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What does an oncology social worker deal with in patient consultations? - An empirical study

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ABSTRACT

The oncology social worker is a core profession in the psychosocial care of cancer patients, and has been scrutinised according to its role, function, and delivery of care, primarily from an Anglo-Saxon perspective. There is, however, a lack of studies outside this context, and empirical studies based on individual data. This study is a contribution by exploring the variability in clinical practice from a Swedish perspective. It is based on documentation from one oncology social worker’s (OSW’s) patient contacts over the course of one year. The essence of the majority of contacts was counseling and the patients displayed a wide variety of motives for seeing an OSW. The function of the OSW is thus multifaceted, and the findings suggest that the OSW, in addition to guiding patients in social legislation issues, also should be prepared to act as an anchor in an acute crisis, contain despair in different phases of the trajectory, and facilitate the ‘carrying on as before’ or finding a ‘new normal’. The paper discusses the importance of the OSW being acquainted with different counseling/psychotherapy perspectives in the illness context, but primarily the importance of having the ability to establish a ‘working alliance’ with their patients.

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Cancer; counseling; clinical practice; oncology social work

Introduction

The increasing number of patients afflicted with cancer or living with cancer as a chronic disease stresses the importance of paying attention to rehabilitative efforts. In Sweden, as in many other Western countries, cancer rehabilitation is frequently referred to as an important mission in clinical practice as well as in research. Most studies in this field focus on cancer patients’ symptoms of psychosocial distress and the development of symptom-reducing interventions to promote patients’ well-being. The rationale is that identified distress then should be addressed by health care professionals.

From other studies, however, we learn that there is rarely any correlation between distress on the one hand and patients’ desire for support on the
other (Morasso et al., 2010; van Scheppingen et al., 2011), that counseling is not appropriate for all (Moynihan, Horwich, & Bliss, 1999), that the readiness to address distress and emotional needs varies during the treatment trajectory (Baker et al., 2012), and that patients with cancer have different motives for seeking psychological counseling, not all of which are related to cancer distress (Morasso et al., 2010; Salander, 2010). Many patients seem to be able to deal with the challenges implied by cancer with support from ordinary health care, family and friends, while others, especially at certain stages of the illness trajectory, look for professional psychosocial support. Moreover, studies focusing on distress per se, do not tell us anything about the psychology of the distress, i.e. what is distressing.

In clinical oncology care, psychosocial services are, broadly speaking, most frequently provided by psychologists, followed by physicians, oncology nurses, and oncology social workers (OSWs) (Mehnert & Koch, 2005). In Sweden, however, there are very few psychologists involved in adult oncology care and the OSW is the core profession in adult psychosocial care (Isaksson, Lilliehorn, & Salander, 2017). Internationally, and primarily in Anglo-Saxon societies, oncology social work has received quite extensive attention in the literature concerning its role, function, and delivery of psychosocial care (Gadalla, 2007; Kowalski, Ferencz, Weis, Adolph, & Wesselmann, 2015; Pockett, Dzidowska, & Hobbs, 2015; Zebrack, Walsh, Burg, Maramaldi, & Lim, 2008), but there is a lack of studies outside the Anglo-Saxon context.

**Hospital social work in Sweden**

All social workers in Sweden receive the same basic training and social workers in health care are called hospital social workers (HSWs), of whom some work full-time or part-time in oncology, i.e. OSWs. HSWs are the only health care professionals with higher education and who are engaged in patient work in Sweden that lack legislation. There is no general regulation of work tasks for the profession and the clinical role and function of the HSW is quite vague. However, the HSWs’ overall assignment is commonly described as supporting and guarding a psychosocial perspective in the care of patients and as bridging between the biomedical and the social perspective in the medical context (NBHW (National Board of Health and Welfare), 2014). Carried out in clinical practice, this means providing patients and their next of kin with psychosocial support and counseling to strengthen their ability to cope with stressors connected to symptoms, illness, trauma, or crises, and moreover to work for changes in the patient’s social environment. The clinical work is primarily carried out in face-to-face contacts with patients and to some extent on a group level or as a part in multidisciplinary teams.
However, the literature on OSWs’ daily clinical work in both Sweden and internationally is sparse. We are rarely informed of what the clinical OSW role can entail in concrete terms, and studies based on individual data have accordingly been called for (Kowalski, Ferencz, Singer, Weis, & Wesselmann, 2016). This study is a contribution to this by adding a clinical, empirical perspective to the broader perspective of the OSWs’ role and function. With a benchmark in clinical social work, the aim of this study was to explore what an OSW deals with in psychosocial consultations with cancer patients.

Method

This study is part of a larger research project focusing on OSWs in Sweden and their function, status, and prospects for the future by exploring how they are working with psychosocial oncology and rehabilitation. The project was approved by the local ethics committee (Dnr: 2015/401-31Ö). Within the larger project, a nationwide survey was conducted in which the Swedish OSWs’ role and overall function was explored at a more descriptive level (Isaksson et al., 2017). We learned from the survey that the large majority (92%) of the OSWs are women, and that the ‘typical’ patient they meet is a middle-aged woman with breast cancer (Isaksson, Lilliehorn, & Salander, 2018). We also learned that for a majority of the Swedish OSWs’ their main clinical function seems to consist of psychosocial counseling and therapy for patients, which differs from OSW functions in other countries, where OSWs seem to be more occupied with screening, psychosocial assessment and discharge planning (Isaksson et al., 2017). Typically, contacts are initiated out of patients’ feelings associated with being diagnosed with cancer, and issues such as moving on in life and dealing with relationships are then added over the course of the consultations (Isaksson et al., 2018).

As a complement to these previous studies in the project, the present study takes a more explorative turn. By systematically focusing on what patients want to talk about in psychosocial consultations with an OSW, the focus is on exploring the variability in clinical practice rather than defining patterns in quantitative terms. Such an exploration was previously conducted regarding consultations with a psychologist in oncology care based on the case books of one psychologist’s patient contacts (Salander, 2010). The rationale of the present study was informed by that study (2010), and is based on the documentation of an OSW’s patient contacts over the course of one year.

Study context

This study is based on medical records and casebooks written by an OSW at a department of oncology at a regional hospital in Northern Sweden. The department is the main centre for specialised oncology treatment in the region, which is a largely rural area with a low population density. At the
time of data collection, the department had three positions for OSWs working with cancer patients in a similar way, and there was thus no differentiation as to the type of cancer they worked with. No psychologists worked at the department. New patient contacts were typically initiated by referrals from nurses or physicians, and contacts with out-of-town patients or their next of kin were in general completed or handed over to an OSW at the patient’s local hospital when the patient’s specialised treatment ended. One of the OSWs in the department was interested in participating in the study, a woman with three years’ experience in oncology, who was working part-time (75%) and was mainly engaged in outpatient cases.

To avoid biased data, e.g. that the research ambition might have an impact on the contacts between the OSW and her patients, only already completed patient contacts from the previous 12 month period (January 2015–December 2015) were included in the study. From a total of 105 cases, 18 less significant cases were excluded, i.e. cases without intervention from the OSW, such as when the patient declined contact or was referred to another OSW. Eighty-seven cases thus formed the basis for this study.

**Analysis**

SL compiled information on the patient’s age, sex, diagnosis, how the case was referred to the OSW, the number of sessions, the initial motive for contact, and the main themes/concerns that patients talked about with the OSW. A summary was made of each case, and the analysis continued according to the following steps:

1. The first (SL) and last (PS) authors read the summaries naïvely and discussed them in terms of their meaning in order to identify typical cases.
2. SL categorised the summaries by means of the similarities-differences technique in grounded theory (Strauss, 1987). Six preliminary categories emerged.
3. SL and PS jointly discussed the essence of, and demarcations between, the categories, and adjustments were made until inter-subjective agreement was reached (Kvale, 1996).
4. To test the confirmability of the categorisation, the second author (JI) was given the case summaries and the categories with the task of assigning the cases to the found categories.
5. The inter-rater agreement of the categorisation was tested by means of Cohen’s Kappa (Fleiss, Levin, & Paik, 2003). The resulting Kappa value was 0.45, and the z-value was significantly large (z = 6.56, p < 0.0001), which implies sufficient inter-rater agreement. Thus, no further reallocation of the categories was made.
Findings

A total of 302 face-to-face encounters with 87 patients were analysed. In 52% of the cases, the number of sessions was one or two, and the mean number of sessions was 3.9 (range 1–19, median 2). Sixty-seven percent of the patients were women, and the median age of the patients was 59 years (mean 62; range 25–89). Thirty-seven per cent of the patients were diagnosed with breast cancer and 22% with gastrointestinal cancer. Twenty per cent of the patient contacts were handed over to OSWs at the patients’ local hospitals when their treatment at the regional hospital ended.

The majority of the patients were referred to the OSW by nurses (41%) and physicians (31%). However, when considering the gender distribution of the referrals, obvious differences emerged: 53% of the women were referred by nurses and 26% by physicians, while 17% of the men were referred by nurses and 41% by physicians.

Of the 87 cases, 16 were exclusively administrative (category 1). The essence of all of the remaining 71 cases was counseling (categories 2–6). The categories and distribution of contacts are presented in Table 1.

Category 1. Information and guidance in social legislation issues (16)

These cases dealt with administrative help in patients’ economic situation, in the process of sick leave and return to work, rehabilitation options, or when in need of services outside of oncology care. The OSW gave information and guidance in how to claim rights and benefits and sometimes functioned as a mediator and coordinator of resources. These contacts were often held partly or only by telephone and were in general brief, but included a lot of indirect and miscellaneous client work such as making phone calls to authorities.

### Table 1. Age, gender and number of sessions sorted by categories (N = number of patients)

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<td>Women</td>
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<td>8</td>
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<td>58</td>
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<td>Men</td>
<td>5</td>
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<td>1</td>
<td>7</td>
<td>7</td>
<td>4</td>
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<td>Sessions</td>
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<td>Mean</td>
<td>3.6</td>
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<td>4.1</td>
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<td>Median</td>
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<td>1</td>
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<td>2</td>
<td>7</td>
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<tr>
<td>Range</td>
<td>1–13</td>
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<td>1–16</td>
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</tbody>
</table>
Category 2. Talking about the onset of cancer (10)

These contacts (5 women + 5 men; mean age: 60 years) were initiated shortly after diagnosis or in the early phase of treatment. The contacts were very brief, with a mean of 1.6 sessions (range 1–5), and the focus was often clearly defined and demarcated. It was common to talk about the experience of becoming ill, including the overall impact of being diagnosed with cancer and how life suddenly became different. When initiated around the time of diagnosis, the sessions mostly dealt with worries and a wish to understand the new situation:

At the age of 65, Ms 29 was diagnosed with metastasised lung cancer. She deteriorated rapidly and asked to see an OSW in order to grasp the fundamentally new life situation. She also asked for guidance in how to talk to her family. She was referred to an OSW at the local hospital when going home. (Two sessions)

Patients already in treatment when the OSW contact was initiated were often psychologically better off, but still wanted to talk about their experiences of becoming ill:

The onset of Mr 27’s brain cancer was complicated by intensive medical care. A couple of months later, when he felt better both physically and mentally, he and his wife wanted to talk to an OSW. The consultations concerned the traumatic onset of the illness and their thoughts and feelings connected to it. (One session)

In addition, patients with small children asked for guidance in their role as parents, or wanted to talk about their experiences of being in treatment far away from home.

Category 3. Talking about moving on in life after treatment (14)

Most of the contacts in this category (13w + 1m = 14, mean age: 53) were initiated at the end of or just after ending curative intended treatment. The mean number of sessions was 3.7 (range 1–17). All but one patient were women and most of them were still of working age. To some extent, these contacts dealt with becoming and being ill, but the substantial part of the focus was on life after treatment, on navigating their new life situation forward: internally, by means of existential reflections and reappraisals of life, and externally, when returning to a more ordinary family life and working life.

Internal navigation

Patients were concerned about existential thoughts such as facing an uncertain future, managing fear of recurrence, and thoughts on a possible untimely death:

Ms 14 asked for contact with an OSW at the end of her breast cancer treatment period. The cancer made her confront her mortality, and when about to move on after treatment she found it difficult to look ahead. The fact that she had retired
close to the time her cancer was diagnosed increased her burden – she could not find any contours of a trustful future. (Seven sessions)

**External navigation**

Moving on was also associated with re-engaging in the external world in terms of work, family, and leisure life while at the same time often struggling with remaining side effects. Returning to work was the most prominent issue, and many of these patients had a drawn-out recovery phase. They talked about the frustration due to impaired function and sought guidance in how to deal with reduced cognitive and physical function:

Ms 48 underwent treatment for breast cancer. She experienced only minor physical side-effects from treatment and returned to full-time employment just after ending radiotherapy. However, she apparently suffered from severe cognitive impairments and had to interrupt her return to work. Contact with the OSW was established, and the gap between her self-image and ability to function was, to her despair, identified. The OSW also collaborated with her employer and other involved actors. (17 sessions)

Even though a few patients were explicitly engaged in either internal elaborations or external affairs, most patients were engaged in both as they overlapped in the process of ‘moving on’. For example, many patients renegotiated their life priorities, which sometimes conflicted with their former way of living. Many patients found the transition from being in treatment to returning to a more ordinary everyday life to be complex; desired, but often unexpectedly burdensome.

Ms 87 was in the midst of her studies when she found out that she had gastrointestinal cancer. At the end of her treatment she was relieved but was also suffering from psychological turmoil. She had difficulty resuming her studies and reflected on how to move on with her life. She asked for a referral to an OSW. (Six sessions)

**Category 4. Talking about how life is clearly restricted by illness (17)**

The contacts in this category (10w + 7m = 17, mean age: 62) was initiated either in connection with a relapse or when patients with chronic cancer experienced life as restricted. The mean number of sessions was 2.8 (range 1–9). These consultations concerned how to live with a narrowed perspective and how to be attentive and find meaning in life when knowing that death was approaching. Patients described how they struggled with sorrow, losses and anxiety, while at the same time trying to be present in everyday life. To many of the patients, the body was of special concern. A deteriorating body reminded of illness and death:

Ms 85’s breast cancer developed when she was a young adult. When her cancer had metastasised, her physician recommended an OSW contact. She talked about
how she felt different and excluded from a normal life because of her illness and side effects. She also talked about the paradox of being bound to the clinic and treatments that reminded her of illness and death. (Six sessions)

Relationships were another common theme in these contacts. Patients appreciated the concern from their next of kin, but also found it troublesome to burden them:

Mr 25 knew already from the diagnosis of his gastrointestinal cancer that his remaining time was short. He met with an OSW both with his wife and on his own. They were both shattered by the sudden change in their lives. His primary subject of concern was, however, around his wife and how she would manage to see him deteriorate and then manage on her own. (Five sessions)

**Category 5. Psychiatric problems, extensive worry and anxiety (15)**

In contrast to categories 2–4, the contacts in this category (8w + 7m = 15, mean age: 59) were initiated at different stages of the disease trajectory. The contacts were on average longer compared to the categories above with a mean of 6.7 sessions (range 1–16), and the focus was to manage and reduce distressing symptoms, i.e. severe anxiety and worry. Every third of these patients had a previously established anxiety syndrome that was aggravated when the cancer was diagnosed:

Mr 19 suffered from severe claustrophobia already before the onset of his cancer. He panicked at the radiotherapy department, and an OSW contact was initiated. Over a week’s time, the OSW saw him at every radiotherapy session. (Five sessions)

Most of these patients were, however, suffering from more existential vulnerability:

Ms 75 asked for an OSW contact at the end of her breast cancer treatment. She was terrified that the cancer would relapse and end her life, and she asked for help in dealing with her severe anxiety. (Five sessions)

Unexpected changes in treatment, administrative blunders, or discontinuity in physician relationships could also trigger the anxiety.

**Category 6. Specific problems or concerns in life outside the illness (15)**

Most contacts in this category (11w + 4m = 15, mean age: 60) were initiated early in the illness trajectory. The mean number of sessions was 4.1 (range 1–19). Patients’ problems or concerns did not primarily emanate from, but was accentuated by, the disease. In about half of the cases they were a matter of complicated family contexts, i.e. the patients were formal or informal caregivers to a next of kin with physical or mental illness or had a problematic relationship with a specific family member:

Mr 59 had been a caregiver to his disabled wife for many years when he was diagnosed with gastrointestinal cancer. This implied a sudden and problematic
shift of positions. In the OSW contact, he did not pay much attention to his own situation. His concerns were with his wife and how to arrange a sustainable everyday life situation at home. (Two sessions)

In other cases, the problems were connected to patients themselves, such as prior to the cancer having fatigue syndrome, addiction problems, or, as in the case of Ms 34, being in a by and large transitional phase in life:

Ms 34’s life had changed in many respects. A few years from retirement, she had moved and changed both her work place and position, and then the breast cancer added another, more disruptive, change. When ending treatment, she found herself uncomfortable in her new situation. Not because of the cancer experience per se but how it shed a new light on her previous life changes. She asked for an OSW contact in order to make sense of things. (Four sessions)

Compared to cases in category 2–5, the cases in this category to a greater extent included practical/administrative matters such as arranging contacts with other social agencies.

Discussion

Collecting the documentation of an OSW’s patient contacts over the course of one year presented some interesting findings about what the clinical OSW role entails and the diversity of the OSW’s everyday clinical practice. Two thirds of the patients were women, and the majority of the patients had breast (37%) or gastrointestinal cancer (22%). The contacts were in general brief, and this was to some extent due to contextual circumstances at the regional hospital – every fifth patient were handed over to OSWs at patients’ local hospitals. The OSW had a purely administrative function for one fifth of the contacts, dealing with patients’ social legislation issues, while the essence of the remaining contacts was counseling.

Neither the age nor sex distribution in the material reflects the general distribution in cancer incidence. The over-representation of women with breast cancer corresponds with other studies (Gadalla, 2007; Kowalski et al., 2016), and it is especially middle-aged women with breast cancer who are seen as the ‘typical patients’ in psychosocial care (Mehnert & Koch, 2005). The over-representation of women might of course be due to different needs among men and women. However, it might also reflect that staff carried gendered norms and ideas of men as having different needs, implying that the referrals of patients from nurses and physicians to the OSW displayed a gender bias (Courtenay, 2000; Hamberg, 2008; Hamberg, Risberg, Johansson, & Westman, 2002; Moynihan, 2002). Nurses were more prone to refer women, and physicians to refer men. The causes for this are open to question, but because the majority of nurses are women, it can at least be suggested that, due to identification, women are more prone to refer women. Finally, the OSW in this study was a woman, but findings from other
studies tell us that the over-representation of referred women hardly depends on the gender of the psychosocial counsellor (Salander, 2010).

We furthermore only found obvious gendered distribution differences in category 3. The over-weight of middle-aged women might, as noted in a previous study (Lilliehorn, Hamberg, Kero, & Salander, 2012), be due to a double burdened situation of having the main responsibility for domestic work while recovering from side-effects of cancer treatment and preparing for a return to work. Otherwise, men and women seemed to have similar needs and asked for similar kinds of support.

The most obvious finding of the study is that patients for various reasons predominantly looked for counseling in their contacts with the OSW, which is in line with findings from previous studies on Swedish HSWs in general (Sjöström, 2013; Svärd, 2016) and Swedish OSWs (Isaksson et al., 2017, 2018) in particular. Overall, the OSW dealt with facilitating patients in coming to terms with the cancer and its consequences. In patient contacts where the cancer per se was in the forefront, the cancer seemed to have implied a ‘biographical disruption’ (Bury, 1982) to the patients, expressed in terms of psychological turmoil close to the time of the diagnosis (category 2) or by despairing symptoms such as anxiety or extensive worry elicited by the cancer or aggravated by it (category 5). In these consultations, the patients seemed to ask for an “anchor”, providing a space for talking about and exploring overwhelming feelings. The merit of a therapeutic context, a ‘safe place’, with an informed counsellor/therapist is in line with several studies on helpful aspects of counseling and psychotherapy in oncology (Hoeck, Ledderer, & Ploug Hansen, 2017; MacCormack et al., 2001).

In other patient contacts, main focus was on the consequences of the disease, e.g. how the illness had complicated already burdened lives and how it affected family members (category 6) as well as the multifaceted aftermath of treatment (category 3). Here, the patients seemed to ask for a facilitator in finding a ‘new normal’ (Baker et al., 2016), looking for guidance in the social, relational, and psychological adjustment to a new life situation. This emphasises the importance of the OSW’s contextual experience in meeting with cancer patients (Omylinska-Thurstone & Cooper, 2014).

Further, in one group of contacts (category 4), focus oscillated between the cancer as such, when knowing that the illness was infinite, and its consequences, e.g. losses and a narrowed life that accompanies a chronic illness. On the one hand, the patients seemed to ask for a container for their despair brought about by the prospect of a shortened and uncertain future (Refsgaard & Frederiksen, 2013) and, on the other hand, they asked for help in striving to maintain a normal life and to ‘carry on as before’ (Salander & Lilliehorn, 2016).

The variety of subjects that the OSW dealt with in patient consultations is in line with previous survey studies (Isaksson et al., 2017, 2018). The findings
also confirms that patients with cancer seek psychosocial counseling for subjects with no or only secondary connection to their cancer (Salander, 2010). Patients’ needs depend on the illness trajectory but also on their life context as a whole (Brennan, 2004; Isaksson, Salander, Lilliehorn, & Laurell, 2016; Salander, Lilliehorn, Hamberg, & Kero, 2011).

**Conclusion**

The findings of this study suggest that the range of what cancer patients want to talk about when seeking an OSW is wide and multifaceted. Patients ask for guidance in social legislation issues, an “anchor” in an acute crisis, a container of despair in different phases of the illness trajectory, and a facilitator in the strive to ‘carry on as before’ or to find a ‘new normal’. The character of the OSW’s function raises the question of acquaintance with different counseling/psychotherapeutic schools of thought, such as CBT for anxiety, systemic interventions for dealing with relationships, and humanistic/existential understanding for the new vulnerability (Miller, 2012). However, comprehensive research tells us that what primarily matters is competence in creating a ‘helping relationship’, be that in psychotherapy/counseling in general (Wampold & Budge, 2012) or, more specifically, in cancer care (MacCormack et al., 2001; Morgan & Cooper, 2015; Salander, 2010). This relationship has the potential to offer the patients a ‘safe haven’ (Ainsworth, 1989) to attach to when in strain. That the patients in the present study seemed to ask for an “anchor” and a container for guidance and facilitation can be interpreted from this perspective.

**On method**

There are some methodological shortcomings of this study. First, even though the identified assignments are in line with a previous survey (Isaksson et al., 2017, 2018), we cannot get away from the fact that the results are based on patient contacts with an OSW during one year at a regional hospital in Sweden. Second, because of the exclusion of ongoing contacts, the material does not cover the full range of long-term contacts. Third, the medical records and the case books are not pure reflections of a clinical reality, but to a certain extent constructions that might be influenced by the OSW’s experience, clinical knowledge and preferences. Transferability of the findings might thus be restricted. However, the intention of the study was not to generalise by quantifying types of consultations, but rather to delve into the diversity of OSWs’ everyday clinical reality – to explore what kinds of assignments they should be prepared for.

This study also has some obvious merits. Previous studies focusing on psychosocial support have concerned the provision and effectiveness of counseling
(Goerling et al., 2010; Kowalski et al., 2016, 2015), and useful therapeutic approaches (Boerger-Knowles & Ridley, 2014), and much attention has been given to the design and promotion of the most adequate interventions for specific problems (Bussell & Naus, 2010). These studies are undoubtedly important, but they do not capture a picture of the never-ending complexity of clinical reality. In contrast, informed by the rationale of Salander’s study (2010), the present study is based on empirical, consecutive material and focuses systematically on one OSWs’ clinical practice and what is dealt with in patient consultations. Further, the results are in line with previous studies based on a nationwide survey on Swedish OSWs, which consequently confirms the validity of the study.

**Practice implications**

Contextual circumstances in Sweden, such as the OSW being the core profession in psychosocial oncology and the main content of the patient work being counseling, implies special demands on the training and education of OSWs in order to match educational framing with clinical reality. Based on our findings, it is important that educational programmes provide students in social work with competence in different counseling/psychotherapeutic schools of thought, without forgetting the importance of building confiding relationships (MacCormack et al., 2001). Further, health care staff in the oncology setting can be of great assistance to patients by being familiar with the role and function of oncology social work and recurrently informing patients about the availability of an OSW-contact during the illness trajectory. Due to the over-representation of women receiving psychosocial consultation, seen in this study and elsewhere, it might also be a good idea to put emphasis on health care staff’s awareness of potential gender blindness and stereotyped preconceptions. Gender bias is an unintentional process, it is therefore reasonable to believe that critical reasoning and reflection are important for identifying and learning about it (Hamberg, 2008). This can be achieved by educational interventions of offering different kinds of reflecting forums in cancer care. Dealing with gender bias is important as stereotyped preconceptions might for instance imply that men’s psychosocial needs are being neglected.

**Disclosure statement**

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