Mindful
Continuing Education

Clinical Intervention in Oncology Social Work

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Section 1: Introduction

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The History of Oncology Social Work

Oncology social work has been a specialty within medical social work for over 40 years. Several historical events led to its development and recognition as a distinct profession.

First, in the 18th and 19th centuries, hospitals became established in large American cities, including Philadelphia, New York, Boston, and Baltimore. Next, in the 20th century, more hospitals were being built throughout the country, mainly to address the growing need to manage infectious diseases. Early in the 20th century, from 1905 to 1915, social workers were hired into more than 100 hospitals across America, including Ida Cannon, one of the most noteworthy medical social workers in history (Fobair et al., 2009).

Cannon spent 40 years of her career at Massachusetts General Hospital (Mass General), establishing the first hospital-based social work program in America and advancing the profession nationwide in immeasurable ways (Massachusetts General Hospital, n.d.). She worked to promote “the expansion of the social work role in the hospital and the inclusion of the social perspective as a regular part of the medical treatment plan” (Massachusetts General Hospital, n.d., para. 9). Today, this is known as interdisciplinary care, a foundation of cancer care.

In addition to creating a social work department at Mass General that combined sound clinical practice with advocacy and community service, Cannon and her colleague, Dr. Richard Cabot, a senior physician at Mass General, developed and implemented systems to measure social work interventions and document them in medical charts. Furthermore, Cannon hired Harriett Bartlett, the department’s first education director, to create programs that helped medical social workers further define their role and the quality of their work, while also broadening their professional growth. Throughout her career, Cannon was instrumental in developing several national health care and social services programs, as well as a standardized training program for medical social workers at the Boston School of Social Work (Massachusetts General Hospital, n.d.). She was also a founding member of the American Association of Hospital Social Workers. Cannon was a true pioneer in the field from the time she entered it. She was also an early role model for oncology social workers today.

In the late 1930s and early 1940s, there became a growing interest in health issues, including cancer. Innovations in cancer care began in the 1940s, with significant advancements in the 1950s. Around the same time, social work became an expanding profession. In the 1940s, the American Hospital Association determined that social work services were important for accreditation. Then, about 10 years later, oncology social workers started writing about patients' psychological experiences related to their cancer diagnosis in medical journals.

Shortly thereafter, cancer centers began increasing their social work staff to meet the needs of cancer patients in clinical and research settings. In the 1970s, the National Cancer Institute published a National Cancer Program Plan that indicated federal interest in psychosocial issues of cancer patients. As interest in psychosocial oncology increased, medical social workers became more specialized in cancer care. Professional psychosocial oncology groups also began to form (Fobair et al., 2009).

By the 1980s, “oncology social work was articulated as a speciality within medical social work” (Fobair et al., 2009, p. 12). The National Association of Oncology Social Workers was established in 1984, and ten years later, it became the Association of Oncology Social Work (AOSW) (Fobair et al., 2009). Today, AOSW is a “non-profit international organization dedicated to the enhancement of psychosocial services to people with cancer, their families, and caregivers" (AOSW, n.d.a, para. 1).

AOSW has established Standards of Practice for oncology social workers. Within the scope of practice is delivering "services to cancer survivors, families, and caregivers through clinical practice providing comprehensive psychosocial services and programs through all phases of the cancer experience" (AOSW, n.d.b, para. 1). Some of the functions of clinical practice beyond screening and assessment are to:

- Develop multidisciplinary care plans, with input from patients, survivors, and their loved ones, that are aligned with mutual goals.
- Use of a range of therapeutic techniques and other interventions, including supportive counseling, group work, and education, to address issues in each phase of the illness (AOSW, n.d.b, para. 5).

Oncology social workers also practice in alignment with the values of the social work profession and the guidelines published in the National Association of Social Work's Code of Ethics (AOSW, n.d.b).

Oncology social workers practice in different settings, including comprehensive cancer centers and large health systems, smaller community hospitals, community organizations, and private practice. They are often integrated into a larger interdisciplinary team or agency staff, and "engage in specific practice behaviors throughout the continuum of care and across multiple practice settings" (Zebrack et al., 2025, p. 2).

Services provided to cancer patients and their loved ones by oncology social workers must reflect the following principles:

- Interventions need to be based on an understanding of a patient's diagnosis and treatment plan, as well as on their social and emotional situation.

- Interventions are designed to help people feel more in control of a situation (the cancer diagnosis) that likely causes them to feel helpless and out of control.
- Oncology social workers should focus their interventions on helping people cope with the physical, emotional, and social problems they encounter throughout the cancer experience (Blum et al., 2001).

According to Blum et al. (2001), interventions depend on the specific needs and issues that are identified through screening and assessment. Some interventions may occur only once, while others may be ongoing. For example, a referral to a community resource may be needed only once, whereas supportive counseling may continue throughout the disease trajectory. Interventions are most likely to be effective when health care professionals, including oncology social workers, have an understanding of the vast needs that may arise after a cancer diagnosis and when they are flexible and skilled in using various clinical strategies (Fawzy, Fawzy, Arndt, & Pasnau, 1996, as cited in Blum et al., 2001).

This course will review the following core competencies of clinical intervention in oncology social work, expanding on the first two Oncology Social Work Practice courses in this series on assessment.

- Use theories of clinical practice and apply them to oncology social work practice to provide emotional support and counseling to patients and survivors.
- Provide the ongoing assessment and monitoring of patient, caregiver, and/or family psychosocial needs, coping, role changes/transitions, and the impact of the treatment plan.
- Provide supportive care, counseling, and skill building to the patient, their caregiver, couples, and other family members regarding the adjustment to

and coping with a cancer diagnosis, treatment, side effects, late effects, and/or end of life.

- Facilitate serious illness conversations, including those on goals of care. Assist patients and families in advance care planning and decision-making, including long-term care planning and/or advance directives and POLST forms.
- Facilitate communication between family members and health care providers.
- Effectively work with the support of other psychosocial team members, such as child life specialists, psychologists, expressive therapists, financial navigators, palliative care providers, and bereavement specialists.
- Facilitate support groups, including psychoeducational, experiential, and psychotherapeutic groups.

Section 1 Key Terms

<u>Medical social work</u> - “a field that focuses on meeting the various needs of individuals, families, and communities navigating challenges in health and wellness. When people are sick, in addition to physical care, they may also need support with the emotional, financial, and social complications that can arise. They may feel overwhelmed when dealing with the health care system, need help planning their after-care transition, or want counseling support to help them process the changes in their lives. Medical social workers address all of these needs in a variety of settings” (University of Southern California Suzanne Dworak-Peck School of Social Work, 2019).

<u>Oncology social work</u> - “the primary professional discipline that provides psychosocial services to patients, families, and significant others facing the impact

of a potential or actual diagnosis of cancer. The scope of oncology social work includes clinical practice, education, advocacy, administration, policy, and research" (AOSW, n.d.b, para. 11).

Interdisciplinary care - an approach in health care that allows each team member to operate within their discipline and scope of expertise, while encouraging collaboration through communication, interaction, and knowledge integration. Professionals work together to develop a shared understanding of a problem or a patient's situation, share information, and create a comprehensive care plan to meet a patient's needs. This approach can foster a "deeper understanding of complex health care issues by drawing on diverse knowledge bases and promoting coordinated care delivery" (Zimmerman, 2024, para. 3).

The Association of Oncology Social Work (AOSW) - a "non-profit international organization dedicated to the enhancement of psychosocial services to people with cancer, their families, and caregivers. Founded in 1984 by social workers interested in oncology, AOSW has become the world's largest professional organization dedicated entirely to the psychosocial care of people affected by cancer. AOSW membership is comprised of an international set of professionals and students who practice in hospitals, cancer centers, home care agencies, hospice, community-based oncology practices, community programs, patient advocacy organizations, educational institutions, and other settings" (AOSW, n.d.a, para. 1).

Section 2: Theories and Therapies in Clinical Oncology Social Work Practice

References: 2, 5, 7, 8, 9, 10, 11, 14, 17, 18, 20, 21, 23, 24, 25, 28, 29, 31, 32, 33, 34, 35, 36, 38, 40, 43, 44, 45, 46, 47, 48, 49, 52, 53, 54, 58, 59, 60, 61, 62, 63, 70, 71, 72, 73, 74, 76, 77, 78, 79, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 93, 94, 95, 96, 97, 98, 100, 101, 102, 103

One recent study examined oncology social work practice behaviors and found that approximately 94% of oncology social workers provide direct patient services, including psychotherapy/counseling, case management, and resource referrals. Oncology social workers reported spending most of their time on psychosocial assessments, followed by psychotherapy/counseling (Perlmutter et al., 2021). Oncology social workers can use a range of theories and techniques in clinical practice. This section will provide descriptions of several of them.

Of note, a few terms are used interchangeably in this section:

- “clinician” and “oncology social worker”
- “client” and “patient”

Psychodynamic Theory

Dr. Sigmund Freud initially developed the psychodynamic theory, which focuses on the interactions between the conscious and unconscious minds, the significance of childhood experiences, and the interplay between human instincts. He believed that all of these play a role in an individual’s development, personality, and behaviors (The Institute for Clinical Social Work, 2025).

In psychodynamic theory, the unconscious mind drives human behavior. It can affect behavior in many ways, including causing negative thoughts, self-defeating behaviors, relationship difficulties, and unhealthy habits. It is where distressing or unpleasant feelings, thoughts, urges, and memories are held. If these come into consciousness, they can cause pain, anxiety, or conflict (Cherry, 2025c; McLeod, 2025).

Psychodynamic theory holds that childhood experiences have a significant impact on adult life and shape personality. Behaviors and feelings in adulthood are thought to be rooted in childhood experiences. They often live in the unconscious, causing problems that people are unaware of.

Additionally, Dr. Freud believed that behavior could be explained by intrapsychic conflict. He developed the idea that personality has three parts: the id, ego, and superego, which develop starting at birth and into childhood. The ego is the decision-making part that balances the id's satisfaction demands with the superego’s values and morals, which are often learned from an individual’s parents. The ego resides in the conscious mind, while the id and superego reside in the unconscious mind. They are constantly in conflict with the ego. When the ego cannot resolve the disputes, anxiety can arise, and defense mechanisms can prevent people from addressing their anxiety appropriately.

In psychodynamic therapy, people are encouraged to talk openly (free association) without an agenda. A clinician often learns about an individual’s current difficulties and traces the issues back to childhood, when the problem first arose. For example, a person who has ongoing relationship issues may have attachment issues like emotional neglect or abandonment in childhood. As another example, people with anxiety may have unresolved unconscious conflict. When the clinician and the individual connect the past to the present, the situation enters the conscious mind. The clinician and the individual can then work through the problem as the person processes it, gains insight, and learns to recognize and block their defense mechanisms (McLeod, 2025; Yuppa & Meyer, 2017).

Clinicians who use a psychodynamic approach in working with cancer patients believe that it is beneficial because:

> *“Cancer is a deeply personal experience, and the psychodynamic framework enables patients to establish connections between their illness and childhood experiences, patterns of thinking and relating to others, past*

> *traumas and fears, complex and ambivalent emotions, and the symbolic meaning of cancer” (Stiefel & Michaud, 2025, p. 2).*

According to Yuppa & Meyer (2017), “each patient presents with his or her own life experiences and unresolved conflicts, which in the setting of a cancer diagnosis and treatment are often amplified in intensity” (p. 474). For example, patients may have transference towards their health care providers, which can affect their care. The transference could be based on prior negative experiences of being cared for by another person, such as a caregiver in childhood. They may also attribute their illness to an unconscious meaning, such as guilt about certain life choices or behaviors leading to their cancer diagnosis. Additionally, patients may have intrapsychic conflict that arises when they become dependent on another person to meet their needs, leading them to feel ashamed that they cannot meet their own. Furthermore, patients may have specific defense mechanisms, such as denial, that prevent them from facing their diagnosis and coping with it (Postone, 1998; Yuppa & Meyer, 2017).

Therefore, in psychodynamic therapy, cancer patients can work through any feelings of transference, bring the unconscious meaning of their illness into consciousness, resolve intrapsychic conflict, and manage their defense mechanisms, all in an effort to reduce their cancer-related suffering (Postone, 1998).

Ego Psychology

Dr. Sigmund Freud initially developed ego psychology, which was later strengthened by his daughter, Anna Freud. As noted above, the ego is the part of the personality that serves as the mediator between the id and superego (Cherry, 2025a). It “prevents us from acting on our basic urges (created by the id) but also works to achieve a balance with our moral and idealistic standards (created by the superego)” (Cherry, 2025a, para. 3). The ego operates on the reality principle, which satisfies the id’s desires in a way that is realistic and socially appropriate.

Anna Freud developed the defense mechanism aspect of ego psychology. The purpose of defense mechanisms is to decrease an individual’s stress and internal conflict. They can persist or evolve from childhood to adolescence to adulthood, or regress to earlier phases of life in response to stress. Defense mechanisms may be internalized or externalized and linked to specific behavior problems. Anna Freud identified ten defense mechanisms, but other psychoanalysts have identified several more over the years (Bailey & Pico, 2023). She proposed that an individual carried out all of the ego’s defenses against the id undetectably in real time and that these defenses could only be noticed retrospectively (Cherry, 2025a).

Defense mechanisms have been studied in a variety of people living with cancer. One systematic review examined 15 studies using validated defense assessment instruments. Results were organized into a hierarchical model based on the Defense Functioning Scale in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (Di Giuseppe et al., 2018). These studies found that patients who use high-adaptive defenses (the highest level in the hierarchy), such as altruism, anticipation, humor, and self-observation, among others, tended to have “higher physical and emotional functioning, acceptance of social support, and higher survival probability” (Di Giuseppe et al., 2018, p. 84). One reason may be that these specific mechanisms are considered healthy processes as they can help people deal with stress and internal conflict while also maximizing gratification and allowing them to be consciously aware of feelings, ideas, and their consequences. On the opposite end of the spectrum, patients who used action defenses (the lowest level in the hierarchy studied in people with cancer), such as acting out, apathetic withdrawal, help-rejecting complaining, and passive aggression, were the most maladaptive, had sleep disturbances, and had a lower survival probability. One reason may be that these defense mechanisms happen when people feel threatened and act out, either directly or passively, to hurt themselves or others, without feelings of guilt or shame. Several other defense mechanisms fall in between high adaptive and action defenses.

Studies have shown that detecting maladaptive defense mechanisms early in the cancer experience may foster appropriate therapeutic interventions and prevent the illness from worsening (Di Giuseppe et al., 2018). Therefore, when clinicians can identify and understand defense mechanisms, they can implement appropriate interventions to address them. Additionally, interpersonal communication and recognition of patients' defense mechanisms by various members of the health care team, including oncology social workers, psychiatrists, psychologists, nurses, and other medical providers, can “help to orient the team and enhance patient-centered care” (Bailey & Pico, 2023, para. 25).

Stages of Psychosocial Development Theory

Erik Erikson introduced the psychosocial development theory in the 1950s, which includes eight sequential stages of human development that are influenced by biological, social, and psychological factors throughout the lifespan. Erikson proposed that as individuals progress through different stages of life, they face decisions and turning points (Orenstein & Lewis, 2022). Each stage has “two opposing psychological tendencies - one positive and one negative” (Orenstein & Lewis, 2022, para. 2). If a positive virtue is adopted, the stage's conflict is resolved, and a stable foundation of internal and external core beliefs continues to be established. If a negative virtue is adopted, conflict is not resolved, and personality development can become maladaptive. The eight stages are as follows:

- Stage 1 - Infancy - Birth to 18 months

    - An infant’s ability to trust depends on their caregiver’s capacity to provide everything they need to survive, including food, safety, love, and nurturing. Infancy is considered the most fundamental stage.
        - Conflict - Trust vs. Mistrust
        - Virtue - Hope vs. Withdrawal
- Stage 2 - Early childhood
    - A child develops a sense of personal control and some independence.
        - Conflict - Autonomy vs. Shame and Doubt
        - Virtue - Will vs. Compulsion
- Stage 3 - Play age
    - A child begins to show their control through play and other social interactions.
        - Conflict - Initiative vs. Guilt
        - Virtue - Purpose vs. Inhibition
- Stage 4 - School age
    - A child begins to feel proud of their accomplishments and abilities.
        - Conflict - Industry vs. Inferiority
        - Virtue - Competence vs. Passivity
- Stage 5 - Adolescence
    - A teenager begins to develop their sense of self and identity.
        - Conflict - Identity vs. Confusion

        - Virtue - Fidelity vs. Repudiation
- Stage 6 - Young adulthood
    - A young adult explores personal relationships and learns how to form intimate, loving relationships with others.
        - Conflict - Intimacy vs. Isolation
        - Virtue - Love vs. Distance
- Stage 7 - Adulthood
    - An adult begins to create and nurture things that will outlive them, such as children or positive changes in other people's lives/the world.
        - Conflict - Generativity vs. Stagnation
        - Virtue - Care vs. Rejectivity
- Stage 8 - Old age
    - An older adult reflects on their life and determines whether they are happy with it or regret it.
        - Conflict - Integrity vs. Despair
        - Virtue - Wisdom vs. Disdain (Cherry, 2025b; Orenstein & Lewis, 2022)

Of note, while there is a sequence to the stages, "resolution can be a life-long process, reactivated at various times depending on life events that affect the ego strength or maldeveloped belief pattern" (Orenstein & Lewis, 2022, para. 10). Also, when a person moves on to a new stage, the ones prior are questioned and should be reintegrated.

In practice, Erikson's theory can provide a framework when working with patients who are going through periods of adjustment or turning points in their lives, such as a cancer diagnosis. The theory can help patients gain a better awareness of themselves and consider the tasks they can accomplish and the conflicts they should resolve based on where they fall in the sequence (Orenstein & Lewis, 2022).

For example, from a developmental perspective, a young adult is creating their sense of identity and forming intimate relationships. If a cancer diagnosis occurs during adolescence and young adulthood (AYA), when identity is being formed, more independence is being sought, and relationships are being formed, a person may feel frustrated or confused as they explore different roles, or may have difficulty forming and maintaining relationships because they feel different or are becoming different from other people their age. The milestones of pursuing higher education, entering the workforce, earning an income independently, moving out of their family's home, developing romantic and sexual relationships, and having children may also be interrupted by the diagnosis. Additionally, AYA patients remember their life before cancer and can understand the implications of their diagnosis and treatment, which can bring forward other psychosocial issues (Brand et al., 2018; Darlington et al., 2025). An oncology social worker working with a young adult with cancer can be mindful of their developmental stage and the psychosocial implications of the diagnosis, which can help them implement appropriate supportive interventions.

Attachment Theory

Dr. John Bowlby and Dr. Mary Ainsworth are the primary figures responsible for developing and extending attachment theory, which provides a framework for how emotional bonds form between individuals, particularly a child and their primary caregiver, such as a parent. Bowlby developed the theory, and Ainsworth created individual attachment styles (secure, avoidant, and anxious). The premise of the theory is that “humans are biologically programmed to form attachments to survive, and that the quality of these attachments affects our development and our experience of life and relationships throughout our lives” (Bowlby, 1979, as cited in McGarvie, 2024, para. 8).

An emotional connection with a caregiver begins in infancy. The idea is that a child will reach out to a caregiver when they are distressed or when things feel uncertain. Through these interactions, a child’s foundation of secure or insecure attachment develops. Either a child has a “secure base” where they know their caregiver is a point of safety, or they do not. Those with a secure, stable bond with at least one caregiver typically feel confident in exploring their environment, learning new things, becoming goal-oriented, and fostering healthy connections with others. The opposite tends to happen when a child does not have a secure bond with a caregiver: they are less confident, less motivated to learn new things, less likely to set goals for themselves, and may have difficulty establishing healthy relationships. Over time, the nature of a child’s bond with a caregiver affects how they navigate adult relationships and cope with stress. For example, research has shown that children with a secure attachment style grow into adults who can form healthy, trusting relationships, have high self-esteem, and exhibit better emotional regulation than children with an insecure attachment style (McGarvie, 2024; The Attachment Project, n.d.).

Attachment theory is used in practice to help clinicians learn about a client’s early relationships and how they have influenced the ability to form healthy relationships as an adult. Early relationships can also help a clinician understand a client’s motivation and goal orientation. For people who seek therapy for relationship issues, for example, a clinician will explore early childhood events and may learn that attachment issues stem from that time. Attachment-based therapists help their clients regulate their emotions, take control of their lives, and build trusting relationships with others. This work involves supporting clients in reflecting on their childhood experiences, re-parenting their inner child, and focusing on their current relationships with others and themselves. Once a person can foster their own sense of security, they can better regulate their emotions, which transfers into skills in other areas, such as goal orientation, self-confidence, healthy relationships, and overall quality of life (The Attachment Project, n.d).

Attachment theory has been studied in cancer patients to help explain emotional responses and adaptation to the diagnosis. Research has shown that patients with insecure attachments report more distress than those with secure attachments. Additionally, patients with secure attachments initially show high levels of distress at the time of diagnosis or progression. Still, they can adapt and return to their baseline more quickly than patients with insecure attachments, who often experience chronic, high levels of distress, both with and apart from an illness.

Furthermore, patients with secure attachments are more likely to adapt to the challenges that come with a cancer diagnosis. They often have significant social support and the confidence to act independently to reduce distress and solve problems. These feelings and skills may reduce anxiety and foster positive coping strategies when dealing with stressors. In contrast, patients with insecure attachments may have more difficulty adapting to the diagnosis. They often have limited social support and may reject any caregivers who try to help them. They are also more reluctant to seek social support from others, including their health care team. They have difficulty problem-solving and minimal coping skills.

In practice, attachment theory can help oncology social workers understand patients' attachment styles. As a part of a psychosocial assessment, they can learn more about a patient’s relationship with their primary caregiver in childhood, their adult relationships, current available social supports, problem-solving abilities, and coping strategies. Information about attachment styles can help an oncology social worker identify which patients need support and the type of support that will help them address their needs and develop positive coping strategies (Hinnen, 2016).

Attachment theory can also inform bereavement work. For example, when a person with a secure attachment loses someone to whom they are attached, it can affect their feelings of security and how they interact with the world, which can leave the grieving person to renegotiate their attachment to the deceased person and form other attachments that create safety and security (Knowles et al., 2024).

Humanistic Theory

Dr. Abraham Maslow developed a theory based on human needs and behavior in the mid-20th century. After studying humans for many years, he found that some needs are more pressing than others and that we can use this information to understand what motivates behavior. Maslow created the hierarchy of needs framework and divided needs into the following five categories:

- Physiological - things that humans need to survive, including breathing, sleeping, having enough food to eat when hungry, and fluids to drink when thirsty. These are concrete needs to have homeostasis in the body.
- Safety and security - feeling safe, being healthy, and having the resources needed to survive, such as a home.
- Love and belonging - feeling accepted by and connected to other people, such as a romantic partner, family members, and friends. This need also includes the ability to be loved by others and to feel love towards others.
- Self-esteem - feeling self-confident and good about oneself. Self-esteem also includes feeling valued and recognized by others.

- Self-actualization - living life with meaning and engaging in activities that align with personal values.

Maslow proposed that these needs could be ranked by their importance to human functioning, with physiological needs being the most basic and self-actualization being the most advanced. The theory is that these needs build on one another, and as individuals progress through them, they experience more motivation and fulfillment in their lives. Maslow acknowledged that meeting each need is not an “all or nothing phenomenon,” meaning that one need does not have to be completely satisfied for the next need to arise. He also acknowledged that most people typically have their needs partially met, and that the lower-level needs are the ones people make more progress in meeting (Huntington, n.d.).

Maslow’s framework can also support patients across all of these areas to promote their overall well-being while living with an illness. In practice, clinicians can apply Maslow’s theory in a psychosocial assessment and when considering appropriate interventions. During an evaluation, an oncology social worker can learn whether a patient’s basic physiological and safety needs are being met, whether they have a support system, whether they are struggling with self-esteem, and what self-actualization may look like in their life. Then, they can implement appropriate interventions based on the patient’s identified needs and concerns. For example:

- When a patient is struggling with basic needs, there are opportunities to connect them with resources.
- If there are safety concerns, they can be explored and addressed.
- When a social connection is lacking, an oncology social worker can help a patient build their support network and/or address any issues that may be preventing healthy relationships in their life.

- An oncology social worker can also help a patient build self-esteem by recognizing their strengths and leveraging them.
- Lastly, an oncology social worker can discuss opportunities for self-actualization by exploring a client's values and goals (Therapy Trainings, 2024).

An oncology social worker can work collaboratively with others, including the patient, their loved ones, the medical team, and other resources, to support patients in these areas.

Person-in-Environment Theory

Person-in-environment theory is a foundation of social work. The history dates back to the work of Jane Addams and Mary Richmond, two pioneers in the field. Addams focused on societal reform, while Richmond concentrated on working with individuals and families. Richmond eventually brought both ideas together and proposed that social workers should be able to focus on individuals and their environments in their practice (Biscontini, 2024).

According to Biscontini (2024), the person-in-environment theory,

> *"Acknowledges that the environment in which people spend time influences how they view the world. It also involves examining an individual's prior life experiences to better understand their current perspectives and actions. Through gaining a more complete understanding of individuals' perspectives, social workers are better able to assist them in achieving their goals" (para. 7).*

Different approaches exist within person-in-environment theory, including micro, mezzo, macro, biopsychosocial-spiritual, systems, and ecological.

Micro, Mezzo, and Macro Approaches

The micro, mezzo, and macro approaches guide oncology social workers to examine all levels of a person's system to understand how they connect and how they impact one another. These levels can also help an oncology social worker determine the type of support a person may need.

- Micro - a person's individual needs, such as practical, mental health, social, interpersonal, and spiritual.
- Mezzo - interactions with family, friends, co-workers, neighbors, their church, and other community organizations, and their impact.
- Macro - larger systems that impact an individual, such as policies, laws, and the health care system (Tyler, 2020).

Biopsychosocial and Spiritual Approach

The biopsychosocial and spiritual approach guides social workers in assessing a person's functioning across all areas of their life. It goes more in-depth on the micro level.

- Biological - a person's overall physical health and functioning.
- Psychological - aspects of a person's life related to mental health, self-esteem, beliefs, coping skills, emotions, personality, and more.
- Social - a person's family and friend relationships, other social supports, education, job, and socioeconomic status, among others.
- Spiritual - a person's beliefs in spirituality or religion, and if they feel connected to a higher power (Tyler, 2020).

Systems Theory

Systems theory states that behavior is influenced by interconnected factors that function as a system. Each factor plays a role in the system's overall function, and, in turn, the whole system supports the parts. The micro, mezzo, and macro parts of a person’s life influence how they think and act. Therefore, oncology social workers can assess all of the individual’s systems to understand how they contribute to behavior and well-being. An oncology social worker can also work with the person to strengthen their systems.

Roles are also part of systems theory, including those of parent, child, spouse, sibling, leader, worker, and many others. Roles are components of a person’s identity that can reinforce either positive or negative feelings, depending on the associations they carry. When an oncology social worker knows the roles that a person is connected to, they will better understand their needs and experiences (Tyler, 2020).

Ecological Theory

According to Tyler (2020), “ecological theory focuses on the interaction between the individual and their environment. It discusses the active involvement of people with their environments and development, as well as both (environment/development) continuously changing” (para. 23). One key aspect of this theory is that perception is an essential consideration, meaning how a person interprets their environment and experiences impacts their overall functioning and well-being. Therefore, social workers should explore how a client views their situation before assuming it is problematic.

Dr. Urie Brofenbrenner, the psychologist who developed ecological theory, proposed that a person’s development is influenced by everything in their environment, and that the environment comprises five levels: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

- Microsystem - the system closest to a person and one with direct interactions, such as work, school, family, friends, or caregivers.
- Mesosystem - the way that microsystems are interconnected and how they influence each other, which has a direct impact on a person.
- Exosystem - a setting where a person is not an active participant, but they are still affected by it.
- Macrosystem - the cultural environment where a person lives and the systems within it, such as the economy, political systems, and cultural values.
- Chronosystem - the life transitions and shifts that a person goes through, and the timing of these events in a person's development (Tyler, 2020).

Any of these approaches can be used by an oncology social worker to better understand a patient in their environment. Since cancer impacts all areas of a person's life, understanding their systems and how they are affected will help the healthcare team provide more comprehensive, supportive care to patients.

Family Systems and Family Life Cycle Theories

Family systems theory was developed by Dr. Murray Bowen, who focused on family relationships and their influence on people's lives. He considered the family an emotional unit in which relationships and roles within the system shape a person's beliefs, emotions, and behaviors. He proposed that people could not be fully understood without considering their family unit. Family life cycle theory, developed by Betty Carter and Dr. Monica McGoldrick, builds on family systems theory by focusing on the developmental tasks that families face and the reasons stress appears at specific points in a family's development.

Carter and McGoldrick proposed that "family is the context within which individuals grow and develop throughout a lifetime (Collins et al., 2010). Relationships with parents, siblings, and other family members change as they move along the life cycle" (Carter & McGoldrick, 1999, as cited in Collins et al., 2010, p. 226). Carter and McGoldrick also proposed that families typically go through developmental stages, each involving issues, tasks, transitions, changes in roles and responsibilities, and crises to resolve. Times of transition often intensify stress within the family system and its relationships. The way events unfold during developmental stages will be unique to each family, and each family will react differently. The stages are as follows:

- Stage 1 - Marriage/coupling/pair-bonding
    - People commit to a relationship, compromise and negotiate their needs, formulate their roles, and start separating from their families of origin.
- Stage 2 - Families with young children
    - The marital unit adjusts and stabilizes with a triangle.
    - Bonding happens with a child, and they become integrated into the family.
    - Relationships are realigned based on career responsibilities and domestic chores.
- Stage 3 - Families with school-aged children
    - Children become more independent, and families start to understand and accept role changes.
    - Family boundaries expand to accommodate new people and institutions, such as schools.

- Stage 4 - Families with teenagers
    - Teens seek independence and redefine their personal autonomy while boundaries are being adjusted. There may be role negotiation, rule changes, and limit setting.
- Stage 5 - Launching
    - A young person begins preparing for independent living, and their self-sufficiency is promoted.
- Stage 6 - Bommerang
    - Adult children may return home, and the family system adjusts as they renegotiate space and roles.
- Stage 7 - Middle-aged parents
    - The couple adjusts to new roles and relationships outside of their children's lives.
- Stage 8 - Aging family members
    - Families begin addressing aging-related issues while maintaining an older adult’s dignity and independence. Grandchildren and their partners may become more involved in the family as well (Collins et al, 2010).

For clinicians, understanding these developmental stages can provide a framework when working with families. Clinicians who are aware of “developmental issues facing the family are in a better position to assess the family’s issues, the crises that occur as a result, and the coping tools used by families to address them” (Collins et al., 2010, p. 227). It is important to consider culture, socioeconomic status, and gender, as these factors can also affect the stages.

A cancer diagnosis during any of these stages can present additional challenges to the ones a family may already be experiencing. When working with people with cancer and their families, oncology social workers can consider the developmental stage of the family, how cancer is impacting it presently, and how it may continue to affect it in the future. These considerations provide a framework for assessment, understanding, and intervention.

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) is a therapeutic approach developed by Dr. Aaron Beck that examines how a person's thinking affects their feelings and behaviors (Caba et al., 2024). CBT can help patients challenge their unhelpful thoughts or behaviors and change them, so that they can manage any mental health symptoms and cope more effectively with their illness.

According to the American Society of Clinical Oncology (2024), "the goal of CBT is to target automatic thoughts or core beliefs that may be harmful to mental health" (para. 5). Automatic thoughts are those that come naturally in response to something. Core beliefs are those people hold about themselves, others, and the world that shape their perspective and how they interpret experiences. When a person's thoughts and beliefs are negative, they can lead to mental health issues, such as depression or anxiety.

Studies have shown that approximately 30% of cancer patients have symptoms of anxiety, and about 25% experience symptoms of depression (Naser et al., 2021, as cited in Caba et al., 2024). Oncology social workers often learn about a patient's mental health concerns and psychosocial distress through screening and/or assessment. Once these issues have been identified, CBT can be a helpful intervention to manage distress, anxiety, and depression. It has also been shown to improve mental health and quality of life for cancer patients.

During CBT, a trained clinician, such as an oncology social worker, can help a patient identify their automatic thoughts and core beliefs, and how they play a role in the current situation. Once these thoughts and beliefs have been identified, the oncology social worker can help the patient challenge and reframe them to be more favorable. Then, they can provide support and guidance to the patient as they learn to change their thoughts, beliefs, and behaviors, ultimately leading to more rational responses, positive thoughts, and an overall better adjustment to their illness (American Society of Clinical Oncology, 2024; Association for Behavioral and Cognitive Therapies, n.d.).

Problem-Solving Therapy

Dr. Arthur Nezu and his colleagues, including Dr. Christine Maguth Nezu, developed problem-solving therapy, which is a form of CBT. It is a brief, solution-focused therapy that equips people to identify problems and solve them. The goal is to improve an individual's quality of life and reduce the adverse effects of physical or psychological illness and other life stressors. Problem-solving therapy focuses on the present moment and has two primary components:

- Applying positive ways to solve problems - a person accepts that problems are a regular part of the human experience, views things optimistically, and embraces self-efficacy.
- Using problem-solving skills: a person learns to identify and define the problem, understand it in depth, set goals, explore alternative solutions, choose the best course of action, implement the plan, and evaluate the outcome.

Both of these components can help people become more adaptive to problems in their lives and see them as solvable, which supports feelings of empowerment, resilience, and self-efficacy.

Problem-solving therapy has been shown to help depression in people living with cancer and cancer caregivers (Cuncic, 2024).

Acceptance and Commitment Therapy (ACT)

Acceptance and commitment therapy, also known as ACT, is a behavior therapy focused on taking action that is guided by personal values. Dr. Steven Hayes, a clinical psychologist and researcher, developed ACT. According to Harris (2009),

> *"ACT gets you in touch with what really matters in the big picture: your heart's deepest desires for who you want to be and what you want to do during your brief time on this planet. You then use these core values to guide, motivate, and inspire behavioral change" (p. 2).*

One of the foundational messages of ACT is to accept what is beyond personal control, commit to taking action that enriches life and makes it meaningful, while acknowledging that life inevitably brings pain (Harris, 2009). This aspect of ACT can be beneficial for people living with cancer because there are often many things that accompany the diagnosis that are out of a person's control. ACT can help them accept their diagnosis and take actions that help them feel more in control of their life. People living with cancer, especially those with a metastatic diagnosis, are facing their mortality and may want to start living their life in a more meaningful way, or they may want to strengthen specific ways they already live their life. ACT can also support them in these actions.

According to Harris (2009), ACT teaches people psychological flexibility, which enables them to manage difficult thoughts and feelings effectively, thereby reducing their impact on a person's life. This is known as mindfulness skills. ACT also helps people clarify what is important to them (their values) and use that information to guide and motivate them to set goals and take mindful actions, thereby staying fully engaged and present in the behavior change they are making.

Six core processes exist in ACT. The first is being present in the moment, meaning to be consciously connected and engaged in whatever is happening. It means not to get caught up in thoughts about the past or the future. The second is cognitive defusion, which is learning to detach from thoughts and take them more lightly, rather than getting caught up or being driven by them. The third is acceptance: opening up to what is painful and giving it space, rather than running from or getting overwhelmed by it. The fourth is self-as-context, which differentiates the thinking self from the observing self. The idea is that thoughts and feelings change, but the person who notices or observes them never changes, which supports identity and that people are more than the things in their lives that change. The fifth is values, which drive how people want to behave on an ongoing basis to live a meaningful life. The sixth and final core process is committed action: doing what it takes to live a life aligned with personal values. These core processes are not separate from one another (Harris, 2009). They all work together to foster psychological flexibility, defined as “the ability to be in the present moment with full awareness and openness to our experience, and to take action guided by values” (Harris, 2009, p. 12). The more that people are mindful, open, and living aligned with their values, the better their quality of life, because their responses to challenges are more effective (Harris, 2009).

In practice, a clinician will help a person learn more about themselves, including their experiences, thoughts, feelings, self-talk, and life goals. A clinician will support a client as they set and achieve their goals, practice mindfulness, define their values, and change their behaviors. The six core processes will be incorporated into each of these exercises, ultimately promoting the development of new skills (Cleveland Clinic, 2024).

ACT is an intervention shown to have beneficial effects in people with physical health conditions, including “reduced distress, improved quality of life, and more effective self-management of chronic illness” (Hubert-Williams, 2021, p. 440). In cancer care, ACT has been shown to improve anxiety, depression, emotional distress, quality of life, and psychological flexibility in cancer patients. Similar improvements have been observed when using ACT with cancer survivors (Mathew et al., 2024). Since a cancer diagnosis can bring forward several different stressful experiences that cause people to experience difficult emotions, ACT can help them deal with these emotions, cope with the diagnosis, and support patients as they pursue a value-aligned life.

Dialectical Behavior Therapy (DBT)

Dr. Marsha Linehan is the founder of dialectical behavior therapy (DBT), a therapeutic approach that teaches people to cope with emotional dysregulation (when emotions occur more quickly, frequently, and intensely). DBT can give people skills to manage intense emotions, cope with difficult situations, and improve relationships (Corliss, 2024).

In DBT, people learn how to use mindfulness techniques to “pay careful attention to the nature, quality, and volume of their thoughts” (Corliss, 2024, para. 8). Though this may sound similar to CBT, DBT is different in the way that it acknowledges and validates a person’s thoughts instead of teaching people how to change them. Once the thoughts have been recognized and validated, people are encouraged to consider that two things can be true at the same time (dialectical thinking), rather than viewing situations in extremes.

In addition to mindfulness, people learn distress tolerance, emotional regulation, and interpersonal effectiveness.

- Distress tolerance is the ability to be present in the moment and use techniques to manage emotional distress.
- Emotional regulation is acknowledging, accepting, and coping with intense emotions.
- Interpersonal effectiveness helps people focus on communication in their relationships, strengthening them and improving self-esteem.

While each person with cancer responds in their own way to their diagnosis, some common emotions and concerns happen, including fear, anxiety, sadness, grief, and psychosocial distress. Sometimes, these emotions can be intense and significantly impact a person's ability to function in day-to-day life. DBT can teach people how to allow these feelings and concerns, while also turning them down when they are stronger than what is useful (Stuntz & Reitz, 2021a).

DBT can help patients live in the moment, develop healthy coping strategies, balance and regulate emotions, and improve their relationships (Caba et al., 2024).

- Mindfulness skills enable people to be more present in their experience, to understand what is happening fully, and to inform their decision-making. Mindfulness is also a coping mechanism, alongside other actions people may find helpful, such as practicing gratitude, journaling, or using humor (Stuntz & Reitz, 2021a; Stuntz & Reitz, 2021b).
- Labeling and regulating emotions help people calm their nervous system and improve their coping (Stuntz & Reitz, 2021a). Additionally, balancing unproductive thoughts and checking the facts can help people make clearer, less emotionally driven decisions (Stuntz & Reitz, 2021b).
- Communication with the self, loved ones, and the health care team is also a critical component of oncology care, so learning to improve communication

skills can strengthen relationships. Self-compassion and compassionate self-talk can boost a person's resilience. Interpersonal skills can help people communicate their experiences and needs (Stuntz & Reitz, 2021b).

Narrative Therapy

Narrative therapy was initially developed in the 1980s by Michael White and David Epston. The American Psychological Association (2018b) defines narrative therapy as a:

> *"Treatment for individuals, couples, or families that helps them reinterpret and rewrite their life events into true but more life-enhancing narratives or stories. Narrative therapy posits that individuals are primarily meaning-making beings who are the linguistic authors of their lives and who can reauthor their life stories by learning to deconstruct them, by seeing patterns in their ways of interpreting life events or problems, and by reconstruing problems or events in a more helpful light" (para. 1).*

Narrative therapy considers the broader context of people's lives. It recognizes that, as stories develop, people often focus on specific information and tell the same story repeatedly. As a result, their perspective on their lives is shaped in a certain way. For some people, the focus shifts from their identities to their problems, and they can see themselves in a negative light. As people share their stories, clinicians trained in narrative therapy look for these trends, then help people see the hopes, values, and desires within themselves, ultimately reauthoring their stories (Narrative Therapy Centre, n.d.).

Narrative therapy has three main concepts:

- Each person's agency and dignity are respected. They are not treated as if they are not good enough.

- An individual is not blamed for their problems, and they are encouraged not to blame others. It is not helpful to assign blame to anyone or anything.
- Each person is an expert in their own life.

Narrative therapy also uses the following techniques:

- Telling one's story - An individual tells their story in their own words with the intention that storytelling is how they find meaning and purpose in their experience. People can also rewrite their story, either by alternating or by writing a new one.
- Externalizing - By taking a closer look at the stories people tell themselves, narrative therapy can help them distance themselves from the problem and externalize their issues rather than internalize them. Internalizing problems can lead people to develop a negative self-view that ultimately affects their quality of life when they subscribe to it. However, when the issue is external, it is easier to change since it is not a core personality characteristic.
- Existentialism - An individual is encouraged to find their own meaning and purpose instead of an absolute truth that they do not resonate with.
- Deconstruction - This technique can make problems feel less overwhelming when they are examined more closely and specifically, rather than generally. It can help people understand the root of their problem, its meaning, and the pattern in their lives.
- Reconstruction - In this technique, people can change their storyline to be more affirming and meaningful, or to foster a positive view of their identity. A clinician can help encourage a person to move forward in their life with a new storyline (Ackerman, 2017).

When narrative therapy is used with people who have been diagnosed with cancer, they have the opportunity to distance themselves from their diagnosis and view themselves as a person who is living with a disease. One thing that may be helpful is for a person to view themselves as “living with cancer” instead of a “cancer patient.” People also can externalize the cancer and any symptoms that are impacting them to “regain a sense of personal agency and a renewed capacity to shape their lives” (Anderson, 2025, para. 6). They can also change their cancer storyline, one that has likely overtaken many aspects of their lives, to one where they are connected to themselves - their identity, values and strengths. Additionally, they can take charge of their personal narratives and be empowered to continue writing their story, despite an illness that may leave them feeling they lack control (Anderson, 2025).

Witness Positions

Outside witnessing is an idea introduced by one of the founders, Michael White, into narrative therapy. An outside witness is “a third-party audience invited into a therapeutic conversation to acknowledge ‘preferred stories and identity claims of the person consulting the therapist’” (Carey & Russell, 2004, as cited in Taylor, 2020, slide 9). An outsider witness could be a family member or friend of the client, for example. The outsider witness listens to the story the client tells the clinician, then is interviewed by the clinician, with the client present, to share their thoughts about the narrative they heard. This conversation is followed by the clinician interviewing the client about their experience of hearing the outsider witness’s perspective. Sometimes the group can process the experience together at the end. The hope of this exercise, which is called a definitional ceremony, is that an outsider witness can help the client affirm their identity and support the work they are doing in therapy. Note that all participants must provide informed consent before this exercise takes place, as it falls outside the typical confidentiality guidelines.

In oncology, outside witnessing may be beneficial for people who resonate strongly with the identity of being a cancer patient, in support group settings, and at the end of life, as the definitional ceremony can help a family engage in legacy work (Taylor, 2020).

Trauma Therapy and Trauma-Informed Care

The Substance Abuse and Mental Health Services Administration (2024) states the following about trauma:

> *"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (para. 2).*

One estimate states that approximately 70% of people in the United States have experienced at least one traumatic event in their lifetime, which is over 220 million people (The National Council for Behavioral Health, 2022). With this prevalence, clinicians must understand trauma, its diverse manifestations, and its impact on individuals' lives (Yadav et al., 2024).

Trauma therapy is "any therapy that uses cognitive, emotional, or behavioral techniques to facilitate the processing of a traumatic experience, with the trauma focus being a central component of the therapeutic process" (Yadav et al., 2024, para. 16). Common therapeutic modalities include DBT, trauma-focused CBT, and eye movement desensitization and reprocessing (EMDR). These therapies can help people work through memories, thoughts, and perceptions of traumatic experiences. Common elements of trauma therapy include psychoeducation, emotional regulation, coping skills, exposure, cognitive processing and restructuring, and meaning-making.

Trauma-informed care can be implemented at the clinician and system levels. On a clinician level, trauma-informed care provides a holistic approach that goes beyond treating trauma symptoms and recognizes the broader effects of trauma on an individual's life. Trauma-informed clinicians create a safe, supportive, and empowering environment for their clients. They realize the prevalence and impact of trauma, understand its effects, and integrate this awareness into their practice, which often includes cognitive, emotional, and behavioral techniques. At the system level, there are five guiding principles for providing care: safety, trustworthiness, choice, collaboration, and empowerment. These principles have set a standard for a variety of organizations (Yadav et al., 2024).

A cancer diagnosis is considered a traumatic event as it is a threat to a person's life and hopes. Every aspect of a person's life is touched by their cancer diagnosis from the time that they receive their diagnosis, through treatment, and either into survivorship or end of life. They may also become retraumatized by adverse physical effects from treatment, as well as psychosocial issues that cause ongoing changes in their life.

It is beneficial to patients when clinicians and organizations provide trauma-informed care at both the individual and system levels. This looks like providing a physically and emotionally safe space, using open communication with patients and colleagues, seeing patients as experts in their own experiences, offering options and hearing their concerns, and collaborating with other team members involved in the patient's care.

Research has shown that providing trauma-informed care in medical settings has positive effects. First, patient-provider collaboration increases, and more transparent discussions are had about the cancer itself, treatment, side effects, quality of life, and end-of-life issues. Next, patients experience increased satisfaction with their care, improved treatment adherence, and greater safety. Additionally, staff feel autonomous and satisfied in their work, leading to retention. Lastly, organizations enhance their policies and procedures, increase transparency, and decrease turnover rates (Archer-Nanda & Dwyer, 2024).

Crisis Theory and Intervention

Crisis theory started developing in the 1940s, based on the work of two psychiatrists, Dr. Erich Lindemann and Dr. Gerald Caplan, who worked with survivors of the Boston Coconut Grove nightclub fire that killed close to 500 people. Lindemann and Caplan identified common grief reactions to this crisis. Caplan expanded on Lindeman’s work and defined two types of crises: normal life transitions and hazardous events. He also added the stages of a crisis reaction to the theory. Crisis theory expanded over the course of many years, during wars, the suicide prevention movement, and as the importance of addressing acute psychosocial crises gained recognition. Today, most social workers receive crisis intervention training, either in school or on the job, because it is acknowledged that any client may experience a crisis (Walsh, 2010).

A crisis typically occurs when a person faces a severe stressor with which they have no prior experience. The stressor can be biological, interpersonal, environmental, or existential (Walsh, 2010). The American Psychological Association (2018a) defines a crisis as “a situation (e.g., a traumatic change) that produces significant cognitive or emotional stress in those involved in it” (para. 1). In an illness, a crisis could be the turning point in which things become better or worse (American Psychological Association, 2018a).

Typically, after a crisis, a person is unable to function as before and/or cannot manage the event using their usual coping methods. They are considered to be in a state of disequilibrium. They may feel overwhelmed and unable to focus their energy on processing the crisis, or they may lack the knowledge to do so. According to Caplan (1964, as cited in Kurre & Bose, 2020), “crisis intervention based on this theory aims to restore equilibrium by providing immediate support, addressing underlying issues, and enhancing coping skills” (p. 1017).

Crisis intervention includes the following practices and stages on behalf of a clinician:

- Rapid rapport building - connecting quickly with the client by showing acceptance, empathy, reassurance, and a sense of optimism. The clinician can also be active in helping the client focus and make decisions.
- Encouraging the client to express their painful feelings - helps them understand their emotions and feel calmer, making them better able to focus on pressing issues.
- Assessment - a quick, yet thorough assessment of precipitating factors, the meaning of the crisis to the client, their capacity for adaptive functioning, and the client’s support system.
- Restoring cognitive functioning - reflecting conclusions about the crisis and the meaning of it to the client.
- Planning and implementing interventions - drawing from many different options, but interventions should typically be time-limited, structured, and focused on the present moment.
- Environmental work - linking the client with social support and appropriate resources.
- Ending and follow-up - reflecting the plan of care to the client and developing a plan for follow-up care (Walsh, 2010).

Another effective crisis intervention model is the six-step model developed by James and Gilliland, which emphasizes assessment and collaboration with the client. The following steps are included in this model:

- Assessing the crisis
- Ensuring safety
- Providing support
- Exploring alternatives
- Making plans
- Obtaining commitment

Other models include the ABC (affect, behavior, cognition) model, the task-centered model, and critical incident stress debriefing. Specific to suicidality, the collaborative assessment and management of suicidality (CAMS) model (Kurre & Bose, 2020) can be used.

Since a cancer diagnosis and related events can be considered crises, an oncology social worker should be trained and skilled in crisis intervention.

Play Therapy

Play therapy is a therapeutic approach that uses playful tools to support people as they express themselves and communicate their thoughts and feelings. Not only does it support self-expression, but it can also help access suppressed memories and emotions from earlier in life. Additionally, it provides stress relief and problem-solving skills.

Play therapy can be used with children, adolescents, and adults, and should be considered based on an individual's needs. For some people, it may be more comfortable than verbal expression or talk therapy. It is a topic that a clinician should approach with sensitivity, understanding, and reasoning.

Some play therapy techniques that are tailored for adults include sand tray therapy, art therapy, drama or role-playing, and movement or dance therapy.

- Sand tray therapy allows people to recreate scenes that reflect their personal experiences, feelings, or conflicts, offering insights into their subconscious.
- Art therapy gives people the opportunity to process emotions and express themselves through different modalities, such as drawing, painting, or photography.
- Movement or dance therapy helps people express emotions through their bodies, especially when they cannot find the words.
- Drama or role-playing allows people to reenact situations, providing opportunities for reflection and for considering what they might have done differently (Wisen-Vincent, n.d.).

One article about drama therapy in cancer states that it can be used for “patients experiencing transition, loss, social stigma, and isolation” (Fors, 2023, para. 2). It helps with anxiety, depression, and trauma, as well as supporting healthy relationships and empathy. By playing different roles or engaging in storytelling in a safe, controlled environment, patients can explore their emotions and share them without judgment, leading to better well-being and self-efficacy. Through improvisational theater (improv), patients can improve their communication skills and foster connections with others, which may help them voice their needs in other situations, like in their cancer care. Improv can also teach mindfulness, or the skills of being present in the moment, which is a helpful way to cope with the stress of a cancer diagnosis (Fors, 2023).

Couples Therapy

Couples therapy is a type of counseling that involves both partners in a relationship. It is typically provided to help couples resolve conflicts and reduce stress in their relationship, either by addressing issues specific to one partner or both. It can promote well-being, improve communication, and deepen the emotional connection between two people (Restivo, 2025).

It is common for a cancer diagnosis to cause various issues in a couple's relationship. It may worsen existing problems or cause new ones. Communication can be strained when people cope differently, and one or both may become more guarded to protect the other. Unmet needs may also go undiscussed, causing tension. Role changes can also occur when a person becomes ill and is unable to do the things they used to do in the relationship, such as managing finances or household tasks. These role changes may cause the person living with cancer to feel like they are a burden, and may cause additional stress and feelings of resentment for the partner who is not sick. Intimacy issues also arise from the disease's symptoms, treatment side effects, or changes to the body or appearance. Emotional concerns may also cause the person with cancer to feel more vulnerable and less like they want to be intimate with their partner. Furthermore, financial problems can strain a relationship, especially when a financial situation changes, and there is added pressure from medical costs (Hines, 2013; White, 2021). Depending on the individuals within the couple, other concerns may arise, such as mental health conditions, adjustment issues, expectations for normalcy, and facing mortality (White, 2021).

According to Kontoulas (as cited in White, 2021), couples therapy can "help couples navigate these changes as they happen and even anticipate problems that might arise later. This type of therapy can improve communication, facilitate the expression of feelings, identify unmet needs, and build emotional and physical intimacy" (para. 14). There are different approaches used in couples therapy, including CBT, emotionally focused therapy, and the Gottman method (Restivo, 2025). Research on interventions for couples impacted by cancer has increased over the last several years. Some effective interventions have been time-limited (6 to 8 sessions), educational, and draw on these approaches, while also engaging partners in efforts to help the patient adjust to their illness as part of the couple.

For couples facing an early-stage cancer diagnosis, a clinician may focus their interventions on strengthening each person’s coping skills, and the couple’s communication patterns, responsiveness to each other’s needs, support provision, and problem-solving. A clinician may also focus their interventions on disruptions in sexual and emotional intimacy due to treatment side effects. Sessions tend to provide psychosocial education and give the couples exercises to practice at home to support their skill-building.

For couples facing an advanced-stage cancer diagnosis, there are more losses that they often face. One person in the couple frequently takes on more extensive caregiving responsibilities while they witness their partner become less functional. Couples are also dealing with end-of-life concerns and discussions, such as saying goodbye, resolving conflicts, and spending time with loved ones. Couples therapy can support communication around these complex topics, while also working through the anticipated loss and existential concerns. Some effective interventions have included teaching self-care strategies, coping skills for managing the cancer, joint problem-solving skills, relationship maintenance, and CBT strategies. Another emotionally focused intervention helped couples identify when they were distancing themselves or acting destructively, then taught them new ways of interacting that supported closeness and emotional expression (Zaider & Kissane, 2021). If a couple is functioning well, it is important to acknowledge that they “may simply benefit from having dedicated time together to address end-of-life concerns with guidance from a psychosocial provider” (Zaider & Kissane, 2021, p. 483).

Overall, “relationship-focused interventions delivered at both the early and advanced stages of cancer do effectively strengthen the quality of family relationships and reduce the risk for psychiatric morbidity” (Zaider & Kissane, 2021, p. 485). Interventions that are focused on relationship enhancement for couples can be “delivered normatively, across relatively few sessions, and can be administered by trained healthcare practitioners of medical and psychosocial disciplines” including oncology social workers (Zaider & Kissane, 2021, p. 485).

Motivational Interviewing

Clinical psychologists William Miller and Stephen Rollnick developed motivational interviewing. It was initially created for substance abuse treatment, but for over 30 years now, it has been applied to physical conditions, medication adherence, pain management, and other issues. While motivational interviewing is not a specific theory, it draws on concepts from a variety of theories (Walsh & Corcoran, 2010). Motivational interviewing can be helpful when people feel incredibly ambivalent about change, their confidence to make the change is low, their desire is also low, and they do not recognize the importance of the change or its benefits and disadvantages (Motivational Interviewing Network of Trainers, 2021).

Motivational interviewing is a therapeutic approach that is focused on behavior change. By its founders, it has been described as a:

> *“Collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion” (Miller & Rollnick, 2013, as cited in Motivational Interviewing Network of Trainers, 2021, para. 2).*

A few key qualities of a clinician engaging in motivational interviewing include:

- Guiding clients, which is between listening and giving advice.
- Empowering clients to change by helping them draw out their own meaning, importance, and capacity to change.
- Respecting clients and being curious in a way that supports the natural process of change and their autonomy.
- Collaborating with clients as an equal partner, not one that gives advice, confronts, instructs, directs, or warns. These are viewed as likely to increase a client’s resistance to change. Collaboration involves a non-hierarchical relationship in which the clinician listens to the client’s concerns, emphasizes when they engage in “change talk,” and helps them develop self-efficacy and confidence in their ability to change (Motivational Interviewing Network of Trainers, 2021; Walsh & Corcoran, 2010).

In practice, clinicians need to be mindful that their relationship with the client is part of the client's motivation. There is no formal assessment process, as the client can direct the topics they would like to explore. The following four principles are key in motivational interviewing:

- Begin where the client is and do not make assumptions about the client’s readiness to change.
- Explore problem behaviors and reflect the client’s perceptions while listening with empathy.
- Reinforce the client’s statements about wanting to change, and point out any discrepancies in the client’s values and goals.
- Affirm the client’s statements about their ability to change to help build their confidence.

The specific intervention techniques in motivational interviewing are eliciting self-motivated statements, handling resistance, the decisional balance, and building self-efficacy (Walsh, 2010).

In cancer care, motivational interviewing can foster a sense of autonomy when a person feels out of control because of the diagnosis. It has been shown to resolve patients' ambivalence about certain behavior changes, such as quitting smoking, exercising, or joining a support group. A few techniques used in motivational interviewing, such as reflection statements and summarizing, can help patients express their feelings, accept help, and adhere to treatment (Caba et al., 2024).

Meaning-Making Model

Crystal Park and Susan Folkman developed a meaning-making model focused on stress and difficult events, as well as on people's reactions to them. Their model has two levels of meaning: global and situational (Park & Folkman, 1997).

- Global meaning is a person's beliefs, values, and goals, or the way they view many situations (Park, 2013). It can provide people with stability, optimism, and a sense of personal relevance (Park & Folkman, 1997).
- Situational meaning is the interaction between a person's global meaning and a specific instance or event (Park, 2013; Park & Folkman, 1997, p. 116). A person will look for meaning in the event through "initial appraisals of the situation, the revision of global and appraised meanings (the meaning of the stressor), and the outcomes of these processes" (Park, 2013, p. 40).

Park and Folkman propose that people cope with stressful events through meaning-making. Park (2013) states,

> *"The meaning-making model is discrepancy-based, that is, it proposes that people's perception of discrepancies between their appraised meaning (the*

> *meaning of the stressor) of a particular situation and their global meaning creates distress, which in turn gives rise to effects to reduce the discrepancy and resultant distress"* (p. 40).

Problem-focused and emotion-focused coping strategies can help people cope with discrepancies in meaning. In situations where people have minimal control, such as trauma, loss, and serious illness, meaning-making is the most adaptive. People typically seek a more favorable understanding of their situation and its impact on their lives. People will work to change the meaning of the stressor by assimilating it into their lives or by changing their global beliefs to improve the fit between it and their beliefs. This process can lead to better adjustment, mainly if adequate meaning is found (Park, 2013).

After a cancer diagnosis, people may search for meaning in it as they adjust and cope with the diagnosis. Understanding meaning-making can help patients process the diagnosis and find meaning within it.

Dignity Model

Dr. Harvey Max Chochinov developed dignity therapy to support people who are facing the end of their lives. Questions asked during dignity therapy are based on some aspects of the dignity model. Research has shown that three categories of factors can support or compromise a person's dignity when they are dealing with a medical issue. These factors make up the dignity model.

- The first category is illness-related issues, or how the illness affects a person's feelings about their dignity.
    - Patients may be concerned about losing their functional and cognitive independence and experiencing distressing physical and psychological symptoms.

- The second category is the dignity-conserving repertoire, or how a person’s perspectives and practices can impact their dignity.
    - Patients may perceive their situation based on the following aspects:
        - Autonomy and a sense of control
        - Acceptance of what is happening
        - Maintenance of pride
        - Hopefulness about the future
        - Role preservation
        - Continued sense of self
        - Resilence
        - Generativity/legacy
- The third is the social dignity inventory, or how others treat the person with a disease, which can support or erode dignity. Studies point to the following five factors as most significant to patients from a social perspective:
    - A sense of control over privacy and boundaries
    - Social support
    - Being treated with respect and kindness
    - Being a burden to others
    - Worrying about the suffering of people they love after death (Dignity in Care, 2022)

For clinicians providing cancer care, it is beneficial for them to be aware of these factors and to know how to intervene appropriately. Dr. Chochinov offers several strategies to address dignity-related concerns.

Grief, Loss, and Bereavement Theories

Clinicians may use several different grief, loss, and bereavement theories in psychosocial oncology care. This section will discuss the awareness context theory, anticipatory grief, disenfranchised grief, ambiguous loss, and continuing bonds.

Awareness Context Theory

Awareness context theory was developed in the 1960s by Dr. Barney Glaser and Dr. Anselm Strauss. Through studying the process of dying, they found that patients were often unaware they were dying, while family members and hospital staff were aware of it. Glaser and Strauss reported that the reason for this discrepancy was that doctors and nurses took a paternalistic approach in medicine and controlled the amount of information they shared with patients. More often than not, they would not inform patients that they were dying.

Through their research, Glaser and Strauss identified the following four types of awareness contexts:

- Closed awareness - Family, friends, and medical staff are aware that a patient is dying, but the patient themself is not aware.
- Suspected awareness - The patient knows their condition is concerning, but no one is telling them. So, they look for cues in the behavior of the people around them to confirm their suspicions.
- Mutual pretense awareness - The patient and everyone around them know that they are dying, but no one talks openly about it.

- Open awareness - The patient and everyone around them know they are dying, and they openly acknowledge it.

They found that a closed awareness context was most commonly used in patient care, which heightened awareness and concern about this issue. Over time, an open awareness context became preferred with medical providers having open, honest conversations with patients so that they are aware of their condition, they can make decisions, and plan for their deaths.

Awareness context theory has developed over the years, with other researchers recognizing the role that patients play in this dynamic. Most recently, it has been found that while doctors may control how and when they share information, patients also control what they do with it. For example, some patients accept information without question, while others seek clarifying information. Some patients may also dismiss information and believe what they want, while others believe what they hear and seek information when they feel it is needed (Furber, n.d.).

Awareness context theory is relevant to cancer care as more than 618,000 people are expected to die from cancer this year (American Cancer Society, 2025b). Awareness context theory can inform clinical practice by helping health care providers acknowledge the importance of the information they share with patients, how they convey it, and the pace at which they deliver it. At the same time, health care providers also need to consider what patients will do with the information, how they feel about it, and how they perceive it. Both sides are essential in health care communication.

Anticipatory Grief

Anticipatory grief is the term for the grieving that occurs before a loss. More often than not, deaths occur with some forewarning, and during that time, a person anticipates the loss and starts the tasks of mourning and experiencing grief. Some studies have shown that anticipatory grief helps post-death bereavement, while others have shown that it does not shorten or provide relief to the bereavement process (Worden, 2009). Oncology social workers can support patients and their loved ones as they process anticipatory grief and begin the tasks of the mourning.

Disenfranchised Grief

Dr. Kenneth Doka initially developed the concept of disenfranchised grief, which refers to “losses in the mourner’s life of relationships that are not socially sanctioned” (Worden, 2009, p. 2). These could be deaths that are considered unimportant by society, such as a miscarriage, a pet, or a person who was not a spouse or blood relative, or the relationship or cause of death could be stigmatized by society. Relationships that may be stigmatized by society include a same-sex partner or a partner from an extramarital affair. Causes of death that may be stigmatized are death by suicide, a drug overdose, or death due to HIV/AIDS. People with these types of losses and others may have their grief minimized by people that they love, causing them to feel ashamed and like they are grieving alone. It is common for people with disenfranchised grief to have difficulty moving through the grieving process or to struggle significantly with subsequent losses. They are also at risk for illness, low self-esteem, and using alcohol or drugs to cope with the loss (Kennedy, 2023).

People with early-stage cancers or lifestyle-related cancers may experience disenfranchised grief. For example, people with early-stage cancers typically have a good prognosis and may not receive as much acknowledgment of their experience living with cancer. They may be told that they have a “good” type of cancer or that they will be “fine.” People with lifestyle-related cancers, such as lung cancer after smoking, may carry shame for their diagnosis and feel like they are not able to grieve the losses they are experiencing as a result of their actions (Noack, 2024).

Ambiguous Loss

Dr. Pauline Boss coined the term ambiguous loss in the 1970s to “describe losses that are unclear or unconfirmed” (Mooney, 2023, para. 1). Boss proposed that there are two types of ambiguous loss: physical and psychological.

- Physically ambiguous losses are those that happen when a person is physically absent but psychologically present (Mooney, 2023, para. 2). For example, missing persons, people who are deployed, or those who are incarcerated.

- Psychologically ambiguous losses are those that happen when a person is psychologically absent but physically present (Mooney, 2023, para. 3). For example, people living with dementia, traumatic brain injury, or addicted to substances.

Ambiguous losses can be challenging to make sense of. The present person may experience confusion, frustration, and agony. People experiencing an ambiguous loss may benefit from dialectical thinking, learning to understand and communicate their loss, and achieving closure by seeking meaning in it (Mooney, 2023).

After a cancer diagnosis, some of the losses may be unclear, and there may never be closure. Life can feel out of control, things become unknown, good health is lost, and the sense of self can become devalued. People may also lose relationships and obligations, parts of their bodies, and their sense of normalcy. Dialectical thinking can also help patients cope with these experiences, and clinicians can teach patients “both-and” thinking to feel both losses and hopes that may come with the diagnosis (Hill Schnipper, 2022).

Continuing Bonds

Continuing bonds are ongoing attachments to the deceased after a death. Connections are often made in new ways, such as talking with the person, sharing their stories, and engaging in activities they enjoyed, such as cooking or volunteering. Research in this area is ongoing, but some studies have shown that continuing bonds are adaptive for some people, while others are maladaptive. A few positive things about continuing bonds are that they:

- Acknowledge the ongoing nature of grief.
- Normalize staying connected to a deceased loved one.
- Describe many grief-related behaviors.
- Help people cope with grief (Haley, 2018).

When someone has lost a loved one to cancer, continuing bonds can help them stay connected to their loved one and may help them cope with the loss. Clinicians can support people as they find the appropriate place for the deceased person in their lives, “a place that will enable them to go on living effectively in the world” (Worden, 2009, p. 51).

Psychoeducation

Psychoeducation was initially developed early in the 20th century. Still, it emerged in its current form in the 1980s, based on the work of Dr. Carol Anderson and her colleagues, who drew on their research using CBT and family psychotherapy to treat mental health conditions (Rholetter, 2024). Providing information through education or psychoeducation “typically differs in scope, focus, and qualifications of the service provider” (Engstrom, 2006, p. 232). For example, in cancer care, medical providers, such as oncologists, surgeons, advanced practice providers, and nurses, primarily provide education about the cancer itself, the typical course of the disease, the treatments, side effects, and how patients can take care of themselves.

Psychoeducation is different from education in that it assists patients and families with “understanding the condition, including its course, expected outcome, treatment, and psychosocial components” (Engstrom, 2006, p. 232). Professionals trained in mental health, such as oncology social workers, often provide psychoeducation and draw on psychotherapeutic strategies, including understanding cognitive and behavioral frameworks. According to Rolland (1994, as cited in Engstrom, 2006), “the inclusion of psychoeduational approaches allows for the emotional and cognitive processing of the information and may assist people with developing a psychosocial understanding of the condition and its meaning in their lives” (p. 232). For example, an oncology social worker may talk with a patient about the treatment they will receive. In that conversation, the patient may begin to process the psychosocial aspects of the treatment, such as the inability to work or fulfill other responsibilities. The oncology social worker can provide emotional support and help the patient begin to work through this aspect of their lives.

Providing Emotional Support and Normalizing the Cancer Experience

Oncology social workers often provide emotional support to patients and their loved ones throughout the disease trajectory (Zebrack et al., 2025). According to Burleson (2003, as cited in Parincu & Davis, 2024), “emotional support is an intentional verbal and nonverbal way to show care and affection for another… offering reassurance, acceptance, encouragement, and caring, making them feel valued and important” (para. 1). Key ways of providing emotional support include asking a person what they need, connecting and listening to them, asking questions about their experience and validating it, and keeping the focus on them

(Parincu & Davis, 2024). These skills are often inherent in oncology social workers and can be a significant part of their role.

It is beneficial for an oncology social worker to understand the common psychosocial responses, emotions, and needs at each stage of a cancer journey, as this can help validate and normalize the patient and caregiver experience. For example, at the time of a cancer diagnosis, it is normal for a patient to feel disbelief, shock, anxiety, overwhelm, fear, anger, and uncertainty about the future (Wells & Turney, 2001). When an oncology social worker is talking with a newly diagnosed patient, awareness of these common emotional responses helps them assess and listen for the patient's expression of them, and, in turn, they can normalize the patient's experience. On the other hand, if the oncology social worker is not hearing a patient express common emotions at the time of their diagnosis, there may be an opportunity for further assessment, processing, and support. Many more opportunities to offer emotional support exist in psychosocial oncology care and are part of the supportive counseling oncology social workers provide to patients and caregivers throughout their illness.

Normalizing a patient's experience can be a simple yet powerful intervention. When used appropriately, it helps a patient to know that what they are experiencing is a regular part of the human experience or a typical response. Normalizing can help people release shame, decrease perfectionism, reduce isolation, shift their thought patterns, increase resiliency, and improve their relationships (Zuber, 2025). In cancer care, emotional support can reduce psychosocial stress, enhance quality of life, and improve emotional well-being (Caba et al., 2024).

Summary

Oncology social workers can use the theories and therapies outlined in this section as frameworks for psychosocial assessment intervention. When oncology social workers meet patients and their loved ones as early in the disease trajectory as possible, they can conduct an initial psychosocial assessment and develop a psychosocial plan of care. Throughout a patient’s illness, an oncology social worker can continue to assess psychosocial needs, coping, role changes, and transitions, and use the frameworks outlined in this section to support their practice.

Section 2 Reflection Questions

What theories inform your clinical practice?

What therapies do you use most often in your work with patients and caregivers?

Section 3: Serious Illness Conversations

References: 1, 3, 12, 13, 30, 39, 42, 50, 55, 64, 66, 67, 81

According to Shilling et al. (2024), “conversations between patients, caregivers, and clinicians about patients' care preferences, values, and goals for care and life in the context of prognostic awareness, otherwise known as serious illness communication, are essential components of cancer care” (p. 1). Though these conversations are crucial and recommended in national guidelines, research has shown that few patients engage in them with their health care team. Inequities by race and ethnicity also exist, with lower rates of serious illness communication happening between clinicians and Black and Hispanic or Latino patients compared to White patients.

Studies have shown that patients who engage in serious illness conversations with their health care teams receive care that is aligned with their goals, values, and preferences, and that they have lower rates of anxiety and depression compared to patients who have not had these conversations. They also reduce unwanted care near the end of life, including acute hospitalizations, and increase hospice care. Additionally, these conversations are associated with family members feeling less burdened by complex decision-making, better coping, and improved bereavement outcomes (Fromme, 2025; Schilling et al., 2024).

One contributing factor to these benefits may be viewing these conversations as a process that unfolds over time, ideally starting when the patient receives their diagnosis and continuing throughout the course of care, especially when patients are expected to live for a year or less. Viewing conversations as a process can also give patients and caregivers time to process, rather than making difficult decisions as the patient's condition declines. It is also helpful if conversations can adapt to the patient's prognosis and to patients and caregivers changing their care preferences. Another contributing factor may be that these conversations can also create a space for the health care team to understand a patient's and caregivers' knowledge about the illness and prognosis, while responding to their emotions and learning about their communication preferences, values, care preferences, and goals of care, ultimately allowing for open communication among all involved.

While barriers to serious illness conversations exist for patients, clinicians, institutions, and payers, successful strategies for implementing them in clinical practice have emerged. One effective strategy is a multidisciplinary team-based approach, including social workers, to have these conversations (Schilling et al., 2024). Different types of social workers, including oncology social workers, are "uniquely positioned to explore patients' goals and values because of their holistic approach and their skill at simultaneously addressing patients' individual, family, and sociocultural needs" (Aaronson and Greenwald, 2023, para. 2). Social workers are skilled at developing trusting relationships with patients and their loved ones. They are often effective communicators, serving as clinicians who can facilitate conversations among care teams, patients, and caregivers. Social workers can explore the patient's goals and preferences, assess the patient's understanding of their illness and prognosis, and provide a space for them to share their worries about their condition worsening. They can communicate this information to the medical team and assist the patient with completing advance directive documents. Social workers can also identify resource needs and refer people to appropriate community support. They practice cultural humility and can interpret how each individual's unique psychosocial factors influence the medical decisions that they make, which ultimately impact their outcome. (Ariadne Labs, 2023a; Givens, 2023). All of these skills and more help ensure that patients and caregivers receive "supportive, client-centered, and goal-concordant care" (Givens, 2023, para. 19).

The Advance Care Planning Continuum

Izumi and Fromme (2017) developed a model to promote a clinician's understanding of the process of advance care planning. The model looks at advance care planning as ongoing conversations to understand a patient's goals and values throughout the disease process. The goal of advance care planning is "when end-of-life decisions need to be made, and the person is not able to make them, families and health care providers are prepared to make the decisions based on an understanding of the patient's values and preferences" (Izumi & Fromme, 2017, p. 220). Since many end-of-life care preferences are not discussed until there are no curative options or a patient's condition has declined, this model can help with recognizing that advance care planning is "appropriate for any adult with decision-making capacity, including those in good health" (Izumi & Fromme, 2017, p. 220).

Identifying Surrogate Decision-Makers and Completing Advance Directives

The model shows that advance care planning conversations should start when a person is healthy. The first phase is for a patient to name a surrogate decision-maker, which can be documented in the patient’s chart. Then, the patient can move to the next phase: completing advance directives that specify preferences for health care decision-making, particularly regarding end-of-life care and life-sustaining treatment. The documents that are most often considered advance directives are a health care power of attorney (also known as a health care proxy or durable power of attorney for health care) and a living will.

- A health care power of attorney is the “legal appointment of an individual to speak for a person should that person become decisionally incapacitated” (Colon, 2006, p. 622). This document ensures that a patient’s wishes are followed when they are unable to express them verbally. The person appointed should be someone the patient trusts and feels comfortable discussing these topics with, as they will be the one to communicate the patient’s wishes to the health care team. It is helpful if the health care power of attorney is comfortable advocating on the patient’s behalf, as there may be disagreements among family members and/or the health care team.
- A living will outlines a patient’s wishes about receiving or withholding life-sustaining treatment, such as mechanical ventilation, artificial nutrition and hydration, blood transfusions, dialysis, and antibiotics. This document should be viewed as a directive of care when a patient is unable to express their wishes in this area.

Social workers are often the interdisciplinary team members who discuss advance directives with patients, providing education about the documents themselves, how they are used, and the benefits of having them. They can also assist patients in completing the documents and ensure they are included in their medical records. If a patient has already completed the documents, the social worker can review them to ensure the information is up to date and aligned with the patient’s goals and values. Additionally, social workers can help a patient discuss their wishes with their designated health care power of attorney (Colon, 2006).

As noted above, in Izumi & Fromme's model, advance directives should be completed when a person is healthy. However, oncology social workers typically meet patients who already have a diagnosis of cancer and may be at varying levels of their illness. Therefore, it is beneficial for an oncology social worker to discuss advance directives with a patient as early as possible in the disease trajectory.

Serious Illness Conversations

The next phase in Izumi & Fromme's advance care planning model is serious illness and goals-of-care conversations (Fromme, 2025). According to LeBlanc and Tulsky (2025), the term "goals of care" may be used to refer to a patient's preferences for resuscitation, or "code status," during a hospital stay. However, they offer a broader definition that includes decisions about specific treatments, the intensity of care, and planning for future care needs.

Considering the timing of these discussions is key. According to the model, these conversations can begin when a person becomes ill (Fromme, 2025). LeBlanc and Tulsky (2025) state,

> *"Goals of care discussions should occur early and often in the course of a life-threatening illness. Discussing goals of care should be part of every clinical encounter that involves a decision, especially in the setting of progressive life-threatening illness, and should usually occur separately from the delivery of serious news" (para. 7).*

One reason goals-of-care discussions are beneficial early in the disease process is that they can be conversational and exploratory, allowing the health care team to learn about the patient's story and personal context in which they make decisions, rather than occurring in a crisis when things are intense and emotional. When these conversations happen early and often, patients have time to process information, ask questions, discuss topics with their loved ones, and make decisions without pressure. Patients can reflect on how they want to live in the time they have left, their personal goals, and the tasks they want to complete before they die.

Another aspect of timing is considering specific medical situations that prompt discussion of goals of care. In cancer care, these medical situations can include:

- An adult with a limited life expectancy, such as 6 to 12 months or less.
- Patients with certain types of cancer, including non-small cell lung cancer, nonresectable pancreatic cancer, or brain cancer.
- Patients who are starting a new chemotherapy regimen.
- Patients who are 70 years or older with acute myelogenous leukemia.
- Patients who have relapsed after a stem cell transplant.
- Patients who are on their third line of chemotherapy treatment.
- Patients aged 80 or older who are hospitalized.
- Other prognostic factors (LeBlanc & Tulsky, 2025).

Facilitating Serious Illness Conversations

As noted above, a team-based approach is one of the effective ways to implement serious illness conversations. Oncology social workers are often part of the health care team that engages patients in these discussions. Sometimes they lead the conversation alongside the health care team; other times, they may participate in it or speak 1:1 with a patient.

Some best practices for facilitating serious illness conversations include “sharing prognostic information, eliciting decision-making preferences, understanding fears and goals, exploring views on trade-offs and impaired function, and wishes for family involvement” (Bernacki et al., 2014, as cited in ACP Decisions, 2021).

Ariadne Labs (2023a) has published best practices for social workers to facilitate serious illness conversations. First, there are some considerations before the conversation happens, including:

- Whether there is an opportunity to prepare the patient and their loved ones in advance.
    - If the conversation will happen with other members of the health care team, the oncology social worker can coordinate who will inform the patient and arrange a time to meet, if it is not already scheduled.
    - If the oncology social worker will be speaking with the patient 1:1, they can make arrangements with the patient directly beforehand, if possible, and update the health care team.
- Talking with the health care team and any community or consult services ahead of time, whether they will be present during the conversation or not, to ensure the team is on the same page regarding prognosis and care recommendations.
- If members of the health care team will be present, the oncology social worker can share any information outlined below so the team is aware.
    - Whether advance directive documents are in place or if this needs to be discussed during the conversation. The oncology social worker may already have spoken with the patient, so a follow-up about the documents may be all that is needed.
- Thinking about any family or cultural dynamics that might affect the conversation and/or the patient’s plan of care.

- Considering whether the patient has a trauma history.

During the conversation, the following is recommended by Ariadne Labs (2023a):

- Using the Serious Illness Conversation Guide to navigate the conversation.
    - The first step is to set up the conversation by asking the patient whether it is okay to discuss their health and what matters to them.
    - The next step is to assess the patient's understanding of their health at the moment of the conversation. The clinician can also ask the patient what information would be most helpful to discuss.
    - After the patient shares their responses to the two items above, the third step is for the clinician to share their understanding of what may lie ahead for the patient's health (prognosis).
        - If other team members are present during the discussion, prognosis could be discussed by a medical provider, such as an oncologist, advanced practice provider, or palliative care provider (Ariadne Labs, 2023b).
        - If the only person from the health care team present during the conversation is the social worker, there are some approaches a social worker can use to discuss the prognosis without sharing a time-based one.
            - First, they can ask the patient how much information they want to know about the future of their illness.
            - Sharing the prognosis as "anticipatory guidance" that allows for the reality of uncertainty of the patient becoming more ill.

        - The language about uncertainty in the Serious Illness Conversation Guide acknowledges that it is difficult to predict what may happen in the future, that there is hope the patient will feel well for as long as possible, but that it is also likely they will become sick quickly.
        - Instead of focusing on how the patient will feel, it could focus on preparing for how they will function when things become more difficult.
        - No matter the language used, the intent is to prepare for when the patient becomes more ill and is unable to do the things they used to do or are currently doing.
        - The oncology social worker can also team up with a clinician who can provide a time-based prognosis at a later time.
    - Then, allow for silence and provide space for people to speak. The oncology social worker can also validate and explore the patient’s emotions. If a patient’s loved one is present, their feelings can also be discussed and supported.
- The fourth step is to ask questions to explore topics, such as:
    - The most important goals for the patient.
    - Their biggest worries.
    - What brings them strength, and what activities bring meaning and joy to their life?

        - How much the patient would be willing to go through for the possibility of more time.
        - What the patient has shared with those who are closest to them about their priorities and wishes for their care.
        - The hopes for their health (Ariadne Labs, 2023a & 2023b).
    - The fifth and final step is for the clinician to reflect on what is important to the patient and what they are hoping for. Recommendations can also be made by a medical provider or oncology social worker.
        - If other team members are present during the discussion, they can make medical recommendations. Then, they can ask the patient for their thoughts on the recommendations and whether they align with what is important to them (Ariadne Labs, 2023b).
        - If the only person from the health care team present during the conversation is the social worker, they can also do the following things based on what the patient shared:
            - Express any concerns, including mental health concerns, and explore options for additional support. Offer to reach out to others for support, such as a chaplain or a community resource.
            - Encourage the patient to invite someone close to them to their next appointment or conversation, if that person is not already present.
            - Offer to share the information they discussed with the health care team (Ariadne Labs, 2023a).

After the conversation, the following is recommended by Ariadne Labs (2023a):

- Checking in with the patient and their loved one(s), and the health care team to see whether a debrief would be helpful.
- Reflect on any significant distress demonstrated by the patient and/or their family.
- Consider any psychosocial dynamics that are impacting the plan of care.
- Consider if the patient would benefit from any education, support, resources, or legacy work.
- Consider whether an advance care planning documentation conversation would be beneficial.

The oncology social worker should also document their interactions with clients, including serious illness conversations, in their medical record. The National Association of Social Workers (2004) has published standards for palliative and end-of-life care, including guidance on documentation, which is interpreted as follows:

> *"Ongoing documentation of social work service should reflect the assessment, issues addressed, treatment offered, and plan of care, and must assure continuity of care between all settings (for example, hospital to hospice, nursing home to hospital)" (p. 26).*

Physician Orders for Life Sustaining Treatment

The next phase in Izumi & Fromme's advance care planning model is to offer a "Physician Order for Life Sustaining Treatment" (POLST) form when a patient is ill, and the trajectory of their illness is moving towards end-of-life care (Fromme, 2025). There is a national POLST form, but many states have their own version. According to the National POLST Coalition (n.d.), this form is a part of advance care planning and can help direct a conversation between a patient and their health care provider. The purpose of the form is for people who are seriously ill or frail to communicate their wishes about what types of care they would want during a medical emergency, including cardiopulmonary resuscitation (CPR), when they would like to be transferred to the hospital, and whether they would wish to receive artificial nutrition. An oncology social worker can discuss a POLST form with a patient and help them complete it, but it needs to be signed by an authorized provider, such as a doctor or advanced practice professional. Completion of the form should always be voluntary and can be revisited periodically. Additional guidelines for the POLST can be found in the "Appropriate POLST Use Policy" (National POLST Coalition, 2022).

End-of-Life Decision-Making

The final phase of Izumi & Fromme's advance care planning model is end-of-life decision-making (Fromme, 2025). When a patient is approaching the end of their life, it can be very overwhelming for them and the people that they love. Conversations and end-of-life care decisions build on prior discussions at all phases preceding this one. Clinicians can reference advance directives and a POLST form to support decision-making by the patient or their health care power of attorney.

When Patients Have Not Moved Through the Advance Care Planning Continuum

If the patient and their health care team have not engaged in serious illness conversations or if the patient has not completed advance care planning, including advance directive documents, the options depend on the patient's condition when an end-of-life situation arises.

- If the patient is in a condition in which they can make decisions and communicate them, the health care team will ask the patient to identify their surrogate decision-maker and their wishes regarding end-of-life care. They can offer the opportunity to complete advance directives and can document the conversation in the patient's medical record.

- If the patient is unable to communicate their wishes, the health care team will reference their state laws to determine who can make medical decisions on the patient's behalf. They will do their best to locate any family members or friends, or a physician may be assigned to represent a patient's best interests (National Institute on Aging, 2022).

End of life can be a tough time in the disease process, and oncology social workers play an essential role in discussing end-of-life care with people and supporting them through the process. They also play a key role in locating a patient's family members or friends, advocating for patients, and supporting their team members in these challenging situations.

Section 3 Key Terms

Advance care planning -the process of discussing values, goals, and preferences regarding future medical care with patients and those involved in their care. Patients may complete advance directive documents during this process.

Advance directives - health care power of attorney and living will documents. A Physician Order for Life Sustaining Treatment" (POLST) form may also be completed by a patient in some situations.

Health care power of attorney - the "legal appointment of an individual to speak for a person should that person become decisionally incapacitated" (Colon, 2006, p. 622). This document ensures that a patient's wishes are followed when they are unable to express them verbally.

Living will - outlines a patient’s wishes about receiving or withholding life-sustaining treatment, such as mechanical ventilation, artificial nutrition and hydration, blood transfusions, dialysis, and antibiotics. This document should be viewed as a directive of care when a patient is unable to express their wishes in this area.

Physician Order for Life Sustaining Treatment” (POLST) form - completed when a patient is ill, and the trajectory of their illness is moving towards end-of-life care (Fromme, 2025). The purpose of the form is for people who are seriously ill or frail to communicate their wishes about what types of care they would want during a medical emergency, including cardiopulmonary resuscitation (CPR), when they would like to be transferred to the hospital, and whether they would wish to receive artificial nutrition

Section 3 Reflection Questions

What has been your experience in your practice with advance care planning?

What is your comfort level with engaging patients and their loved ones in this process?

What resources for advance care planning and serious illness conversations have you found helpful?

Section 4: Facilitating Communication Between Patients, Families, and Health Care Providers

References: 41, 65

Communication is key to patients receiving adequate health care. When a patient and their health care provider can communicate in ways that lead to understanding one another and exchanging accurate information, studies show that positive results include the following:

- Patients are more satisfied with their care and are more likely to follow through.
- Patients have a better quality of life with reduced anxiety and other symptoms.
- Patients know about their disease and prognosis, and are more likely to participate in a clinical trial (National Cancer Institute, 2025).

Patient, Family, and Health Care Provider Considerations

To their cancer care, patients bring “sets of beliefs, expectations, values, and goals that are culturally constructed in the sense that they are determined by each individual’s life experiences” (Gehlert, 2006, p. 253). For example, if a patient’s family member had cancer, that experience is likely to impact their approach to dealing with their illness. Health care providers also bring their own beliefs, expectations, values, and goals, shaped by their personal experiences, their profession’s culture, and the culture of their work setting. For example, an oncologist’s goal may be to treat cancer as effectively as possible, given the available treatments. Still, some patients may not want conventional therapies, which, in some situations, can cause tension.

The health beliefs that patients and families hold affect their behaviors and communication with health care providers. These beliefs are often learned through socialization and are likely well-established within the group(s) to which a patient and their family belong. Culture can guide how they understand the cause of their illness and its treatments, which symptoms they discuss, their expectations of providers, and the personal meaning they attach to the disease. From a cultural perspective, patients and their families may also view the condition they are dealing with as an illness, one that not only impacts them physically, but also socially, psychologically, and culturally. At the same time, physicians may focus on a condition as a disease that affects organs or other systems of the body (Gehlert, 2006). In general, “the more dissimilar the cultural constructions of the reality of the two, the more difficult will be the negotiation” between the patient and their provider (Gehlert, 2006, p. 257). The cultural construct that illness and disease are not directly correlated can lead to miscommunication, frustration, and a lack of trust between patients and their health care providers, because each person has their own viewpoint. When doctors focus only on the physical aspects of disease while patients look more broadly at the impact of illness across all areas of their lives, their communication is misaligned. Patients may feel their complaints are not being taken seriously, while doctors may feel their recommendations are not being followed.

Families also have their own approaches to illness, with variations in how they work together to manage it, how they work with providers, and how they communicate with each other and others in their lives. For example, some families do not talk about illness with one another, while others may be enmeshed in the patient’s care. It is helpful if an oncology social worker learns about a patient’s family history of illness, as this provides insights into how prior experiences shape the patient’s reality (Gehlert, 2006).

Additionally, the diagnosis of cancer can bring a wide range of emotions, including overwhelm, fear, worry, anger, and sadness. These emotions also fluctuate throughout the illness trajectory. While experiencing these emotions, patients and families are trying to absorb a lot of information about the diagnosis and treatment options, often with unfamiliar terms, and make decisions that are heavily weighted. When people are emotionally and cognitively overwhelmed, they may have difficulty knowing what questions to ask, processing information, coping, and communicating effectively.

The Oncology Social Worker's Role

When things are misaligned between patients, their families, and medical providers, based on cultural perspectives or for other reasons, oncology social workers who are aware of these misalignments can "help to remedy the situation by pointing out the discrepancy, interpreting each side's frustration to the other, and helping to establish a clinical accord" (Gehlert, 2006, p. 258). Dr. Richard Cabot, who worked alongside Ida Cannon, viewed social workers as translators in health care environments, meaning that they can see both sides of the picture and help with the provision of care and information. Therefore, oncology social workers can use their inherent skills of listening with empathy and communicating with all the people involved in the patient's care to get to a place of understanding and collaboration.

Section 4 Reflection Question

What strategies or techniques do you use in your practice to facilitate communication between patients, families, and members of your team?

Section 5: Collaborating with Supportive Services Team Members

References: 4, 6, 22, 26, 27, 56, 76, 80, 99, 103

Oncology social workers practice in different settings, including comprehensive cancer centers and large health systems, smaller community hospitals, community organizations, and private practice. They are often integrated into a larger interdisciplinary team or agency staff, and "engage in specific practice behaviors throughout the continuum of care and across multiple practice settings" (Zebrack et al., 2025, p. 2). One study examining oncology social work practice behaviors found that about 75% of oncology social workers considered themselves part of the interdisciplinary medical team. In contrast, only about 7% considered themselves part of a team of other allied health professionals (Perlmutter et al., 2022). However, oncology social workers often work alongside other psychosocial team members, including psychologists, expressive therapists, palliative care providers, and others, whether they are at their institution or in the community.

Distress screening often indicates a need for psychosocial support, and oncology social workers are usually the professionals responding to distress. Additionally, oncology social workers engage in psychosocial assessments throughout the disease trajectory, explore various aspects of a patient's life, identify their needs, and may refer them to other psychosocial team members for support. For example, a patient may enjoy expressing themselves through art and may benefit from meeting with an art therapist to support coping with their illness. Depending on the oncology social worker's work setting, several supportive services may be available or limited. Social workers often collaborate with other members of the psychosocial team to provide comprehensive, effective patient care. Some of these team members and their roles include:

- Psychologists - In oncology, psychologists assess cognitive and emotional functioning, provide psychotherapeutic management of mental health concerns that impact treatment, and intervene with patients who have high-acuity behavioral and adherence issues. They also offer individual psychotherapy for severe distress and can treat specific symptoms with psychological techniques (Loscalzo et al., 2021).
- Expressive therapists - Art and music therapy are mind-body therapies that use these modalities to help people process their thoughts and feelings, and cope with a cancer diagnosis.
    - Art therapy can include expressive therapies, including dance, somatic movements, and yoga, as well as visual therapies, such as

  drawing, painting, or visual journaling. It has been shown to reduce symptoms of anxiety and depression, and pain (American Cancer Society, 2025a).

  - Music therapy can be clinical or non-clinical. A certified music therapist typically provides clinical music therapy, including guided imagery, music creation, and the selection of music to help regulate emotions. Non-clinical music therapy can include playing or listening to music in a group setting, songwriting, and movement. Music therapy has been shown to help people relax, improve quality of life, and manage anxiety, depression, and pain (American Cancer Society, 2025c).

- Palliative care providers - A specialized type of medical care that is focused on providing relief from symptoms of an illness and/or side effects of treatment. Palliative care providers are often doctors, nurses, social workers, and chaplains who provide an extra layer of support in cancer care. The goal is to improve the quality of life for patients and their loved ones. It is based on a patient’s needs, not on their prognosis. It can be provided at any stage of an illness, either in the clinic or in a patient’s home (Center to Advance Palliative Care, n.d.).

- Child life specialists - In the adult oncology setting, child life specialists can help children understand and cope with an adult’s illness. They can also prepare children for visiting an adult in the hospital and support families as they navigate through difficult conversations (Cleveland Clinic, 2022).

- Bereavement specialists - Bereavement support can be provided by a variety of helping professionals, including social workers, psychologists, counselors, child life specialists, and expressive therapists. Bereavement support typically starts after the death of a loved one. It can help people understand their responses to loss and cope with and process it (CaringInfo, n.d.).

- Financial navigators - Cancer patients experience a greater financial burden than those with other chronic diseases—close to 50% of cancer patients in the U.S. report catastrophic levels of economic hardship. Financial navigators can assess for financial stressors and barriers, review and optimize patients' insurance benefits, and connect patients to programs, such as Medicare assistance, Medicaid, and copay, pharmaceutical, and foundation financial assistance. They can also serve as a point of contact for billing and insurance-related concerns and help patients navigate hospital assistance programs. They can work closely with oncology social workers to help patients through programs that alleviate distress related to medical and everyday costs (Schneider & Fuller, 2019).

The Collaborative Care Model

In 2017, a multidisciplinary task force established by the American Psychosocial Oncology Society reviewed different models that effectively support distressed cancer patients. The Collaborative Care Model has the most substantial evidence for efficiently providing care to large volumes of patients. Through research, the model has consistently shown effectiveness in treating mental health conditions, such as depression, anxiety, and post-traumatic stress disorder, substance abuse, and other psychosocial conditions. It enhances patient satisfaction and outcomes as well. The model is emerging in more psychosocial oncology programs, though the traditional referral-based model still predominates cancer programs today.

The traditional referral-based model provides patients with psychosocial care from multiple providers who work independently, which can lead to care becoming disconnected and limited feedback about the patient being shared among disciplines (Wu et al., 2023).

In the Collaborative Care Model, a team-based approach involves health care professionals providing efficient, comprehensive care. The key features of this model include “effective communication, shared decision-making, measurement-based stepped care, and ongoing collaboration (Wu et al., 2023, p. 34). Patients are assessed and managed based on their acuity and needs. Those who do not follow up or who seem to be improving may be referred to additional supportive services, such as psychiatry, psychology, or other services. The key components of this model include:

- A care manager, who is often a social worker, addresses mental health needs by providing psychoeducation and brief behavioral health interventions. They also facilitate communication between team members and patients.
- Population-based care means that the collaborative team takes responsibility for the well-being of a defined group of patients.
- Measurement-based care that uses patient-reported outcomes to guide shared clinical decision-making.
- Regular case review meetings to discuss patients, their treatment plans, and progress (Wu et al., 2023).

If an oncology social worker’s work setting does not use the Collaborative Care Model, oncology social workers can still collaborate on patient care by making referrals, discussing patients with other team members ahead of time, and debriefing on the support that each discipline is providing to the patient.

Section 5 Reflection Question

Which supportive care services do you interact with in your practice? What have these interactions been like for you? Are there certain aspects of the collaborative care model you could adopt at

Section 6: Facilitating Support Groups

References: 19, 21, 51, 69, 75

Support groups can be an effective intervention for cancer patients and their loved ones. It is common for people affected by cancer to feel isolated and unprepared to cope with the diagnosis. By attending a support group, they can meet people in similar situations, share coping strategies, and develop relationships with people who can relate to them. Support groups also play an important role in helping patients navigate the complex health care system and gain knowledge about cancer.

Oncology social workers are often leaders and facilitators of cancer-related support groups. They set the tone for the group, plan the group, screen potential participants, provide support and guidance during the group, and may follow up with certain members afterwards. Their most important role is creating a safe space where people feel comfortable participating without fear or judgment. To fulfill this role, group leaders need to be engaged and active, consistently demonstrating verbal and nonverbal behaviors that help participants trust the leader (Blum et al., 2001).

Types of Support Groups

In addition, there are different types of support groups, including psychoeducational, experiential, and psychotherapeutic.

- Psychoeducational - These are structured groups that “emphasize learning or developing skills for the purpose of prevention, growth, or remediation” (Niemann, 2002, p. 265). The groups are time-limited, organized, and incorporate learning with traditional group strategies. There is less emphasis on personal disclosure because goals are predefined, specific activities are outlined, and content is limited to particular topics (Niemann, 2002).
- Experiential - These groups use “various forms of expression, interaction, and hands-on activity to re-create and lead the patient safely to re-experience and process difficult emotions” (Keene, 2024, para. 1). Artistic forms of expression can be used in these groups, including music, art, dance, or writing. There may also be hands-on activities such as equine, adventure, and wilderness therapy. The idea with experiential groups is that patients can access subconscious negative experiences or emotions when they are expressing themselves artistically or physically. They can also examine their feelings and learn how to address any issues that arise (Keene, 2024).

- Psychotherapeutic - These groups may be “ongoing, patient-centered, and focused on the general expression of fears and concerns that may be too painful for patients to reveal to family and friends” (Pasacreta, 2024, para. 7). Psychotherapeutic groups typically focus on the cancer diagnosis, including the meaning and impact on people’s lives, and offer education and support (Pascareta, 2024).

Group Composition

Oncology social workers can organize support groups in various ways, including cancer type, disease stage, age, or other common factors, such as a new diagnosis, living with metastatic cancer, or receiving specific treatment modalities.

There may also be groups that are based on the relationship to the person with cancer, such as a group for spouses or parents (Blum et al., 2001). The benefit of a support group with cancer-related similarities is that members may be less overwhelmed by listening to painful experiences that they cannot relate to (Pascareta, 2024). However, support groups can be overwhelming, and people may feel hopeless or discouraged by listening to other people's stories in addition to living their own (Caba et al., 2024).

Next Steps

After the type of support group has been established and the group's composition and design are finalized, oncology social workers can begin recruiting and registering members. They will also need to be skilled in group facilitation skills and can consider additional training, if needed.

Section 6 Reflection Question

What is your experience creating and facilitating support groups?

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