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## Self-Efficacy and Mental Health Services Provided by Rural and Frontier Oncology Social Workers

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**Abstract.** This pilot study explores the relationship between self-efficacy and professional behaviors of a non-random membership sample of the Association of Oncology Social Work (AOSW) who practice in rural and frontier settings (N = 19). The New Generalized Self-Efficacy (NGSE) scale was used to measure provider self-efficacy; a researcher-designed questionnaire was used to assess the professional behaviors of conducting mental health assessments and providing supportive counseling to individuals diagnosed with cancer. Pearson correlation and two-sample t-tests were used to analyze data. While study results did not elucidate relationships explored, results revealed a disparity between participants' overall high sense of professional preparedness and comfort conducting mental health assessments and the regularity with which they perform these functions of oncology patient care.

**Keywords:** oncology social work, self-efficacy, social work, self-efficacy scale, mental health assessment, supportive counseling, professional behavior, rural social work

Holistic treatment of persons diagnosed with cancer requires that medical and allied health professions work collaboratively; however, special attention to the psychosocial needs of persons diagnosed with cancer have traditionally been delegated to oncology social workers (Fobair et al., 2009; Gamm, Stone, & Pittman, 2003; King et al., 2008; Zebrack & Walsh-Burke, 2004). Oncology social workers are the primary providers of psychosocial services related to cancer diagnosis and treatment (Burg et al., 2010; Hewitt, Greenfield, & Stovall, 2006; King et al., 2008; Zebrack & Walsh-Burke, 2004). This important role is magnified in rural or frontier (population  $\leq$  50,000 people) (Cromartie, n.d.) health care settings where oncology social workers assume multiple practice roles and must have specified knowledge about cancer's psychosocial impact (Zebrack, Walsh, Burg, Maramaldi, & Lim, 2008). Anxiety is diagnosed in a higher percentage of rural cancer patients (60-75%) when compared with the general population of cancer patients (50%) (Burman & Weinart, 1997b; Herschbach et al., 2004). Yet researchers have found that mental health concerns are less likely identified and/or addressed in the course of rural patients' oncology treatment for multiple reasons including increased travel distances to oncology care, geographic isolation, limited mental health services, high rates of inadequate health insurance, delayed cancer diagnosis, and frontier values such as stoicism and independence (Davis, Williams, Redman, White, & King, 2003; Eberhardt & Pamuk, 2004; Pistella, Bonati, & Michalic, 1999).

The Association of Oncology Social Work (AOSW) Scope of Practice includes providing clinical psychosocial services for persons diagnosed with cancer, such as conducting psychosocial assessments and therapeutic counseling interventions which are standard practices

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among oncology social workers (AOSW, 2001). The U.S. National Cancer Institute and the Canadian Association of Psychosocial Oncology have pushed to integrate mental health assessment tools into routine oncology care (National Cancer Institute, n.d.a; Wright et al., 2007). Face-to-face psychosocial screenings, structured psychological interventions, and individual therapy with cancer patients are correlated with significant reductions in pain, better physical and social role functioning, better overall mental health, and improved quality of life (Bramsen et al., 2008; National Cancer Institute, n.d.b; White & Macleod, 2002). Early incorporation of mental health assessments and interventions can enhance medical outcomes and may reduce the stigma of mental health concerns for persons diagnosed with cancer (Zabora et al., 2001).

While the benefits of professionals conducting mental health assessments and providing supportive counseling are well-documented and advocated for by national organizations, people diagnosed with cancer largely report dissatisfaction with the way that their emotional distress and mental health concerns are addressed and treated (Cwikel & Behar, 1999; Taylor et al., 2010). This is particularly true among rural patients (Burman & Weinert, 1997a). Sixty-six percent of participants in one study reported their primary unmet need one year after diagnosis was assistance dealing with emotional distress (Cwikel & Behar, 1999). Greater than 70% of patients undergoing radiotherapy for the treatment of cancer report the need for professional psychosocial support during treatment (Brix et al., 2008). Failure to directly address patients' concerns can contribute to the development of additional mental health distress for persons diagnosed with cancer (Parle, Jones, & Maguire, 1996; Taylor et al., 2010). The rate at which rural and frontier AOSW members perform mental health assessments or offer supportive counseling is not well established. Additionally, the self-efficaciousness of these providers and how it is related to their performance of standard job functions have not been well documented.

Few studies have examined the professional practices of oncology social workers (King et al., 2008). Rural oncology social workers' self-efficacy and professional mental health practices remain understudied despite the critical role these professionals can play in cancer patients' lives. Mental health concerns are important to persons diagnosed with cancer, and it appears that professionals in medical and allied health fields are not adequately addressing patients' needs (Burman & Weinert, 1997a; Cwikel & Behar, 1999; Taylor et al., 2010). Additionally, initial exploration of areas of competence of AOSW practitioners reveals a need for additional training on psycho-educational and clinical interventions (Zebrack et al., 2008). This pilot study examined oncology social worker self-efficacy and the professional practices of conducting mental health assessments and providing supportive counseling to cancer patients in rural and frontier settings.

### **Theoretical Framework**

Self-efficacy, a construct of social learning theory, is concerned with a person's belief in their capability to produce given attainments or achieve specific tasks (Bandura, 1977; Peterson & Arnn, 2005). According to Bandura (1977, 2006), individuals who have strong self-efficacy to perform a behavior are more likely to initiate the behavior and to persist in the face of difficulty. Self-efficacy plays a key role in human functioning, influencing how much effort individuals put into the tasks ahead of them, the outcomes they expect their work to produce, and how long they will persevere in the face of adversity (Bandura, 2006). Social workers who practice in rural and

frontier settings need to have a strong sense of self-efficacy, as they may be the only providers in the region who address the psychosocial concerns of persons diagnosed with cancer.

Expectations of personal mastery impact initiation and persistence of coping behaviors. People fear, and therefore avoid, threatening situations they perceive to exceed their mastery level (Bandura, 1977, 2006). A stronger sense of self-efficacy results in greater individual perseverance and active efforts to accomplish a given task, resulting in a higher likelihood of success (Bandura, 1977, 2006).

## **Study Objective**

The objective of this pilot study was to describe rural oncology social workers' self-reported mental health-related professional practices, including preparedness and comfort level, and to examine the relationships between these practices and these social workers' general sense of self-efficacy.

## **Methods**

### **Participants**

University Institutional Review Board approval was obtained for this study. Oncology social workers who were members of AOSW and practicing in rural or frontier communities within the United States (city/town population at or below 50,000) (Cromartie, n.d.) were recruited for participation in this study. The U.S. Bureau of Labor's occupational employment statistics suggest that approximately 16,470 healthcare social workers practice in non-metropolitan areas of the United States (Cromartie, n.d.); however, data are not available which identify what portion of health care social workers may be practicing oncology social workers in rural or frontier areas. Therefore, reaching rural oncology social workers was difficult. As a result, participant recruitment for this pilot study was conducted via one point of contact by means of personal email from the Association of Oncology of Social Work (AOSW) research chair sent to all AOSW members. AOSW is the primary professional organization for oncology social workers, with 1,200 current members (AOSW, 2014). While membership in AOSW is not required for practice, recruiting participants from AOSW membership was an appropriate starting point for this exploratory study. Although it is unknown exactly how many members of AOSW practice in rural locations, a study that yielded over 50% response rate of AOSW practitioners showed that approximately 13% of members ( $N = 80$ ) identify as rural practitioners (Zebrack et al., 2008). Given historically low rates of return in previous AOSW member studies (20-30%) (M. A. Burg, personal communication, July, 2010), participants were encouraged to enter a drawing for one-year paid AOSW membership as incentive.

### **Design and Data Collection**

A quantitative, cross-sectional design with an online survey was used. Contact with potential respondents was limited to a single email sent inviting participants to complete a 10-minute online survey. The email sought to appeal to the unique experiences of rural and frontier oncology social workers. All AOSW members were contacted once via email through the AOSW Research Group with information about the study. No pre-notification or reminder

emails were sent, per the agreement established with the AOSW Research Group. To maintain anonymity, researchers did not access participants' contact information.

The New Generalized Self Efficacy (NGSE) scale was used to measure generalized self-efficacy. The NGSE scale demonstrated strong internal consistency and reliability ( $\alpha = .86-.88$ ) and higher content validity than other measures of self-efficacy (Chen, Gully, & Eden, 2001). The ordinal NGSE scale is unidimensional and uses unipolar ratings of "not at all true," "hardly true," "moderately true," and "exactly true" (Chen et al., 2001). The NGSE scale was chosen based on brevity (eight items), validation in employment self-efficacy studies, and strengths-based orientation of items.

In addition to the NGSE scale, twenty additional survey questions were included. These included a mixture of yes/no, nominal, ordinal, interval and ratio questions to gather information about the participants' basic demographics, educational background, years in practice, practice setting(s), number of social work colleagues at their agency, primary client populations served, expectation of persons diagnosed with cancer to experience emotional distress, frequency of conducting mental health assessments and providing supportive counseling, and assessments of their own preparedness and comfort conducting mental health assessments and providing supportive counseling. The development of this 20-item researcher-designed questionnaire was based on findings from the literature indicating of the following topics warranted investigation: whether oncology social workers perform mental health assessments and/or provide counseling for persons diagnosed with cancer, if they feel adequately prepared to perform these tasks and discuss psychosocial concerns with patients, and when in the cancer disease trajectory they conduct assessments or provide counseling. The questionnaire was designed using principles set forth by Dillman (2007), including defining a clear navigational path to prevent rereading instructions or questions and using visual navigation to guide subjects in order to avoid missing key terms or skipping items. A pretest of the researcher-developed instrument was conducted with two medical and oncology social workers to determine response burden and readability, and recommended changes from this pretest were incorporated prior to dissemination of survey.

### Statistical Analysis

Parametric tests require a normal distribution, a certain level of data (usually interval), and homogeneity of variances when two samples are being compared. While it is acknowledged that with smaller samples non-parametric tests might seem more appropriate, it has long been established that moderate violations of the assumptions may have little or no effect on the conclusions (Cohen, 1969). A recent statistical investigation confirmed Gosset's original intent of using the Student t-test in small sample sizes with and without equal variances when sample sizes are equal (de Winter, 2013).

Statistics used to analyze the data include descriptive, inter-item correlations, Pearson correlation and the two-sample t-test. Significance was set at an alpha of 0.05 (Aron & Aron, 2002). The variables were 1) frequency rate of conducting mental health assessments, and 2) frequency rate of providing supportive counseling. These variables were ordinally classified as *never*, *rarely*, *often*, and *always* based on the information reported on the researcher-designed questionnaire. Reported self-efficacy of rural and frontier AOSW members was measured by their mean NGSE score. These scores were then classified as *low* ( $N = 10$ ) and *high* ( $N = 9$ ),

based on the distribution of scores due to the limited sample size of this pilot study, creating two nearly equal sample sizes. Two-sample (two-tailed) t-tests were conducted to examine: 1) the relationship between self-efficacy of rural and frontier AOSW members and the frequency with which they conducted mental health assessments for persons diagnosed with cancer; and 2) the relationship between self-efficacy of rural and frontier AOSW members and the frequency with which they provided supportive counseling for persons diagnosed with cancer.

## Results

Twenty-one AOSW members responded to the survey; however, two respondents did not complete the survey and their responses were excluded from assessment resulting in 19 useable responses. The estimated response rate represents approximately 24% of AOSW members that identified as rural practitioners based on population response rates from other studies of AOSW members (Zebrack et al., 2008) (see Table 1 for demographic information).

Table 1

### *Basic Demographics of Study Participants*

Participant Demographics	%	N
Female	94.7	18
Male	5.3	1
BSW	10.6	2
MSW	89.5	17
≥10 years in practice	68	13

Rural and frontier AOSW members almost unanimously expect persons diagnosed with cancer to experience emotional distress. Ninety-five percent ( $N = 18$ ) of participants *agreed* or *strongly agreed* that emotional distress is a routine outcome of receiving a cancer diagnosis, while only five percent ( $N = 1$ ) *disagreed*.

Respondents were split into two groups based on the mean (2.34) of respondents' NGSE scores ( $M = 2.34$ ,  $SD = .17$ ), classified as *low self-efficacy* ( $\leq 2.33$ ) and *high self-efficacy* ( $\geq 2.34$ ) in order to accommodate the small sample size of this pilot study (see Table 2 for measures of central tendency for each NGSE item). Consistent with two NGSE scale validation studies with sample sizes exceeding 300 participants each (Chen et al., 2001), the results of this study support the measure's high internal consistency and reliability ( $\alpha = .90$ ) and inter-item correlation, ranging from .369 to .899 (see Table 3 for demographic distribution of two self-efficacy groups).

Fifty-eight percent ( $N = 11$ ) of respondents reported they *never* or *rarely* conduct mental health assessments in their position as oncology social workers. Only two participants (11%) reported that they *always* conduct mental health assessments for persons diagnosed with cancer.

Table 2

*Measures of Central Tendency for Items on NGSE Scale*

NGSE Items <sup>a</sup>	Mean	Median	Mode	SD	Range
I will be able to achieve most of the goals I have set for myself.	2.21	2	2	0.42	2-1
When facing difficult tasks, I am certain I will achieve them.	2.11	2	2	0.71	1-3
In general, I think I can obtain outcomes that are important to me.	2.26	2	2	0.56	1-3
I believe I can succeed at most any endeavor to which I set my mind.	2.21	2	2	0.54	1-3
I will be able to successfully overcome many challenges.	2.37	2	2	0.50	1-3
I am confident I can perform effectively on many tasks.	2.57	3	3	0.51	2-3
Compared to other people, I can do most tasks very well.	2.53	3	3	0.51	2-3
Even when things are tough, I can perform quite well.	2.47	2	2	0.51	2-3

*Note.* Items reprinted from “Validation of a new general self-efficacy scale,” by G. Chen, S. M. Gully, & D. Eden, 2001, *Organizational Research Methods*, 4, pp. 62-83. Reprinted with permission.

<sup>a</sup> 0 = Not True at All; 1 = Hardly True; 2 = Moderately True; 3 = Exactly True

The rate at which participants conduct mental health assessments for persons diagnosed with cancer does not appear to be significantly related to self-efficacy. Frequencies of conducting mental health assessments were collapsed into: low (*never / rarely*) ( $N = 11$ ) and high (*often / always*) ( $N = 8$ ). There was no significant difference in the NGSE scores of participants in the low frequency group ( $M = 2.34$ ,  $SD = .43$ ) and the high frequency group ( $M = 2.39$ ,  $SD = .34$ );  $t=0.29$ ,  $p=0.78$ .

When asked to report the degree to which they felt comfortable conducting mental health assessments, 21% ( $N = 4$ ) of respondents indicated they were *not comfortable*, 58% ( $N = 11$ ) reported that they were *moderately comfortable*, and 21% ( $N = 4$ ) reported they were *fully comfortable*. In contrast, 26% ( $N = 5$ ) of participants reported that they did not feel they were professionally prepared (via their education, training, etc.) to conduct mental health assessments

for persons diagnosed with cancer. A Pearson correlation coefficient shows a strong, positive correlation between rural and frontier AOSW members' sense of professional preparedness and their comfort administering mental health assessments ( $r = .827, N = 19, p = .01$ ).

Table 3

*Demographics of Participants According to Self-Efficacy Group (Low v. High)*

Demographics	Low Self-Efficacy Group		High Self-Efficacy Group	
	%	N	%	Sample Size
Female	52.6	10	42.1	8
Male	0	0	5.3	1
BSW	5.3	1	5.3	1
MSW	47.3	9	42.1	8
≥10 years in practice	37.0	7	31.0	6

Use of the non-standardized clinical interview was reported by 84% ( $N = 16$ ) of respondents. Only four participants reported using standardized assessment tools (Burns Depression Inventory and the National Comprehensive Cancer Network (NCCN) Distress Tool) to evaluate potential mental health concerns of persons diagnosed with cancer.

The most frequently reported time for conducting assessments was at diagnosis (42%). It is notable that all but one participant reported that they *never* or *rarely* conduct mental health assessments after the patient has completed oncology treatment. Open-ended survey responses reveal participants also conduct mental health assessments for persons diagnosed with cancer upon hospitalization, patient request, physician request, and recurrence of the disease.

Frequency of conducting supportive counseling were collapsed into two groups: lower (*rarely / often*) ( $N = 12$ ) and higher (*always*) ( $N = 7$ ). No one in the study indicated they *never* provide supportive counseling. The rate at which respondents provide supportive counseling does not appear to be related to self-efficacy: there was no significant difference in the NGSE self-efficacy scores of participants in the lower frequency group ( $M = 2.31, SD = .38$ ) and the higher frequency group ( $M = 2.45, SD = .41$ );  $t = 0.57, p = 0.58$ ).

A Pearson correlation coefficient reveals a perfect, positive correlation between respondents' sense of professional preparedness and their comfort with providing supportive counseling ( $r = 1.0, N = 19, p = 0.01$ ). The perfect correlation is likely due to the small sample size.

Participants who indicated that their job description includes providing supportive counseling to persons diagnosed with cancer reported that they were more likely ( $M = 3.36, SD = .63$ ) to provide supportive counseling than those who were not required to do so by their employer ( $M = 2.8, SD = .84; t(18) = 1.56, p = 0.14$ ), although the difference was not statistically



significant. Participants reported that patient education (79%), supportive counseling (74%), referrals (95%), and advocacy (95%) are the primary tasks they perform as oncology social workers.

## Discussion

Overall, the rural and frontier AOSW members who participated in this study are comfortable conducting mental health assessments and providing counseling, regardless of whether they regularly perform these tasks. In addition, study respondents are highly educated and have largely spent a great deal of their careers as medical or oncology social workers.

The most significant findings from this study are the strong relationships between professional preparedness and comfort in conducting mental health assessments and providing supportive counseling for persons diagnosed with cancer. Although these results are based on clinical experience, the statistical significance demonstrated among this sample emphasizes the importance of education focused on the role of mental health assessments and supportive counseling in oncology settings.

Despite the push from national organizations, such as the National Cancer Institute and the Canadian Association of Psychosocial Oncology (National Cancer Institute, n.d.a; Wright et al., 2007), routine use of standardized mental health assessment tools for persons diagnosed with cancer does not appear to be the practice norm for rural and frontier AOSW members who participated in this study. Although 16 participants made use of clinical interviews to conduct mental health assessments, 11 of these same participants reported *rarely* or *never* performing assessments. These conflicting figures suggest that participants did not consider the non-standardized clinical interview as an assessment tool when answering previous questions about how frequently they conducted mental health assessments.

Study results indicate that rural and frontier AOSW members conducted mental health assessments most frequently upon diagnosis (42%). While it is important to capture the mental health concerns of individuals upon diagnosis, these concerns can evolve and change over the course of the disease (White & Macleod, 2002). Treatment of cancer, including chemotherapy and radiation, can create new mental health concerns and exaggerate existing symptoms of depression and anxiety, reinforcing the importance of follow-up mental health assessments (American Cancer Society, 2009; Brix et al., 2008; Cwikel & Behar, 1999; National Cancer Institute, n.d.a; National Institute of Mental Health, n.d.; White & Macleod, 2002). Persons diagnosed with cancer often (66%) report that the greatest unmet need one year after diagnosis is assistance dealing with emotional distress (Cwikel & Behar, 1999). However, approximately 94% of study participants report that they *never* or *rarely* conduct any form of post-treatment mental health assessments.

Based on the results of this study, it is possible that by adjusting the job descriptions of oncology social workers to include the expectation that they conduct mental health assessments and provide supportive counseling, employers may increase the frequency at which these tasks are completed, as AOSW membership alone does not appear to influence adherence to the AOSW Scope of Practice among sample members. Literature suggests that conducting mental health assessments and providing supportive counseling can reduce physical pain and increase

life expectancy for persons diagnosed with cancer (Bramsen et al., 2008; Zabora et al., 2001). Therefore, employers may need to be more explicit in their job descriptions about the expectations that oncology social workers conduct mental health assessments and provide supportive counseling in hopes of promoting the best treatment outcomes for persons diagnosed with cancer.

Reimbursement rates from insurance companies and medical practice policies could be additional explanations for the low frequency rates of conducting mental health assessments as reported in this study. For oncology social workers practicing in inpatient centers (hospitals, etc.), these types of mental health assessments are generally not reimbursable by insurance nor required by agency or governmental policy, unlike federal requirements that mandate routine mental health screening in dialysis units. Perhaps health insurance reimbursements and health care policy changes that standardize oncology standards of care involving regular mental health assessments and provisions for supportive counseling could lead to improved patient satisfaction and overall health outcomes.

One important result to emerge from this study is that more than half of rural and frontier AOSW members sampled do not regularly assess the mental health needs of persons diagnosed with cancer; however, 78% of these members provide supportive counseling. It is unclear what guides these supportive counseling sessions. Without some form of assessment, standardized or non-standardized, these supportive counseling sessions may not be adequately addressing the mental health needs and concerns of persons diagnosed with cancer.

Ninety-five percent of respondents expect persons diagnosed with cancer to experience some form of emotional distress related to their diagnosis. The expectation of emotional distress may influence providers to circumvent mental health assessments and operate on the assumption of emotional distress or mental health concerns. However, operating on assumptions of generalized emotional distress and failing to directly and adequately address patients' needs or concerns can contribute to the development of additional mental health issues (Parle, Maguire, & Heaven, 1997; Taylor et al., 2010). This may help explain why some patients are dissatisfied with the way their emotional distress and mental health concerns are addressed and treated during their experience with cancer (Burman & Weinert, 1997a, 1997b; Cwikel & Behar, 1999; Taylor et al., 2010).

The NGSE scale measured participants' general sense of self-efficacy and did not measure their specific occupation or work-related sense of self-efficacy as oncology social workers. Although this scale was developed to evaluate occupational and organizational self-efficacy and correlates similarly with other scales of occupational self-efficacy (Chen et al., 2001), the NGSE may have been too general to capture the unique occupational-specific self-efficacy of oncology social workers in rural and frontier settings.

### **Limitations and Future Research**

This pilot study, which appears to be the first to examine rural and frontier oncology social workers' self-efficacy and practices related to attending to the mental health needs of cancer patients, included a small, non-random sample of rural and frontier AOSW members who work in communities of 50,000 residents or less. While the estimated response rate for this study

is approximately 24% of rural and frontier AOSW members based on population data (Zebrack et al., 2008), it is difficult to determine the exact response rate given that AOSW does not track the rurality of members (M. A. Burg, personal communication, August, 2010). Therefore, study results are not generalizable to the population of rural and frontier oncology social workers in the U.S. Defining “mental health assessments” in the survey instrument could have minimized any confusion by respondents that may have occurred based on inconsistent responses regarding frequency of such assessments and the use of the non-standardized clinical interview (i.e., 58% of participants reporting they rarely or never conduct mental health assessments, while respondents indicated use of non-standardized clinical interview 84% of the time). The perfect correlation between preparedness and comfort providing supporting counseling, while likely attributable to the small sample size of this study, could suggest participants interpreted these characteristics as identical or interchangeable; a qualitative study design may be able to explore how AOSW members conceptualize “mental health assessments” in a way that this study was unable to capture and also parse out the differences practitioners see between preparedness and comfort in relation to providing supportive counseling.

Study results suggest that providers expect persons diagnosed with cancer to experience emotional distress, but this study was not able to fully elucidate how practitioners respond to and address this perceived emotional distress. Future qualitative exploration of the mental health-related professional practices of rural and frontier AOSW members may provide useful into insights of how practitioners define professional preparedness, the factors that contribute to feeling professionally prepared, and the ways practitioners define mental health assessments and supportive counseling. Research is needed to gather more in-depth information since it appears that access to large numbers of rural oncology social workers is difficult and little is known about their professional practices. Additionally, AOSW membership is voluntary and is not required for professional oncology social work practice; therefore, research examining the professional practices of a randomized sample of oncology social workers who practice in rural and frontier settings may yield more generalizable results than this pilot study

Self-efficacy predicts work-related outcomes, such as job attitudes, training proficiency, skill acquisition, and job performance (Chen et al., 2001; Stajkovic & Luthans, 1998). Without moderate self-efficacy, employees will not perform the duties required of their position (Peterson & Arnn, 2005). In particular, self-efficacy is a stronger predictor of task-specific performance than overall job performance (Judge, Jackson, Shaw, Scott, & Rich, 2007). Research examining the professional practices of oncology doctors and nurses suggests that conversations with patients regarding their emotional distress and psychological concerns are among the most difficult and stressful conversations professionals have with persons diagnosed with cancer (Pollak et al., 2007; Wilkinson, Gambles, & Roberts, 2002). In fact, medical professionals report they are less likely to solicit disclosure of patients’ psychological distress (Wilkinson et al., 2002) and frequently terminate the discussion when patients bring up emotional issues during their appointments (Pollak et al., 2007). Future research of oncology social work practices is needed to evaluate providers’ task-specific self-efficacy, particularly in relation to assessing and exploring patients’ emotional distress.

## Conclusion

Based on the outcomes of this pilot study, there does not appear to be a relationship between self-efficacy and the frequency which rural and frontier AOSW members conduct mental health assessments or provide supportive counseling; however, study participants appeared to have a strong sense of self-efficacy overall. This is of significance as they may be the only providers of psychosocial services for oncology patients in their communities (Burg et al., 2010; Hewitt et al., 2006; King et al., 2008; Zebrack & Walsh-Burke, 2004). Respondents reported feeling professionally prepared and comfortable with the tasks of conducting mental health assessments and providing supportive counseling to persons diagnosed with cancer, which are components of the AOSW Scope of Practice (AOSW, 2001); and yet, they are not completing these tasks regularly. This finding is consistent with research documenting patients reporting insufficient mental health care in oncology settings (Burman & Weinert, 1997a, 1997b; Cwikel & Behar, 1999; Taylor et al., 2010).

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