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Two sides of the same coin – Oncology social workers' experiences of their working life and its pros and cons

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ABSTRACT

From the literature we learn that social workers in health care are exposed to different stressors connected to the risk for the development of burn-out or traumatization. However, there is a lack of studies that focuses on the social workers' own narratives on the burdensome, but also the rewarding aspects, of social work in health care. This study focuses on social work in oncology. Thematically structured qualitative interviews were conducted in a narrative form with 20 oncology social workers, half of whom were less experienced and half of whom were more experienced and with additional training in psychotherapy. The interviews focused on 'pros and cons of practicing social work' and the results were categorized by means of the similarities-differences technique. The burdensome cons concerned 'Organizational and professional barriers' and 'Demanding cases', with the latter divided into 'Impasse because of hopelessness' and 'Impasse because of helplessness'. The rewarding pros categories all concerned meaningfulness including 'Organizational meaningfulness', 'Meaningfulness from giving', 'Meaningfulness from receiving', and 'Meaningfulness from personal development'. Our findings indicate that the burdensome and rewarding aspects are two sides of the same coin. They are interconnected in the sense that the strain and challenge of being in situations of psychological despair also imply emotional satisfaction due to an experience of meaningfulness.

KEYWORDS

Cancer; clinical function; counselling; oncology social work

Introduction

The psychological and social impact of the workplace is a major topic in health care research, and there is an existing body of literature on how for example work place conditions, the interpersonal environment, motivators and personal characteristics impact on the worker. Clinical work with patients who are dealing with life-threatening illnesses presents unique challenges to the professional, and in the literature, a predominant focus has been on nurses and physicians, while less is known about other professions in the oncology team.

Oncology social work is a core profession in the psychosocial care of cancer patients, and a few studies have focused on how they psychologically are affected by their work. From these studies we learn about stressors such as the confrontation with mortality (Cunningham 2003), the management of vicarious trauma (Dane and Chachkes 2001), and that oncology social workers (OSWs) experience burnout, compassion fatigue and vicarious traumatization (Simon et al. 2006; Quinal, Harford, Rutledge, 2009; Najjar, Davis, Beck-Coon & Carney Doebbling, 2009). While burnout is a progressive state of emotional exhaustion and reduced accomplishment associated with workplace

characteristics (Sprang, Clark, and Whitt-Woosley 2007), it has been showed that compassion fatigue or secondary traumatic stress, also described as the emotional ‘cost of caring’, implies more advanced psychological disruptions regarding the professional function (Slocum-Gori et al. 2013). Vicarious traumatization, when the professional is traumatized by patients’ narratives, can be related to characteristics of the workplace or situation as well as to aspects of the professional her/himself, e.g. countertransference reactions (Dunkley and Whelan 2006). When it comes to the social impact of the workplace, a few studies have also pointed out that OSWs are affected by organizational barriers in terms of lack of support from their managers (Isaksson, Lilliehorn, and Salander 2017) and a poor understanding from other professions within the oncology team regarding their role (Pockett et al. 2016).

However, the literature is scarce in providing an understanding of OSW’s own experiences of their working life – what they perceive as burdensome and, equally important, what they perceive as rewarding. In spite of the amount of, and the character of, stressors, OSWs seem to be a fairly stable group of professionals (Zebrack et al. 2008; Isaksson, Lilliehorn, Salander, 2017), which indicates mitigating links between burdensome and rewarding aspects of their work. This study focuses on how OSWs’ regard their work and working life with the purpose of identifying experiences of pros and cons of being professionally engaged in cancer care.

Oncology social work in Sweden and internationally

In clinical oncology care in western societies, psychosocial services are, broadly speaking, most frequently provided by psychologists, followed by physicians, oncology nurses, and OSWs (Mehnert and Koch 2005). In Sweden, however, the OSW is the core professional in the psychosocial care of adult patients (Isaksson, Lilliehorn, and Salander 2017), while very few psychologists are involved in adult oncology care. Approximately one third of the OSWs have additional basic training in psychotherapy which might tell us that they prepare themselves for filling the gap of psychologists.

There is no general regulation of work tasks for Swedish hospital social workers (HSWs) and their clinical role and function are quite vague. However, the HSWs’ overall assignment is commonly described as supporting and guarding the psychosocial perspective in the care of patients and as forming a bridge between the biomedical and the social perspectives in the medical context (NBHW, 2014). Carried out in clinical practice, this means providing patients and their next of kin with psychosocial support and counselling to strengthen their ability to, in a broad sense, deal with their changed life situation (Lilliehorn, Isaksson, Salander, 2019). 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 of a multidisciplinary team.

Although there are many similarities between Swedish OSWs and OSWs in other countries regarding their clinical work (cf. Pockett et al. 2020; Zebrack et al. 2008), there are also some differences due to different national contexts and health care policies. For example, there are no regulations about the number of sessions patients and/or next of kin have the right to in Sweden, and thus the number of sessions might be rather high (Isaksson, Lilliehorn, Salander, 2018), especially compared to countries with different health insurance systems (e.g. the United States) and with less funded social work services at hospitals. Furthermore, Swedish OSWs are usually not involved in discharge planning or screening patients for distress, which seem to constitute important functions of OSWs in other countries (Auerbach, Mason & Laporte, 2007; Judd and Sheffield 2010; Zebrack, Burg, and Vaitones 2012). There are no national guidelines in Sweden regarding distress screening, and patients are ordinarily referred to the OSW based on other staff members clinically based judgment of the patient’s well-being. It has previously been shown that the main function of Swedish OSWs consists of providing psychosocial support and counselling (Lilliehorn, Isaksson, Salander, 2019). In this study we focus on the pros and cons of their clinical work.

Material and methods

Study design

The present study is part of a larger research project focusing on the role and function of Swedish OSWs in adult oncology care and was approved by the Ethical Review Board at Umeå University (Dnr 2015/401-31Ö). In that project, a nationwide survey was sent to all OSWs engaged at least 50% in oncology work and a total of 134 OSWs (59%) completed the survey. We got to know that the OSWs had been engaged in oncology social work for on average 8 years, worked 75% in oncology care, and that they typically were in contact with 12 patients and 5 next of kin every week (Isaksson, Lilliehorn, and Salander 2017). Furthermore, the OSWs' clinical function proved to be multifaceted and patients and next of kin contacted OSWs with a wide range of motives (Isaksson, Lilliehorn, and Salander 2018, 2019). Some OSWs commented in the survey about obstacles for optimal functioning either in terms of organizational barriers, or as shortcomings when it comes to demanding groups of patients, symptoms, or situations in clinical work. These kind of comments motivated a more thorough exploration of their situation at work by means of qualitative interviews.

The current study is thus based on qualitative interviews with OSWs who had completed the survey and who indicated interest in further participation in the project. Ten OSWs with more than 8 years of practice in oncology social work, and preferably with basic training in psychotherapy, and ten OSWs with no more than 5 years of practice without further training in psychotherapy were included in the study. The first ten OSW:s in respective groups who accepted the invitation were included. The rationale for including both experienced OSWs and OSWs with less years in practice was to obtain a range of professional experiences in cancer care.

Interviews

The interviews were conducted as well as analysed within a grounded theory approach as expressed by Strauss (1987) and later formulated by Charmaz (2006) in terms of flexible guidelines. The interview guide was thematically structured around the OSWs' experiences and reflections on their role and function in oncology care. The questions posed served as starting points to an exploratory dialogue in an open-ended narrative form. The themes concerned experiences of entering the profession, the pros and cons of practicing oncology social work, and ideas regarding 'the essence' of oncology social work. In addition, the OSWs were asked to reflect on their role in an organizational perspective including their relationships to other health care professionals. This paper focuses especially on the theme 'pros and cons of practicing oncology social work'. The interviewers asked for concrete situations and experiences in order to avoid accounts of general opinions and ideas (Table 1). Analysis of concrete critical situations enables the identification of essential elements in the general and often blurred issues regarding everyday-life (Flanagan 1954; Bradbury-Jones and Tranter 2008).

The interviews were conducted by telephone and lasted between 30 and 80 minutes. SL interviewed the OSWs with fewer years in practice and PS interviewed the more experienced OSWs. The interviews were recorded and transcribed, and both interviewers wrote notes during and

Table 1. Examples of questions connected to the theme pros and cons of practicing oncology social work.

Questions from the interview guide	<ol style="list-style-type: none"> (1) In all professions there are both pros and cons. Put in the oncology context, what are the cons, the disadvantages and the difficulties of oncology social work? Describe in concrete terms. (2) Can you describe some of the more challenging situations and/or patient cases you have met in your work? (3) What are the pros, the advantages and the easy parts of oncology social work? Describe in concrete terms.
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immediately after the interviews. Each transcript was anonymized and labelled with a code. The last interview was conducted in 2018.

Analysis

The analysis was conducted according to the following steps:

- (1) Naive reading of all interviews to get a basic sense of the overall content (SL, PS).
- (2) Joint discussion of the material with a special focus on the theme ‘pros and cons of practicing oncology social work’.
- (3) SL read the interviews again and identified all sections that concerned the theme ($n = 69$). These sections were copied and pasted into two new documents, representing the subthemes ‘cons of practicing social work’ ($n = 46$), and ‘pros of practicing social work’ ($n = 23$). The copied sections were marked with their respective interview code in order to enable continuous comparisons between the sections and the context of the interviews.
- (4) SL and PS then independently coded and categorized the sections according to the similarities-differences technique (Strauss 1987). They focused on one subtheme at a time and clustered those interview sections that expressed a common variation within the subtheme into categories. All authors then jointly discussed the essence of, and demarcations between, the categories, and adjustments were made until inter-subjective agreement, i.e. consensus among the authors, was reached (Kvale 1996).

Results

The findings are presented in three parts. First, a brief description of the participants’ characteristics (summarized in Table 2). Second, the cons of practicing oncology social work are presented, and this is followed by the third part covering the pros of practicing oncology social work (summarized in Table 3).

The participants

The participants had a mean age of 43 years (26–65 years). All had a bachelor degree in social work, and eight out of the ten of the experienced OSWs had at least basic training in psychotherapy (45–60 cts). The OSWs had on average been in oncology social work for 10 years with a range from 6 months to 31 years. Four of the OSWs worked exclusively in cancer care, while 16 OSWs worked at

Table 2. Characteristics of the 20 OSWs.

OSW	Mean years in cancer care (range)	Mean years as social worker (range)	Mean age (range)	Mean working hours in cancer care, % (range)	Additional training in psychotherapy (45–150 cts)
1–0	10	2 (0.5–5)	4.6 (1–11)	33 (26–45)	83 (50–100)
11–8	20	18.5 (8.5–31)	26 (10–40)	53 (36–65)	74 (50–100)

Table 3. Pros and cons of practicing oncology social work.

Cons of practicing oncology social work	Pros of practicing oncology social work
Organizational and professional barriers	Organizational meaningfulness
Demanding cases	Meaningfulness from giving
Impasse because of hopelessness	Meaningfulness from receiving
Impasse because of helplessness	Meaningfulness from personal development

least 50% in cancer care combined with clinical work in other departments, for example in surgery or palliative care. The OSWs worked at different types of hospitals in different regions in Sweden.

The cons of practicing oncology social work

The analysis of the cons of practicing oncology social work generated two categories that represents burdensome aspects of the OSWs' clinical work. The category 'Organizational and professional barriers' concerned organizational aspects, while 'Demanding cases' reflected burdensome aspects in patient work. The latter category was constituted by two dimensions that expressed different aspects of what is demanding in patient work.

Organizational and professional barriers

First and foremost, these interview sections concerned how organizational prerequisites complicated the OSWs' working life. Several OSWs described time-consuming logistical duties due to the increasing complexity in the management of oncology care. For example, OSWs seeing patients who received treatment at different hospitals struggled with communication between caregivers and spent additional time on administration and guiding patients through the health care system. Others described a work overload from simultaneous demands on availability and productivity, i.e. when being expected to be fully booked in outpatient care but also available for acute situations in inpatient care. The OSWs also engaged in other departments and described challenges with being torn between patient groups and having lack of time for all their patients. These organizational barriers were seen to be time-consuming and to generate stress as well as to be barriers for professional development, i.e. hampering the OSWs' engagement in and development of their role in oncology care.

Second, the interview data in this category also concerned different understandings of oncology social work in the oncology care team. For example, some OSWs described a lack of sympathy for the psychosocial perspective and difficulties in getting their concerns heard by other health care staff. Other examples were when staff did not understand the meaning of counselling and thus did not refer patients to an OSW, or, on the contrary, when staff expected OSWs to establish contact with unmotivated patients.

One most challenging situations for OSW 10 (31 years in oncology social work) was a lack of consensus within the team, for example, when the staff asked her to establish contact with a patient in order to process bad news even though the patient kept a distance. She said that health care staff advocated that all patients should be informed about their medical condition – that they should be given the “whole truth”. She, however, did not agree. Rather, she valued the patient's right to decide the amount of information they wanted to receive, and she promoted an adaptive approach, “It's more about accompanying, like a mentor,” she said. She said that other staff could have a lot of opinions, and such pressure could be strenuous for less experienced OSWs.

This position was confirmed by another OSW:

“My first couple of years in practice were a lot about establishing contact with nurses, dieticians, physicians. (...) The nurses had their view on our role, that we should call every patient and offer our contact. It was like that a lot in the beginning, about their requirements; maybe they wanted us to pick up on what they couldn't manage. I was fine with it to begin with, but it was indefensible in the long run. It just didn't turn out well in all cases; some patients found it intrusive.” (OSW 1; 5 years in oncology social work)

Then she described how she and her OSW-colleague clarified their role to other members of the staff and how this initiative caused rearrangements of the routines and an overall improvement in collaboration with other staff members.

Demanding cases

In contrast to the first category that concerned organizational and professional barriers, this category was related to the OSWs' direct patient work and encompassed cases that the OSWs

experienced as demanding. In general, the category depicted cases when the OSW was unable to promote a change. Two dimensions were found – ‘Impasse because of hopelessness’ and ‘Impasse because of helplessness’.

Impasse because of hopelessness. The interview data in this dimension reflected OSWs’ feelings of hopelessness in demanding patient cases. These interview data primarily concerned cases where the OSW found no solution or hope, but the OSW’s hopelessness also reflected a more general confrontation with life-threatening illness and efforts to identify one’s role and function in patient work:

It’s not a special case, I guess, but the inadequacy. To be unable to do . . . or feel that you can’t do enough. What I regard as simply listening, the patients often find to be enough, but somehow you want to perform magic [laughs], to do things that can’t be done. Well, to make the cursed cancer go away! If that would be possible. Today, I find it easier to reconcile with the limited impact of, for example, supportive talk as well as crisis and anxiety interventions. At first, I felt insufficient – I was supposed to do more, but didn’t really know what to do. (OSW 2; 2 years)

Cases with a rapid and *uncontrollable illness* trajectory, especially when the patient was young and/or had dependent children, were typically described as demanding cases and connected to hopelessness:

These are burdensome cases. (. . .) I get a lot of support from my colleagues, but there are no good solutions in these cases. Most often it’s just very tragic, and then you can feel insufficient. (OSW 3; 3 years)

The OSWs felt stuck in a claustrum. They also felt that hopelessness could arise from cases where patients and the next of kin seemed to *manoeuvre against the inevitable*, for example, when maybe not understanding, or suppressing, that death was approaching:

OSW 11 (23 years) found it difficult to meet severely ill young women with young children. Her perception was that these women often suppressed their approaching death with a spirit of survivorship. It was frustrating to her, because of the children’s lack of preparedness for losing a parent. “You understand them [the patients], they just have to survive. Then you feel powerless.”

Torn between different interests – those of the patient and those of the children – and with no obvious solution at hand, the OSW could not achieve closure. Furthermore, exposure to *severe anxiety* was particularly articulated in palliative cases, when patient’s anxiety about death could not be sufficiently handled:

It’s difficult to be motivated to try to do something when you know that the patient is going to die. (. . .) You want to help and to be able to come up with solutions, but in these cases, you can only be there and try to contain the anxiety. That’s hard. (OSW 4; 1 year)

A more experienced OSW clarified the essence of this demanding situation with the words: ‘With incurable cancer, death is a reality. In those cases you can’t work with the anxiety as just a ghost’. (OSW 12; 21 years)

Several OSWs emphasized the impact that oncology social work had on their lives. Supporting patients in their confrontation with mortality and death meant dealing with these matters personally:

When patients are put in front of these existential questions, I have to confront these questions as well. Sometimes it feels too close, especially when I see people of my own age with young children. I think the patients find it difficult as well, to meet someone who is in a comparable life situation, but who will survive. (OSW 3; 2 years)

Impasse because of helplessness. The interview data in this dimension reflected OSWs’ feelings of helplessness in demanding patient cases. In general, this concerned cases and situations in which the OSWs experienced that their level of competence, experience, or authority was restricted or

insufficient. The cases were typically described as a *complex set of problems* involving several arenas of the patients' lives. These cases often implied collaborations with external actors that sometimes were insufficient:

Maybe they've had other diseases before or a family member that has been ill. It might also be a tough financial situation or no stable social network. Eating doesn't work, nor sleep. When the situation includes many diverse problems, those cases are difficult. (OSW 6; 6 months)

Other examples were cases of *psychiatric comorbidity* when the patient refused psychiatric care and/or when the collaboration with the psychiatric care was poor. Furthermore, the complexity of patient cases could be due to the patient's social situation, such as cases of asylum-seeking patients that involved contact with public officials from other social authorities:

OSW 1 (5 years) was troubled by the collaboration between the local authorities and the county councils regarding asylum-seeking patients. Poor communication, few resources and insufficient structures made these cases unwieldy. Her authority in these cases was limited, and she struggled to improve the patients' already vulnerable positions. "They are very demanding, not the patients, but the circumstances. (...) It takes so much time and energy. And I want to promote the patient's well-being, even though their situation is as complicated as can be."

Furthermore, *relational problems* and family conflicts were also common cases, for example when the illness caused a personality change or role changes or conflicts within a family. Performing a negotiating role while still maintaining professionalism in the face of the pressure between conflicting family members was described as highly demanding. One OSW referred to a current case involving a terminally ill patient in conflict with their former partner about their children:

I encouraged them to turn to family counseling about this issue, but they only wanted to see me. I shouldn't engage in that type of conflict, to negotiate between them as a former couple, but I feel a responsibility to try to resolve it because time is limited. (OSW 5; 2 months)

In summary, hopelessness and helplessness evolved from unsolvable situations when not being able to, or doubting the prospects of being able to, facilitate a change. Hopelessness derived from cases without any kind of hope while helplessness emanated from feelings of a lack of competence or authority. Being unable to bring about change seemed to challenge the professional identity of being a helper, especially for the less experienced OSWs. Looking back at her 18 years in oncology social work, one OSW reflected on how as a newly employed OSW she always looked for concrete interventions, while she nowadays, due to experience, she was reconciled by the fact that these situations now only required that she remain present in the situation. She concluded: 'Nowadays I have a better understanding of my limits'. (OSW 13; 18 years)

The pros of practicing oncology social work

The analysis of what the OSWs described as the pros of practicing oncology social work generated four categories that all reflected meaningfulness. 'Organizational meaningfulness', concerns organizational aspects, while 'Meaningfulness from giving', 'Meaningfulness from receiving', and 'Meaningfulness from personal development' reflected individual and personal aspects.

Organizational meaningfulness

The OSWs found oncology to be a meaningful context *per se* by providing good conditions regarding team work, routines and resources and that the OSW was an appreciated part of the oncology team. Furthermore, the OSWs appreciated that their patient work was based on voluntariness and did not include an exercise of authority, which is more common in other social work professions. One OSW split her time between oncology social work and internal medicine:

In this [oncology] team, they turn to you as a social worker. Unfortunately, mental health is still taboo for many, but with cancer diseases it's less odd to be contacted by a social worker. You can always decline of

course, but it's a starting point that makes the job easier. Otherwise, as a hospital social worker you are often isolated in your work. We represent the psychosocial perspective in this very medical context, but in oncology care it goes without saying that psychosocial staff should be involved. (OSW 6; 6 months)

Meaningfulness from giving

The interview data in this category pointed at a sense of meaningfulness that derived from the act of giving something valuable to patients and next of kin. Contributing to a process of change, giving time, and giving commitment and support to patients and their next of kin was described as most meaningful:

To me, it's difficult to imagine something more important than helping someone in this situation. To have someone to talk to and receive emotional support from when you might be having the hardest time in your life. That's what motivates me. (OSW 7; 1,5 years)

Meaningfulness from receiving

In another respect, meaningfulness derived from the opportunity to come close to patients and their families and to receive a grateful response. To gain trust from different people and to take part in their lives was described as a privilege and an honour. Several OSWs described how they felt appreciated and some even loved by their patients and how this added meaning and significance to them as persons and to their working life:

OSW 14 (16 years) felt that she was precious to her patients and that she received a lot of gratitude. She continued by reflecting on what this, in turn, meant to her. To see the patients' suffering and how they developed and moved beyond it was like "winning a million" to her. She said, "To read people's life stories, maybe not the whole book but some chapters, that enriches you as a person".

Meaningfulness from personal development

In yet another respect, also pictured in the quote above, meaningfulness came from how the work experience favoured personal development. Confronting matters of life and death and witnessing human suffering and human strength had the potential to transform the OSWs' own approach to life.

After 18 years in oncology social work, OSW 13 said that she had the best job one can have. Following patients through the cancer trajectory had made her aware of the human resilience, and it also reminded her of the transience of life. These experiences had made her more humble, and she had learned the importance of being present in life. Her work had, as she summarized it, enriched "my philosophy of life".

In summary, oncology was regarded as a meaningful context for social work practice and the clinical work with patients and families in vulnerable life situations created a closeness that was emotionally rewarding, and was even described as promoting personal development.

Discussion

Identifying OSWs' experiences of being professionally engaged in oncology social work revealed some interesting findings on OSWs' working life. The themes of pros and cons that we have presented convey oncology social work as two sides of the same coin – a concurrent source of both burden and rewards. Cons were identified to be 'Organizational and professional barriers' and 'Demanding cases', while all categories of pros reflected meaningfulness, derived from the cancer care context and from giving and receiving something valuable in patient work. That there were twice as many cons identified in oncology social work as there where pros is hardly a surprise. In everyday clinical practice we are often more occupied by the problems we have to deal with, and less by the rewards such practice gives us.

The OSWs expressed both pros and cons with the organizational level of cancer care. On the one hand, it was described as a meaningful context that was well structured and resourceful and in

which the psychosocial perspective was regarded as important and obvious. On the other hand, the OSWs expressed frustration with developments in care management that implied increased and more complex administrative duties, and increased focus on production, effectiveness, and standardized processes. The OSWs' responses might in this way display the transitions that have taken place in the health care sector in Western societies by the implementation of New Public Management in the 1980s and 1990s, emphasizing transparency, administration, measurement and control (Blomgren and Sahlin 2007). Other professionals, such as nurses, have also complained that efficiency pressure and increased administrative routines and cost-consciousness eclipses optimal patient care and conflict with nurses' caring ideals (Debesay, Harsloef, Rechel & Vike, 2014; Blomgren 2003).

Furthermore, the OSWs expressed frustration with professional barriers that concerned their position in the oncology team, a finding consistent with previous studies on OSWs in Sweden (Isaksson, Lilliehorn, and Salander 2017), as well as in Australia (Pockett et al. 2016). Experiences of being poorly understood and of being influenced or even directed by other professionals implies that the OSWs' role is negotiated with the power structure of the oncology team. This is a common challenge for professions in 'host' settings, i.e. a setting whose primary domain of attention differs from the profession in question, and has recently been noted regarding social workers in health care (Glaser and Suter 2016). Spitzer, Silverman, and Allen (2015) explain the organizational motive for including hospital social workers in the healthcare system as goal oriented – to assist the system in reaching its goals by removing obstacles. Sernbo (2019), drawing on Lipsky, discusses a possible understanding of the HSW as a 'pressure-specialist', someone who handles disturbances from, for example, a mismatch between routine procedures and patients. Patients that do not behave according to expectations, for example, when refusing to be told bad news as in the quote from OSW 10 (p. 7–8), might thus become a case for the OSW. Or, as OSW 1 (p. 8) reported on, the OSW can also be expected to unburden other professions. This often includes ethical tensions when social work practice is restricted by the 'host' setting (Spitzer, Silverman, and Allen 2015). The voices from the practicing OSWs in this study tell us that clarifying and establishing the OSW's professional autonomy is an on-going process.

Other cons were related to the OSWs' direct patient work in terms of demanding cases that evoked feelings of hopelessness or helplessness. Hopelessness emanated from cases with no likelihood of a positive outcome, with rapid illness trajectories and/or involving severe anxiety, while helplessness emanated from being restricted by a lack of competence, experience or authority. Both dimensions confirm previous findings of what OSWs in Sweden experience as barriers for optimal function (Isaksson, Lilliehorn, and Salander 2017). It can be suggested that the experience of hopelessness might be a contributory cause of secondary traumatic stress, in other words the 'cost of caring' (Slocum-Gori et al. 2013) or what Dunkley and Wheley (2006) call a 'natural by-product for relieving trauma'. In these intractable cases, the OSWs were exposed to patients' existential vulnerability and questions of justice and meaning, dimensions in life that touch upon our basic assumptions, or 'world-view', that provides us with psychological 'safety' (Janoff-Bulman 1992). Repeated exposure to hopelessness challenges one's 'world-view'. When being in a similar phase in life as the patient, (e.g. OSW 3, p. 10), the psychological burden on the OSW might be aggravated. In these cases, the closeness to the patient's situation might even imply that the OSW's empathic engagement turns into 'projective identification', i.e. the psychological distance is lost and the OSW identifies personally with the patient's vulnerable situation (Kernberg 1987). This, as a kind of 'vicarious traumatization', has been found to be related to the counsellor's experience, and the less experienced are more inclined to be traumatized (Dunkley and Whelan 2006). Besides the importance that experience seem to have, it is also reasonable to believe that additional education is important for the OSW in order to reduce the risk of 'vicarious traumatization'. For example, in a Swedish study, it was shown that OSWs with additional training in psychotherapy were less prone to experience problems with emotionally demanding situations compared to OSWs with no additional training (Isaksson, Lilliehorn, and Salander 2017).

In the cases of helplessness, the OSWs were confronted with professional shortcomings when their level of competence, experience, or authority was insufficient or restricted. Failure to provide optimal support seemed to be a burden that challenged their professional identity. This was more pronounced among the less experienced OSWs. Not being able to fulfill one's professional role might be especially prevalent for professions in 'host' settings (Spitzer, Silverman, and Allen 2015). As regards OSWs, whose primary domain of attention differs from the medical care and the medical professions, this can be figured as being sandwiched between different demands and expectations, for example, between the oncology clinic and other social authorities, between the patient and other team members, or between their own ideas of optimal intervention and their actual achievements. Establishing and maintaining professional autonomy requires a reasonable role definition and also concerns the OSWs' achievement motives.

An interesting finding in this study is that confrontation with suffering, injustice, and death was felt as burdensome by inducing feelings of hopelessness and helplessness, but paradoxically also rewarding by conjuring up existential reflections on the OSW's own part. This was regarded as enriching one's 'philosophy of life', in the words of OSW 13 (p. 13). To share and to *give* something valuable to the one who is suffering might thus be connected to *receiving* gratitude but also to promoting one's own personal development. Our suggestion is that the pros of oncology social work might truly mitigate the cons. These findings are in line with how Råbu et al. (2016) understand therapeutic work as a source of both burdens and privileges. However, we must also keep in mind that the relationship to the patient as a potential source for one's personal development might bring about counter-transference problems. From this perspective, the OSW has to reflect on reasons for different interventions and the sources of their one motivation for caring (Salmon and Young 2009). Professional support is therefore important by different kinds of supervision, typically in individual or group format (Berger et al., 2001; Kadushin et al. 2009). Another suggestion is to implement Balint-inspired reflective groups. These groups rely to a greater extent on peer support for professionals, initially physicians, who in an open atmosphere reflect together on clinical situations which they find professionally and personally demanding (Salander and Sandström 2014). This type of group might as well be useful for OSWs in their professional development and in order to safeguard against substituting professional motives for personal motives. But, it can also be suggested that an interprofessional reflective forum for especially challenging cases might be a way of dismantling the tensions between the different perspectives. Regarding what interventions that can prevent or impact symptoms of secondary traumatic stress, we still lack solid evidence. However, peer support is emphasized in several studies as unburdening and supportive for the professional helper (Råbu et al. 2016; Joubert, Hockin & Hampson, 2013) and is recently identified as having a mitigating effect on symptoms of secondary traumatic stress (Caring et al. 2017).

Conclusions and implications

Working as an OSW is multifaceted and seems to imply a potential for developing a sense of meaningfulness, tolerance, and humbleness, but also the risk of being vulnerable to becoming overwhelmed with isolation, stress, and feelings of helplessness and powerlessness. We suggest further studies of the mitigating links between pros and cons in oncology social work and it might be valuable to more thoroughly address how the OSWs' personal life is impacted by the 'cost of caring' (Slocum-Gori et al. 2013) and by the confrontation with existential vulnerability (Råbu et al. 2016). Oncology social work is a balancing act between rewards and risks that calls for responsibility from leadership to provide supervision (Joubert, Hocking, and Hampson 2013), opportunities to peer support (Caring et al. 2017; Salander and Sandström 2014), and a sound working environment, but it also requires personal responsibility from the OSW to engage in self-care. Training in psychotherapy is surely desirable, but learning of compassion fatigue and secondary traumatic stress should also be on the agenda. This also applies to the basic training of OSWs. In addition, the potential conflict between the medical and social perspective calls for attention to interprofessional education in psychosocial matters.

On method

The present study provides a qualitative account of pros and cons of clinical oncology social work and the mitigating link between them. Including OSWs in early and late stages of their working life enabled us to identify relevant aspects for both experienced OSWs and those with less experience. Further, the results are in line with previous studies based on a nationwide survey and journal records of Swedish OSWs, which confirms the validity of the study.

A potential weakness of the study is the relatively small sample size and that it is restricted to a Swedish context where the OSW's role and function differs somewhat from those in other contexts, especially in the Anglo-Saxon countries (Isaksson, Lilliehorn, and Salander 2017). In Sweden, the OSW's main clinical function consists of psychosocial counselling, while in Anglo-Saxon countries the main focus is on discharge planning and psychosocial screening. Consequently, Swedish OSWs might to a greater extent be exposed to patients' and next of kin's narratives of suffering and transference of the findings outside the Swedish context should thus be done with due caution.

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References

- Auerbach, C., S. E. Mason, and H. Heft Laporte. 2007. "Evidence that Supports the Value of Social Work in Hospitals." *Social Work in Health Care* 44 (4): 17–32. doi:10.1300/J010v44n04_02.
- Berger, C., and T. Mizrahi. 2001. "An Evaluating Paradigm of Supervision within a Changing Health Care Environment." *Social Work in Health Care* 32 (4): 1–18. doi:10.1300/J010v32n04_01.
- Blomgren, M. 2003. "Ordering a Profession: Swedish Nurses Encounter New Public Management Reforms." *Financial Accountability & Management* 19 (1): 45–71. doi:10.1111/1468-0408.00163.
- Blomgren, M., and K. Sahlin. 2007. "Quests for Transparency: Signs of a New Institutional Era in the Health Care Field." In *Transcending New Public Management : The Transformation of Public Sector Reforms*, edited by T. Christensen and P. Lægreid. Burlington: Ashgate.
- Bradbury-Jones, C., and S. Tranter. 2008. "Inconsistent Use of the Critical Incident Technique in Nursing Research." *Journal of Advanced Nursing* 64 (4): 399–407. doi:10.1111/j.1365-2648.2008.04811.x.
- Caringi, J., E. Hardiman, P. Weldon, S. Fletcher, M. Devlin, and C. Stanick. 2017. "Secondary Traumatic Stress and Licensed Clinical Social Workers." *Traumatology* 23 (2): 186–195. doi:10.1037/trm0000061.
- Charmaz, K. 2006. *Constructing Grounded Theory. A Practical Guide Trough Qualitative Analysis*. Thousand Oaks, CA: Sage Publications.
- Cunningham, M. 2003. "Impact of Trauma Work on Social Work Clinicians: Empirical Findings." *Social Work* 48 (4): 451–459. doi:10.1093/sw/48.4.451.
- Dane, B., and E. Chachkes. 2001. "The Cost of Caring for Patients with an Illness: Contagion to the Social Worker." *Social Work in Health Care* 33 (2): 31–51. doi:10.1300/J010v33n02_03.
- Debesay, J., I. Harsløf, B. Rechel, and H. Vike. 2014. "Dispensing Emotions: Norwegian Community Nurses' Handling of Diversity in a Changing Organizational Context." *Social Science & Medicine* 119: 74–80. doi:10.1016/j.socscimed.2014.08.025.
- Dunkley, J., and T. A. Whelan. 2006. "Vicarious Traumatization: Current Status and Future Directions." *British Journal of Guidance & Counseling* 34 (1): 107–116. doi:10.1080/03069880500483166.
- Flanagan, J. C. 1954. "The Critical Incident Technique." *Psychological Bulletin* 51 (4): 327–358. doi:10.1037/h0061470.

- Glaser, B., and E. Suter. 2016. "Interprofessional Collaboration and Integration as Experienced by Social Workers in Health Care." *Social Work in Health Care* 55 (5): 395–408. doi:[10.1080/00981389.2015.1116483](https://doi.org/10.1080/00981389.2015.1116483).
- Isaksson, J., S. Lilliehorn, and P. Salander. 2017. "A Nationwide Study of Swedish Oncology Social Workers: Characteristics, Clinical Functions, and Perceived Barriers to Optimal Functioning." *Social Work in Health Care* 56 (7): 600–614. doi:[10.1080/00981389.2017.1316340](https://doi.org/10.1080/00981389.2017.1316340).
- Isaksson, J., S. Lilliehorn, and P. Salander. 2018. "Cancer Patients' Motives for Psychosocial consultation—Oncology Social Workers' Perceptions of 226 Patient Cases." *Psycho-Oncology* 27 (4): 1180–1184. doi:[10.1002/pon.4633](https://doi.org/10.1002/pon.4633).
- Isaksson, J., S. Lilliehorn, and P. Salander. 2019. "Next of Kin's Motives for Psychosocial Consultation – Oncology Social Workers' Perceptions of 54 Next of Kin Cases." *Psycho-Oncology* 28 (1): 154–159. doi:[10.1002/pon4925](https://doi.org/10.1002/pon4925).
- Janoff-Bulman, R. 1992. *Shattered Assumptions: Towards a New Psychology of Trauma*. New York: Free Press.
- Joubert, L., A. Hocking, and R. Hampson. 2013. "Social Work in Oncology-Managing Vicarious Trauma-The Positive Impact of Professional Supervision." *Social Work in Health Care* 52 (2–3): 296–310. doi:[10.1080/00981389.2012.737902](https://doi.org/10.1080/00981389.2012.737902).
- Judd, R. G., and S. Sheffield. 2010. "Hospital Social Work: Contemporary Roles and Professional Activities." *Social Work in Health Care* 49 (9): 856–871. doi:[10.1080/00981389.2010.499825](https://doi.org/10.1080/00981389.2010.499825).
- Kadushin, G., C. Berger, C. Gilbert, and M. de St Aubin. 2009. "Models and Methods in Hospital Social Work Supervision." *The Clinical Supervisor* 28 (2): 180–199. doi:[10.1080/07325220903324660](https://doi.org/10.1080/07325220903324660).
- Kernberg, O. F. 1987. "Projection and Projective Identification: Developmental and Clinical Aspects." *Journal of the American Psychoanalytic Association* 35 (4): 795–819. doi:[10.1177/000306518703500401](https://doi.org/10.1177/000306518703500401).
- Kvale, S. 1996. *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks: Sage.
- Lilliehorn, S., J. Isaksson, and P. Salander. 2019. "What Does an Oncology Social Worker Deal with in Patient Consultations? - an Empirical Study." *Social Work in Health Care* 58 (5): 494–508. doi:[10.1080/00981389.2019.1587661](https://doi.org/10.1080/00981389.2019.1587661).
- Mehnert, A., and U. Koch. 2005. "Psychosocial Care of Cancer Patients—international Differences in Definition, Healthcare Structures, and Therapeutic Approaches." *Supportive Care in Cancer* 13 (8): 579–588. doi:[10.1007/s00520-005-0779-6](https://doi.org/10.1007/s00520-005-0779-6).
- Najjar, N., L. W. Davis, K. Beck-Coon, and C. Carney Doebbeling. 2009. "Compassion Fatigue: A Review of the Research to Date and Relevance to Cancer-care Providers." *Journal of Health Psychology* 14 (2): 267–277. doi:[10.1177/1359105308100211](https://doi.org/10.1177/1359105308100211).
- NBHW (National Board of Health and Welfare). 2014. *Legitimation För Kuratorer Inom Hälso- Och Sjukvård. [License for Social Workers in Health Care]*. Stockholm: National Board of Health and Welfare.
- Pockett, R., K. Hobbs, R. Araullo, and K. Dave. 2020. "Social Work Interventions in Cancer Care." *Australian Social Work* 1–15. Published online: 28 jun 2020. doi: [10.1080/0312407X.2020.1748673](https://doi.org/10.1080/0312407X.2020.1748673)
- Pockett, R., M. Peate, Hobbs, M. Dzidowska, M. L. Bell, B. Baylock, and I. Epstein. 2016. "The Characteristics of Oncology Social Work in Australia: Implications for Workforce Planning in Integrated Cancer Care." *Asia-Pacific Journal of Clinical Oncology* 12 (4): 444–452. doi:[10.1111/ajco.12482](https://doi.org/10.1111/ajco.12482).
- Quinal, L., S. Harford, and D. N. Rutledge. 2009. "Secondary Traumatic Stress in Oncology Staff." *Cancer Nursing* 32 (4): E1–E7. doi:[10.1097/NCC.0b013e31819ca65a](https://doi.org/10.1097/NCC.0b013e31819ca65a).
- Råbu, M., C. Moltu, P.-E. Binder, and J. Mcleod. 2016. "How Does Practicing Psychotherapy Affect the Personal Life of the Therapist? A Qualitative Inquiry of Senior Therapists' Experiences." *Psychotherapy Research* 26 (6): 737–749. doi:[10.1080/10503307.2015.1065354](https://doi.org/10.1080/10503307.2015.1065354).
- Salander, P., and M. Sandström. 2014. "A Balint-inspired Reflective Forum in Oncology for Medical Residents: Main Themes during Seven Years." *Patient Education and Counseling* 97 (1): 47–51. doi:[10.1016/j.pec.2014.06.008](https://doi.org/10.1016/j.pec.2014.06.008).
- Salmon, P., and B. Young. 2009. "Dependence and Caring in Clinical Communication: The Relevance of Attachment and Other Theories." *Patient Education and Counseling* 74 (3): 331–338. doi:[10.1016/j.pec.2008.12.011](https://doi.org/10.1016/j.pec.2008.12.011).
- Sernbo, E. 2019. "Med avstegen som arbetsplats : en etnografisk studie av hälso- och sjukvårdskuratorns arbete. [Out of line as workplace – An ethnographic study of health social work]." Diss. Göteborg: Göteborgs universitet.
- Simon, C. E., J. G. Pryce, L. L. Roff, and D. Klemmack. 2006. "Secondary Traumatic Stress and Oncology Social Work: Protecting Compassion from Fatigue and Compromising the Worker's Worldview." *Journal of Psychosocial Oncology* 23 (4): 1–14. doi:[10.1300/J077v23n04_01](https://doi.org/10.1300/J077v23n04_01).
- Slocum-Gori, S., D. Hemsworth, W. Y. Chan Winnie, A. Carson, and A. Kazanjian. 2013. "Understanding Compassion Satisfaction, Compassion Fatigue and Burnout: A Survey of the Hospice Palliative Care Workforce." *Palliative Medicine* 27 (2): 172–178. doi:[10.1177/0269216311431311](https://doi.org/10.1177/0269216311431311).
- Spitzer, W., E. Silverman, and K. Allen. 2015. "From Organizational Awareness to Organizational Competency in Health Care Social Work: The Importance of Formulating a "Profession-in-environment" Fit." *Social Work in Health Care* 54 (3): 193–211. doi:[10.1080/00981389.2014.990131](https://doi.org/10.1080/00981389.2014.990131).

- Sprang, G., J. J. Clark, and A. Whitt-Woosley. 2007. "Compassion Fatigue, Compassion Satisfaction, and Burnout: Factors Impacting a Professional's Quality of Life." *Journal of Loss and Trauma* 12 (3): 259–280. doi:[10.1080/15325020701238093](https://doi.org/10.1080/15325020701238093).
- Strauss, A. L. 1987. *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press.
- Zebrack, B., M. A. Burg, and V. Vaitones. 2012. "Distress Screening: An Opportunity for Enhancing Quality Cancer Care and Promoting the Oncology Social Work Profession." *Journal of Psychosocial Oncology* 30 (6): 615–624. doi:[10.1080/07347332.2012.721485](https://doi.org/10.1080/07347332.2012.721485).
- Zebrack, B., K. Walsh, M. A. Burg, P. Maramaldi, and J.-W. Lim. 2008. "Oncology Social Worker Competencies and Implications for Education and Training." *Social Work in Health Care* 47 (4): 355–375. doi:[10.1080/0098138080217395](https://doi.org/10.1080/0098138080217395).