs.

Anxiety

As noted in Taub et al. (2024), worry and fear are common emotions that accompany patients throughout the disease trajectory, as these are normal responses to a life-threatening illness. Screening for anxiety and emotional distress throughout the course of the disease is vital in identifying patients who need additional assessment, intervention, and support from an oncology social worker (Caba et al., 2024).

In a previous section of this course, tools for screening emotional distress were noted, including the GAD-7 for anxiety. Additional screening tools for cancer-related anxiety include the Brief Symptom Inventory, Hospital Anxiety and Depression Scale, and State-Trait Anxiety Inventory. While cancer centers may have different practices for screening for anxiety, if a patient's responses indicate they may be experiencing the condition, an assessment from an oncology social worker should follow. Oncology social workers can also assess for anxiety symptoms as they get to know their patients over time and work with them throughout their cancer experience.

A patient may have anxiety related to their cancer diagnosis, or it may be secondary to something else cancer-related, such as uncontrolled pain or a medication side effect. Therefore, using an appropriate screening tool, like the ones noted above, and conducting a thorough assessment are necessary to make an accurate diagnosis (National Cancer Institute, 2025). The National Cancer Institute (2025) recommends using a screening tool, and when the cutoff score is exceeded, following up with the patient to complete a thorough biopsychosocial assessment and asking questions to understand how much anxiety symptoms are impacting their ability to function in day-to-day life.

Patients can have various anxiety disorders, though general anxiety, phobias, and panic disorder typically predate the cancer diagnosis and can resurface or worsen after a diagnosis. Therefore, completing a thorough assessment of current symptoms and obtaining an understanding of a patient's mental health history can aid in making an accurate diagnosis. According to the National Cancer Institute (2025), one challenge to diagnosing anxiety after a cancer diagnosis is that the "normal fears and uncertainties associated with cancer are often intense. Frequently not clear is the distinction between normal fears and fears that are more severe and reach the criteria for an anxiety disorder" (p. 50). When assessing current symptoms, some are more common, while others are more severe. The more severe symptoms include:

- Constant worry
- Unable to concentrate
- Cannot turn off thoughts most of the time
- Trouble falling asleep or waking up early

- Frequent crying spells that interfere with daily activities
- Feeling fearful and apprehensive most of the time
- Physical symptoms - restlessness, dry mouth, feeling keyed-up
- There are minimal to no ways to reduce anxiety

An oncology social worker may consult one of their colleagues, such as a psychiatrist or palliative care specialist, to also assess the patient and provide support in making the diagnosis and determining the treatment plan. Some effective psychosocial interventions include cognitive behavioral therapy (CBT) and relaxation exercises, such as meditation or guided imagery. Patients may also benefit from pharmacologic interventions (National Cancer Institute, 2025). Therefore, a referral psychiatrist or palliative care provider can help determine the type of interventions that are most suitable for the patient.

Depression

As noted in Caba et al. (2024), feelings of loss and sadness are common at the time of a cancer diagnosis, while depression can negatively impact a patient's quality of life and treatment outcome. Similar to anxiety, screening for depression and emotional distress throughout the disease trajectory is vital in identifying patients who need additional assessment, intervention, and support from an oncology social worker (Caba et al., 2024).

In a previous section of this course, tools for screening emotional distress were noted. Additional screening tools for cancer-related depression include the Brief Symptom Inventory, Hospital Anxiety and Depression Scale, and the Zung Self-Rating Depression Scale (National Cancer Institute, 2025). While cancer centers may have different practices for screening for depression, if a patient's screening indicates they may be experiencing the condition, an assessment from an oncology social worker should follow. Oncology social workers can also assess for depression symptoms as they get to know their patients over time and work with them throughout the disease trajectory.

One challenge in determining the need for psychosocial support in patients with cancer and depressive symptoms is that there can be an overlap in the physical effects of the disease and/or treatment (for example, fatigue and appetite changes) and symptoms of depression (Caba et al., 2024). Caba et al. (2024) state, “while a patient’s initial emotional distress may be normal and expected, major depression may be considered as a differential diagnosis when specific clinical criteria are met as indicated in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*” (p. 112). Therefore, being able to assess depressive symptoms requires an understanding of this diagnostic criterion, cancer itself, and its treatments.

Major depressive disorder is one of the most common types of depressive disorders. It is a chronic condition that typically presents in episodes lasting weeks or months. Typical symptoms include the following:

- Feeling sad, empty, or hopeless more days than not
- Losing interest in enjoyable things and everyday activities
- Changes in appetite that cause significant weight loss or weight gain
- Decreased energy or increased fatigue
- Changes in sleep, by either sleeping too much or not enough
- Trouble concentrating and making decisions
- Slower speech or movement
- Feeling guilty or worthless

- Having thoughts of death or recurrent suicidal ideation without a plan or attempt

  (Cleveland Clinic, 2022)

According to Valentine (2014, as cited in Caba et al., 2024), “major depression is correctly diagnosed when the symptoms are not due to medications (including cancer treatments), metabolic abnormalities, pain, or tumors in the brain, (or brain metastases)” (p. 112). While an oncology social worker can assess for depression based on their understanding of the symptoms, the cancer itself, and the side effects from treatment, they may need guidance from a psychiatrist, palliative care provider, or neurologist with experience in oncology to make the diagnosis and develop the treatment plan (Caba et al., 2024). Based on the oncology social workers' knowledge of cancer and depression, as well as their assessment and understanding of the patient’s situation, they can use their clinical judgment to make referrals to additional supportive services.

According to Taub et al. (2024), “depression symptom management may involve a combination of therapeutic intervention, and medication management and can be guided by ASCO’s guidelines for depression that rely on the use of the PHQ-9” (p. 132). Various therapeutic modalities have shown efficacy in managing cancer-related depression, including cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and dignity therapy (Li, 2016, as cited in Taub, 2024).

Section 3 Reflection Questions

1. What has been your experience working with patients who have pre-existing anxiety and depression?
2. With the challenges in diagnosing anxiety and depression after a diagnosis, what have you found helpful in your practice?

Section 4: Assessing and Fostering Coping, Resiliency, and Adaptation Skills

References: 3, 9, 20, 32

As noted earlier in this course, it can be beneficial for an oncology social worker to learn about a patient's life before their cancer diagnosis. This information can help them gain insights into what life was like before and what it is like now, not only in terms of physical functioning, but also in terms of mental, emotional, and spiritual well-being. One thing in particular that is helpful to learn about in the assessment process is how patients and their loved ones have coped with other challenges or losses in their lives, as a cancer diagnosis may bring up similar themes, yet in a different form. For example, if a patient was acutely or chronically ill before their cancer diagnosis, or if they have had a recurrence, they may have developed coping strategies for dealing with an illness. As another example, they may have experienced other difficult life experiences that they needed to cope with, such as the loss of independence, relationships, or a job, for example, without having an illness. Additionally, they may have struggled with their identity as a result of these experiences. All of this is valuable information when considering how to foster coping, resiliency, and adaptation skills after a cancer diagnosis.

Coping is considered a "broad concept used to describe a wide variety of cognitive and behavioral strategies to manage situations or emotions that are either internally or externally overwhelming" (Dev et al., 2023, p. 166). In cancer, it can be beneficial to assess coping at various time points, including diagnosis, active treatment, post-treatment, recurrence, progression, and survivorship (National Cancer Institute, 2025).

Folkman and Lazarus have classified coping into four groups:

- **Problem-focused** - thinking about how to deal with the problem and taking action, or avoiding it.
- **Emotion-focused** - trying to reduce negative emotions related to the problem, such as reframing, humor, acceptance, and religion, or avoiding the emotions.
- **Support-seeking** - asking for help from others, including emotional and practical support.
- **Meaning-making** - using cognitive strategies to try to make sense of the meaning of the situation (Algorani & Gupta, 2023).

Within these groups, coping strategies are identified as healthy (positive, adaptive, or engaged) or unhealthy (negative, maladaptive, or avoidant). Research has shown that people respond to a stressful event, such as a cancer diagnosis, in complex ways. They often employ various coping strategies, using multiple ones simultaneously, and adjust them over time (Algorani & Gupta, 2023).

The Brief COPE Questionnaire, the Cancer Coping Questionnaire, and the Cognitive-Emotional Coping with Cancer scale have been utilized in studies and practice to gain a deeper understanding of how individuals cope with stressful situations (Dev et al., 2023). Oncology social workers may also use these tools in a semi-structured, focused interview to gain a deeper understanding of a patient’s coping mechanisms. In addition to using screening tools, when getting to know a patient, the oncology social worker can consider asking the following questions or different versions of them:

- Do you see this illness creating any problems? If so, what are they?
- How do you see yourself dealing with them?

- Who do you turn to for support or help? (Weisman, 1979, as cited in Blum et al., 2001)
- When you experienced something difficult in your life before your cancer diagnosis, how did you deal with it? How did it work out?
- How have you been coping since your diagnosis? Are there any strategies that you have found helpful?

Once the oncology social worker has learned about the coping strategies that have been beneficial to the patient, they can work with them to develop and foster these skills, building resilience and helping them adapt to their cancer diagnosis. For example, if a patient has found journaling helpful in processing experiences throughout their life, they can work with the patient on ways to continue journaling, even if they are not feeling up to it at times. As another example, if a patient finds connecting with friends helpful but feels more isolated due to their illness, they can offer suggestions to help the patient still connect with their friends, even if it looks different after their diagnosis. Building on existing coping strategies, or teaching new ones, can help patients manage their distress, solve problems, and feel more in control. These ideas can also apply to caregivers, as they may also need support in coping with their loved one's illness.

As the oncology social worker and the patient, caregiver, or family member create or build on existing coping strategies, the oncology social worker should continue to assess how these strategies are working for them and whether they feel the need to explore different ones. It can be helpful to assess coping at different time points, such as at diagnosis, during active treatment, post-treatment, recurrence, progression, and survivorship (National Cancer Institute, 2025).

Section 4 Key Terms

Coping - a broad term that is used to describe thoughts and behaviors that patients and caregivers use to adjust to a cancer diagnosis.

Section 4 Reflection Questions

1. What coping strategies have you found most beneficial to patients and caregivers?
2. What have you used in your practice to help people cope and adjust to their illness? For example, a strengths-based perspective.

Section 5: Assessing Understanding of a Cancer Diagnosis and Treatment Adherence

References: 9, 13, 22, 41, 50, 51

Cancer encompasses a wide range of diseases and treatment options that continue to evolve and change over time. According to Blum et al. (2001), an oncology social worker must understand cancer-related concepts, including stage, local versus systemic treatments, and the associated risks and benefits of treatment. It is also beneficial for them to have a vocabulary that includes terms to describe diagnostic tests, various types of cancer, and treatments such as chemotherapy, radiation, and hormone therapy. Blum et al. (2001) state that the oncology social worker “who is knowledgeable about the treatment for and prognoses of specific types of cancer is better able to help patients set priorities, make choices, and experience a greater sense of control” (p. 52). Blum et al. (2001) also state that interventions, particularly those of an oncology social worker, “must be based on an understanding of the patient’s specific cancer diagnosis and treatment plan, as well as on the patient’s emotional and social situation” (p. 53).

If an oncology social worker works in a medical setting, they can learn cancer-related information by reviewing patient charts and attending multidisciplinary rounds. They can also participate in patient and family meetings where information is being delivered by a doctor or advanced practice professional, as this can help them understand both the medical information and what the patient is being informed of. Outside of the medical setting, many cancer-related organizations offer educational materials and continuing education opportunities. Professional conferences are another way to learn information and connect with other oncology professionals.

Assessing Understanding of a Cancer Diagnosis, Treatment Options, Side Effects, and Outcomes

Research has shown that when patients have the knowledge and tools they need to understand their condition, make informed decisions, and take action, they are more likely to stay on track with their care and have better health outcomes. The impact of truly understanding their condition, available treatments, and how to manage their care includes improved engagement, better treatment adherence, informed decision-making, increased trust in their healthcare team, earlier diagnosis and treatment, and lower readmission rates (Carter, n.d.).

Oncology social workers play a crucial role in assessing patients' understanding of their diagnosis, treatment options, potential side effects, and expected outcomes. The following are example questions that an oncology social worker can ask a patient to assess their understanding of their cancer diagnosis:

Understanding the Diagnosis

- Tell me about how you were diagnosed with cancer.
  - How was the cancer found?
  - How were you feeling at the time?
  - Were you experiencing any symptoms or issues that concerned you?
- What have you been told about your condition?
- What is your understanding of your illness? Are there certain things that you do not understand? Would you like to learn more about them?
- Where is the cancer in your body? Has it spread?
- Did the doctor say whether the cancer was found early or late?
- What types of symptoms are you having now, if any? How are they impacting you?
- What is the next step in your care plan? Will there be any steps after that?

Understanding Treatment Options and Side Effects

- What kind of treatment(s) did the doctor recommend for you?
  - For radiation, chemotherapy (oral or intravenous), and other targeted therapies (oral or intravenous), will you come to the cancer center for treatment, or is it something you can do at home?
- How often will you have appointments?
- How will the treatment make you feel?
- How will it impact you in the day-to-day?

- Will you be admitted to the hospital during your treatment?
- Do you have any concerns or questions about the treatment and its side effects?
- How often will you have a scan and/or follow-up tests?

Understanding Prognosis

- Did you and the doctor talk about your prognosis (how long you will live)?
- What is the goal of the treatment? Will it eliminate all the cancer, or prolong your life by slowing its growth?
- How does this illness impact any plans you have for the future?
- What do you think is likely to happen in the coming months or years?

Other Questions

- What is your understanding of what is happening currently?
- Is there anything about your condition that you would like to know more about?
- What is most important to you right now?
- What are your fears or worries about the future?
- What are your goals?
- What activities would you still like to do given your condition?
- Are there things you are hoping for?
- If your health gets worse, what are your most important priorities?

- Are the people who are closest to you aware of what is happening and what is important to you?
- Are there any other topics you would like to talk about that we have not covered yet?
- Do you have any questions for me or the doctor? (Blum et al., 2001; Duke NUS Medical School, n.d.; Prakash, 2019; Tu et al., 2025)

Oncology social workers can use some of these questions and adapt others when speaking with caregivers, family members, or loved ones. Since social support is critical in oncology care, it is essential to assess the understanding of those who will provide support to the patient and be involved in their care.

Assessing Treatment Adherence

As noted in the section above, patients are more likely to adhere to their treatment when they understand their illness and the treatment options available to them. However, this is not the only factor that is linked to adherence. Having the financial resources and insurance coverage to afford costs related to the disease and managing it has also been associated with improved adherence. Additionally, having emotional support and help from family members or friends is also linked to more adherence to treatment.

Studies have yielded mixed results regarding patient characteristics, such as age, ethnicity, education level, and psychosocial factors, including emotional states and optimism, in relation to treatment adherence (Theofilou & Panagiotaki, 2012). However, Theofilou & Panagiotaki (2012) have noted the following key reasons for patients not adhering to their treatment plan:

- Poor health instructions

- Poor memory
- Low health literacy
- Inability to afford medications or care
- Inadequate social support
- Depression
- Cultural factors
- Health beliefs
- Patient’s personality traits
- Poor relationships between the patient and their healthcare provider
- Disagreement between the patient and the healthcare professional about the need for treatment

Since many different factors can impact adherence and non-adherence, the oncology social worker can conduct a biopsychosocial and spiritual assessment, alongside asking questions that assess a patient’s understanding of their disease. Having a comprehensive understanding of the patient’s psychosocial situation and any concerns related to their treatment plan can help the oncology social worker identify which aspects of a patient’s life may facilitate adherence to their treatment and which aspects may require intervention or support. If the oncology social worker is unable to complete a full psychosocial assessment due to various reasons, such as time constraints, they can ask focused questions related to the patient’s treatment plan and any barriers the patient may be experiencing in adhering to it. For some patients, the need for help with transportation to appointments or financial assistance may be a concern, while for others, several factors may need to be considered and addressed.

Section 5 Reflection Questions

1. What questions do you find most helpful in assessing a person's understanding of cancer? Do you find it helpful to assess understanding at different points in time?
2. What are the most significant barriers to treatment adherence that you have experienced in your practice?

Section 6: Assessing for Abuse and Neglect

References: 2, 16, 27, 30, 37, 39, 44, 52

Various factors can contribute to a cancer patient's risk of neglect, financial exploitation, and physical, emotional, and sexual abuse. The nature of the disease itself and side effects from treatment can make people more physically dependent on others because they may be ill, frail, or weak. Not only do these issues cause physical dependence, but they also lead to patients spending more time at home with a caregiver and becoming more isolated from other people. Patients may also be mentally and emotionally dependent on others for support because of the psychological impact of the illness. Additionally, patients may become more financially dependent on others due to a loss of income or the need for insurance coverage. All of these things cause patients to be more vulnerable to abuse or neglect, either starting or making already existing issues worse (Marie Curie, 2025).

Older Adults

Older patients may be more dependent on others for help with activities of daily living, both inside and outside the home. They may also require assistance with transportation to medical appointments and other aspects of managing their illness. In addition to cancer, they may have multiple comorbidities, take several different medications, experience malnutrition, and have cognitive dysfunction, all of which increase the risk of elder abuse. While prevalence statistics for elder mistreatment in cancer were limited, one study showed that close to 40% of patients aged 70 and older who received outpatient care were at risk for elder abuse based on their sociodemographic characteristics (Akagunduz et al., 2021).

Women

Studies in women with cancer have shown that they are at an increased risk of domestic abuse based on several factors. In addition to being physically vulnerable because of cancer symptoms and treatment side effects, cancer may have different impacts on women because of changes to their body image and sexual functioning, which can affect their partner relationships as well as their mental and emotional health. In general, they may be more financially dependent on their partner, which can worsen due to the financial strain that a cancer diagnosis can cause. Furthermore, they may have challenges managing family issues due to decreased time and energy, which may cause domestic abuse to occur.

One review looked at 24 studies on intimate partner violence (IPV) and found that 6% to 54% of women with cancer experienced IPV during the time of their illness. These rates are significantly higher than those of men with cancer, in which 2 to 15% experienced IPV.

Risk factors for IPV in these studies included being younger, as well as having lower education and income levels. In addition to these risk factors, women experiencing IPV reported:

- Poor overall well-being
- Lower life satisfaction

- Inadequate social support
- Dissatisfaction with relationships
- Isolation from family and friends
- High levels of pain
- Psychological symptoms associated with stress, anxiety, and post-traumatic stress disorder
- Control by their partners over intimate parts of their lives
- Sexual concerns in their relationship
- Higher incidence of binge drinking and smoking
- Higher use of illegal drugs

Women were also more likely to be diagnosed with breast or cervical cancer and have multiple co-morbidities. Additionally, they were more likely to make poor treatment decisions, delay treatment, and have disease progression (Ni et al., 2024).

Informal Cancer Caregivers

Informal caregivers can also experience significant distress related to another person's cancer diagnosis. For example, they likely have additional responsibilities in caring for another person, and they may not have received adequate training or preparation for these roles. The amount of care required can be very challenging as cancer patients typically need assistance with some combination of personal care, meals, housework, shopping, mobility, transportation, communication, emotional support, and help managing their own illness. In addition to having someone be dependent on them, caregivers may have their own physical and/or mental health issues or be experiencing burnout. Their social support may be limited, and they may become more isolated. Additionally, they may feel burdened by their work or financial situation (Girgis et al., 2012). All of these factors can take a toll on caregivers and make them more susceptible to being abusive or neglectful, or can worsen these already challenging behaviors.

The Role of the Oncology Social Worker

Knowledge and Understanding

Oncology social workers should have an understanding of the factors that contribute to abuse, neglect, and financial exploitation, as well as the types of things that cancer patients typically report when they are in these situations. They should also be aware of the warning signs of abuse and neglect, including:

- Physical
    - Injuries that do not make sense or match the explanation of what occurred
    - Repeated injuries or injuries to multiple sites
    - Bruises (including those in hidden sites)
    - Wounds (including those that are at various stages of healing)
    - Basic needs are not being met
    - Being unclean
    - Having medication errors or missing medications
- Behavioral
    - Becoming quieter, angrier, or more withdrawn/isolated

    - Being hesitant to speak openly
    - Having symptoms of depression or anxiety
    - Being unusually friendly or happy
    - Appearing scared or anxious around certain people, often a caregiver
    - Not wanting to be left by themself or alone with a particular person
    - Abusing substances or using an eating disorder as a coping mechanism
- Financial
    - Having less money than normal
    - Not having access to their own money
    - Missing funds
    - Partner withholding financial resources

In older adults, there are additional warning signs, including:

- Physical
    - Fractures
    - Pressure sores
    - Malnutrition and dehydration
    - Untreated medical issues
- Behavioral
    - Confusion

    - Increased dependency
- Financial
    - Abrupt changes to wills or property transfers (Marie Curie, 2025; Ohio Department of Health, 2012; Social Work Test Prep, 2024)

Assessment of Abuse and Neglect

There may be different scenarios when it comes to assessing for abuse and neglect. For example, if an oncology social worker is meeting with a patient to conduct a psychosocial assessment and there are no identified concerns about abuse or neglect prior to the evaluation, they can still include questions about these issues and normalize them as part of the assessment process. They can ask about a patient's safety at home, if anyone is physically or emotionally hurting them, if they have ever been threatened or felt controlled, and if abuse is a problem for them in any way UNC Medical Center, 2021). They can also ask about any past or current experiences of trauma.

As another example, if abuse or neglect is suspected either by the oncology social worker or another healthcare provider, the oncology social worker should conduct a psychosocial assessment and ask specific questions related to these issues. The Ohio Department of Health (2012) recommends being honest with the patient and explaining the reason why abuse and neglect are being inquired about. The oncology social worker should review confidentiality with the patient, including what their state laws outline regarding what must be reported versus what should not be reported. The evaluation should also take place in a private space with no one else present in the room. It can be beneficial to the assessment process to approach the patient with compassion and patience as well.

Some questions to start the assessment about abuse or neglect include:

- How are things going at home?
- You seem worried. Is there something you would like to discuss?
- How can I help support you? (Marie Curie, 2025)

When assessing for domestic abuse specifically, the oncology social worker can also ask non-threatening questions about the patient's partner and/or caregiver. Some examples of these questions include asking if the person is supportive, if they give the person time and space with family and friends, what the cancer diagnosis has been like for both of them, what stressors they are experiencing, and their coping mechanisms, for example. If the patient discloses abuse, their immediate safety should be assessed. This evaluation can include asking if they are in immediate danger, if the abuse is escalating, if they have been threatened, if the person has access to weapons, if there are children in the home who are at risk of being harmed, and how they keep themself (and others) safe (Ohio Department of Health, 2012).

The patient may not disclose abuse, neglect, or share everything in the first conversation. In that instance, assessing for immediate safety should be done at a minimum. It can be beneficial to build a relationship with a patient over time through smaller, more frequent conversations, which helps them feel more comfortable and open to sharing their experience. As the relationship is built and more information is learned, the oncology social worker can ask further, more specific questions about what is happening in their home, as well as with their safety, relationships, behaviors, and finances, which can help to address the warning signs outlined above (Marie Curie, 2025).

Intervention

If abuse or neglect is suspected or identified in an older adult, the oncology social worker should consult the laws in their state, which likely require them to report the incident to adult protective services (APS) for further assessment and intervention. If an older patient is in immediate danger, the oncology social worker should notify local law enforcement first (Cleveland Clinic, 2023b). The oncology social worker should inform the healthcare team, coordinate care with APS as needed, and continue to assess the situation at follow-up visits.

If domestic abuse has been identified, the Ohio Department of Health (2012) recommends discussing the importance of a safety plan and assisting them with one. They also recommend reassuring patients about confidentiality and explaining its limits, assuring the patient that their caregiver will be treated no differently, affirming that it takes courage to discuss this complex topic, and telling them that they are not alone. They can also offer to connect them with resources for support and assistance.

Section 6 Reflection Question

Think about a time when you needed to report elder abuse or worked with someone who was being abused or neglected by their caregiver. How did you handle that situation?

Section 7: Case Study

Cindy is a social worker in a bone marrow transplant program. Each patient who is a candidate for transplant is required to have a comprehensive biopsychosocial and spiritual assessment to help determine their appropriateness for the procedure. Since patients are also required to have a caregiver for a certain amount of time afterwards (based on the type of transplant and the cancer center’s requirements), Cindy meets with caregivers, either alongside the patient or individually, as part of her role. She assesses whether any biopsychosocial concerns may impact their ability to care for the patient.

Cindy recently met a young adult male patient with relapsed non-Hodgkin Lymphoma, who, based on her assessment using the questions in section 2 above, is an appropriate candidate for transplant. The patient's mother and identified caregiver accompanied him during the assessment. During the appointment, Cindy met with the patient and his mother together and began identifying concerns about the patient's mother, as she appeared very overwhelmed throughout the meeting. Cindy was concerned that the patient's mother may already feel overburdened with responsibilities, and the transplant caregiving role would only add more to her. Cindy decided to ask the patient if she could meet with his mother individually to complete a more in-depth caregiver assessment, to which the patient agreed.

During this evaluation, Cindy completed a caregiver assessment using the questions in section 2 above. She learned that the patient's mother has already been caring for her son for quite some time, both during his initial diagnosis and since his relapse. He has been quite ill from chemotherapy and has required a great deal of support, more than she was initially anticipating. He has also been admitted to the hospital for fevers and infections. She is concerned that her son is depressed, as she feels he is becoming more isolated and less hopeful about his health. She shares that he has felt discouraged by some of his setbacks, but is hopeful about the transplant and the outcome he will have from it.

Cindy also learned that, in addition to her caregiving responsibilities, the patient's mother works full-time and has a teenage daughter at home. She is the primary person responsible for caring for both of her children, spouse, and other family members as needed. The patient's mother is concerned about taking on more responsibility and additional time off work. She has been feeling overwhelmed by the situation and her emotions, and is unsure of what to do next.

Section 8: Case Study Review

Cindy took the appropriate approach by meeting individually with the patient’s mother/caregiver to learn more about the family’s psychosocial situation as well as how things have been going for her in all of her different roles. Now that Cindy has a better understanding of the patient and family psychosocial situation through the assessment process, she can intervene appropriately and work with the patient to develop a transplant caregiving plan that includes more support from other family members. She also works with the patient’s mother on prioritizing and developing coping strategies to better manage herself during her son’s illness. She plans to continue to assess the patient and family situation throughout the transplant process.

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