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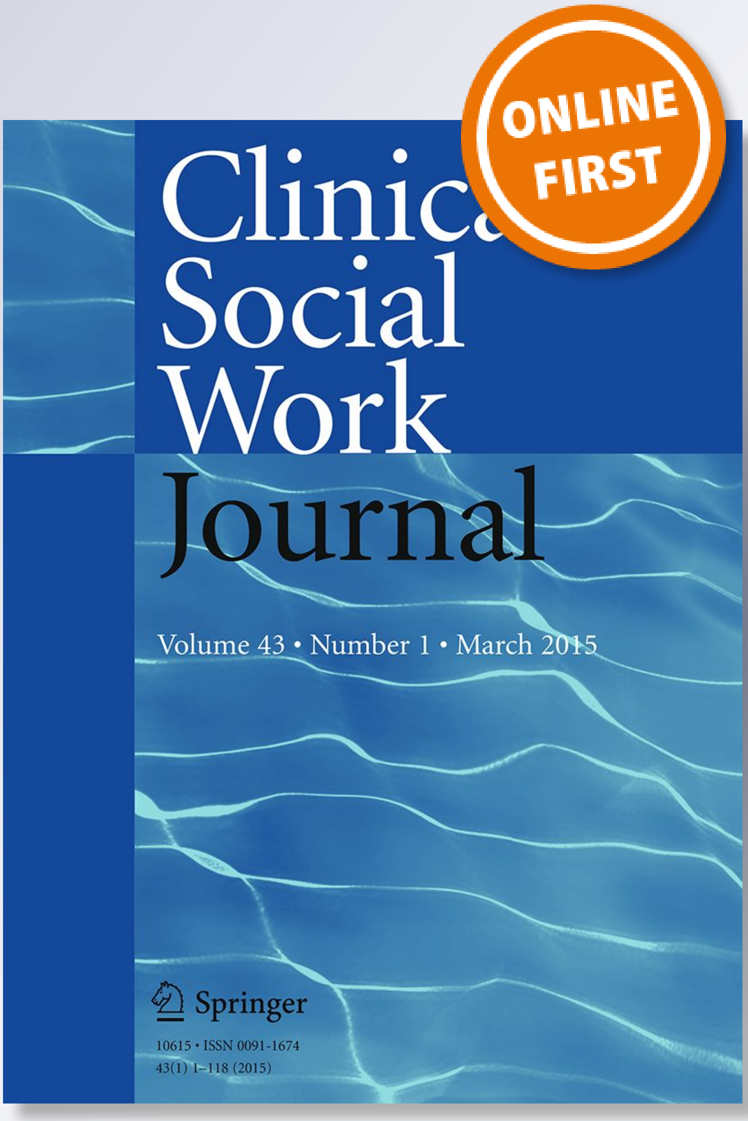

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ORIGINAL PAPER

The Hidden Cost of Cancer: Helping Clients Cope with Financial Toxicity

Maria Chi[1]

Abstract *Financial toxicity* is a term that is increasingly used in the medical literature to describe objective and subjective measures of financial strain that many people with cancer face as a result of costly care and treatment. The author first reviews the literature for evidence of financial toxicity and its impact on quality of life, especially anxiety and depression. Maslow's (Motivation and personality, 2nd edn., Harper & Row, New York, 1970) hierarchy of needs is then presented as a theoretical basis for the impact of financial stress on clients' ability to cope with their cancer experience. Finally, a clinical vignette illustrates the double burden of cancer and financial strain, highlighting the need to assess for and address financial hardship as a key part of our clinical practice. Psychosocial interventions—such as problem-solving, cognitive-behavioral therapy, family and group support, and meaning-centered therapy—may be utilized to decrease cancer-related distress, even when financial toxicity cannot be fully alleviated. Once financial obstacles are identified and acknowledged, however, the pathway to effective coping is clearer.

Keywords Cancer · Financial toxicity · Financial strain · Financial stress · Financial burden · Quality of life · Maslow · Hierarchy of needs

> *"Am I going to die? Can I pay for my cancer treatment?"*
> *-Deborah, newly diagnosed with metastatic cancer*

Introduction

As of 2014, there were approximately 14.5 million people in the United States living with or beyond a cancer diagnosis (National Cancer Institute 2016). *Financial toxicity* (FT), defined as the "patient-level impact of the cost of cancer care," is a relatively new term in the medical field that describes a growing phenomenon (Zafar et al. 2013, p. 381). FT is a measure of objective out-of-pocket expenses, as well as subjective emotional distress, associated with the high cost of cancer care and treatment (Zafar and Abernethy 2013).

According to the National Cancer Institute (NCI), almost 40% of men and women in this country will be diagnosed with cancer at some point in their lives (2016). Due to rising medication prices, health insurance costs, limited access to medical care, and other treatment-related expenses, the financial burden of cancer is substantial for many patients. Indeed, Americans with cancer experience higher out-of-pocket costs than do patients with any other chronic illness (Bernard et al. 2011). Americans are also getting older: by 2040, people aged 65 and older will comprise almost 22% of our population, versus 15% in 2014 (U.S. Department of Health and Human Services 2017). By 2030, it is predicted that the incidence of cancer in older adults will rise by 67% (Smith et al. 2009). As our population continues to age, more and more people will face the FT that may accompany a cancer diagnosis.

At the same time, advancements in technology, medicine, and treatment will permit many people to live longer with cancer, assuming they have access to treatment. Ostensibly, extended life spans mean that people have the opportunity to focus on the quality of their lives beyond sheer survival. Just as people with other chronic illnesses face a cumulative financial burden due to increased medical expenses, more

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and more people with cancer are experiencing that strain. In fact, many patients report that figuring out how they will pay for their treatments constitutes their greatest concern related to having cancer (Lilly Oncology 2012). The increased incidence of cancer, combined with the overall decline in its mortality rate (NCI 2016), leaves more survivors to manage the financial aftermath of their cancer experience.

Various surveys show that as many as 47% of people with cancer in the U.S. report "catastrophic" levels of financial hardship (Chino et al. 2014, p. 416). This prevalence alone warrants further investigation of FT. As clinicians, we cannot afford to ignore the psychosocial cost of financial strain for people with cancer. The purpose of this paper is to briefly review the literature on both FT and its impact on quality of life and to underscore the importance of addressing financial challenges in our initial assessment of clients and throughout the therapeutic process. A clinical vignette is presented to illustrate the effects of financial stress on our clients' cognitive and emotional adjustment to cancer and to demonstrate the utility of core clinical interventions (e.g., problem-solving, cognitive behavioral therapy, family and group support, and meaning-centered therapy) to facilitate coping.

Financial Toxicity: What Is It?

Certainly, financial stress is not unique to cancer but is associated with other serious and chronic illnesses as well. At least one in five Americans report problems paying for food, housing, and transportation because of increased medical expenses for conditions such as diabetes, heart disease, and depression (May and Cunningham 2004; Tu 2004; Institute of Medicine 2008). This paper will focus on the financial burden of cancer in particular as an example of a population facing the challenges of both serious illness and the increasing costs of medical care. However, the concepts presented may be generalizable to (and inform interventions for) people living with other chronic or life-threatening diseases.

As people with cancer live longer and incur greater expenses for longer-term treatment, financial toxicity may only intensify. The term *financial toxicity* (FT) was first introduced into the health literature by oncologists (Zafar and Abernethy 2013) who recognized that cancer-related financial stress could be just as toxic as the effects of chemotherapy or other cancer treatments. Specifically, FT describes both measurable out-of-pocket expenses and the emotional stress associated with the high costs of cancer care (Zafar and Abernethy 2013). Although not always using the term *financial toxicity*, there has been a recent proliferation of research on similar concepts. Researchers have examined financial strain, stress, or burden in people with cancer due to cost of health insurance or treatment (especially medications, outpatient care and hospitalization), increased transportation expenses, diminished savings or retirement funds, higher debt and medical bankruptcy, greater borrowing from friends or family, eviction or home foreclosure, loss of income, and the inability to afford other basic expenses (Shankaran et al. 2012; Zafar and Abernethy 2013; Zafar et al. 2013).

For example, in a national survey of people with various types of cancer (N = 509), one-third of respondents ages 25–54 reported having to forfeit basic needs like groceries and transportation in order to pay for their cancer treatment (CancerCare 2016). In the same study, 21 and 17% of the respondents could not pay at least one utility bill or rent/mortgage bill, respectively. A full 5% declared bankruptcy. All of the participants in this survey had some type of health insurance or treatment coverage, whether through Medicare, Medicaid, the marketplace, their employer, or local charity care. However, they still experienced heavy out-of-pocket expenses related to their cancer treatment. Participants in this survey aged 25–64 spent an average of $1112 per month, while those 65 and older spent about half that (CancerCare 2016). Rising co-pays, deductibles, and insurance premiums, decreased income from time off work, and increased transportation expenses all contributed to this financial burden.

In a sample of 284 people with colon cancer, 38% reported at least one financial challenge related to their treatment, even with health insurance. Twenty-three percent of these patients disclosed having medical debt (Shankaran et al. 2012). Similarly, one study of 584 patients found that 30.3% of them were concerned about how they would pay for their cancer treatment, even though 99% of this sample had health insurance. Only 8.3% of these patients were confident that their insurance would cover most aspects of their health care needs (Stump et al. 2013).

Despite using financial coping strategies (e.g., depletion of savings, incurring credit card debt, and borrowing money) or cutting costs in other areas of their lives, people with cancer may not always alleviate their financial burden (de Souza et al. 2017). Consequently, they often postpone treatment or go without care. In a retrospective study of women with breast cancer, higher prescription copayments were associated with non-adherence to adjuvant hormonal therapy (Neugut et al. 2011). Similarly, in the 2006 *National Survey of U.S. Households Affected by Cancer*, 8% of respondents who had health insurance either delayed or did not get cancer treatment; 25% who did not have insurance either delayed or went without treatment. Both groups cited the financial burden of cancer as the reason for foregoing care (USA Today et al. 2006). Cancer*Care*'s *Patient Access and Engagement Report* revealed that 39% of respondents between ages 25–54 had delayed or missed doctor appointments; 38% had delayed filling a prescription; and 34% had skipped dosages of their cancer-related medications, all due to financial strain (2016).

How Toxic Is Financial Toxicity?

Clearly, the financial burden of cancer may affect people's ability to access or continue treatment, which may impact their survival. Financial stress thus has serious consequences for patients' physical health and well-being. As defined earlier in this paper, another important component of financial toxicity is the emotional distress that patients experience in relation to their out-of-pocket cancer costs (Zafar and Abernethy 2013). This more subjective aspect of FT may have major implications for our clients' quality of life and their ability to cope with cancer.

When working with people who are newly diagnosed with cancer, oncology social workers often help their clients with multiple concrete and clinical tasks: facilitating their ability to process what is often shock at initial diagnosis; accessing outside resources; communicating with friends, family, and doctors; addressing existential and spiritual concerns; engaging or expanding social support networks; mourning the loss of a healthy self; examining altered roles; and fostering hope while promoting a realistic assessment of their diagnosis (Fleishman and Messner 2015). These interventions help clients to integrate the troubling knowledge of their illness into a more bearable framework, one that allows emotional expression and ventilation alongside more manageable and practical steps toward coping.

Financial hardship, however, may make it more difficult for clients to mobilize the physical and mental energy needed to start the coping process. For example, the author met with Jason, who had been diagnosed with prostate cancer several months prior to beginning counseling. During that time he had been struggling to pay for his increased expenses, including transportation to his daily radiation treatments and copays for his doctor visits. His need to take time off work added to stress about his family's already precarious financial status, as his wife recently lost her job. Not only was Jason feeling helpless and anxious about his reduced income but he was also struggling with the loss of his identity as a household provider. When he entered counseling, he was emotionally exhausted but ready to process and manage his feelings.

As the literature shows, financial stress also compounds the initial anxiety, depression, and feelings of helplessness that often accompany a cancer diagnosis. In a small qualitative study, for example, Klimmek et al. (2010) found an association between financial and health insurance-related challenges and the self-reported incidence of distress. The authors interviewed women in four different U.S. cancer centers about their experience with managed care organizations, difficulty in getting authorization for treatment, being denied coverage for certain procedures, and trying to plan for out-of-pocket expenses. Participant interviews indicated high emotional distress and anxiety around these financial challenges (Klimmek et al. 2010).

Similarly, a cross-sectional study compared 149 adults with advanced cancer, half in private cancer centers and half in public hospitals in the U.S. (Delgado-Guay et al. 2015). Both samples reported high levels of financial distress—defined as a subjective experience of distress attributed to financial problems—regardless of health insurance status. In fact, levels of financial distress were found to be greater than self-reported levels of physical distress, other emotional distress, and social or family distress. Furthermore, patients in both groups who experienced high financial distress reported significantly more anxiety and depression (Delgado-Guay et al. 2015).

The link between financial burden for people with cancer and negative psychological outcomes has also been researched internationally. A recent qualitative study consisting of semi-structured interviews with 20 patients in Ireland differentiated between "financial strain"—the individuals' subjective perception of financial difficulty—and "financial stress"—a more objective measure of their burden as measured by cancer-related expenses and existing resources (Sharp et al. 2013, p. 750). Both financial strain and financial stress were strongly related to adverse emotional effects, such as anxiety and depression (Sharp et al. 2013).

Waiting for more specific diagnostic information, whether in the form of test results, staging, or treatment options, is often the most anxiety-inducing part of the cancer experience. As one waits for information that will inform prognosis and treatment planning, anxiety about not actively addressing the tumor in one's body can peak (Schnipper and Varner 2015). Oncology social workers play a critical role in helping clients manage that anxiety, by eliciting strengths and past coping strategies, teaching relaxation exercises and other forms of stress reduction, fostering effective communication with their medical team, and providing simple validation and normalization of their experience (Hartmann 2015). Financial strain, however, often exacerbates the anxiety that a newly diagnosed patient may experience. When patients are concurrently worried about the exact nature of their diagnosis and potential treatment costs, it may be difficult to focus on the present and activate problem-solving skills.

Even with today's technological advancements in the treatment of many cancers, a cancer diagnosis still brings the prospect of death into the room. Thus one of the initial tasks for patients is to process and accept the reality of their diagnosis and determine how to integrate this new reality into their daily lives. Clark and Bolte (2015) identify this activity as "sense-making," which they define as "a cognitive and emotional process central to the creation of the ubiquitous *new normal* perspective that blends medical science and personal meaning" (p. 52). When experiencing financial strain, one's capacity to make sense of the diagnosis may be compromised, as attention is directed toward finding the resources to pay for treatment and related expenses.

Financial concerns may also impact a patient's ability to find or create their new normal in relation to the important people in their lives. Participants in a small qualitative study (N = 40 patients and 17 caregivers) reported an impact on their family roles and relationships (Amir et al. 2011). A consistent theme was identified across interviews: participants experienced a major strain on their marriages or relationships due to financial concerns, as well as anxiety about altered roles and relationships within the family (e.g., Who could still work? Who now had the higher income?) (Amir et al. 2011). Even without financial stress, cancer itself may impact family dynamics (Hedlund 2015). Changes in household routines, fearing the death of the sick family member, taking on the tasks of caregiving, increased conflict, and breakdowns in communication are all ways in which family structures may be altered by cancer (Hedlund 2015). Moreover, studies shows that caregiver distress is positively correlated with the anxiety and depression of their loved ones (Segrin et al. 2007), with caregivers sometimes experiencing more distress than the patient (Hodges et al. 2005). When finances are strained to meet cancer-related expenses, these relationships may be further compromised.

For example, when one young adult client, Ella, became a caregiver for her mother with metastatic breast cancer, the client moved back to her childhood home and put her own life on hold. While her father worked extra hours to meet growing medical expenses, Ella provided round-the-clock care for her mother. Unresolved conflicts and old feelings of resentment were reactivated as Ella spent more time with her mother and her father spent less time in a caregiving role. Both Ella and her father wished they could hire a home health aide but could not afford to do so. As the patient became increasingly depressed, so did her husband and daughter.

In addition to its added strain on families, its impact on anxiety and depression, and its demonstrated effects on overall quality of life, financial toxicity is sometimes a troubling obstacle for people seeking help for their distress. In Cancer*Care*'s (2016) national financial survey of 509 people with cancer, 58% of participants ages 25–54 disclosed that they felt distressed about their financial situation during treatment. In the same survey, 24% reported having to "often or always" miss a psychological or supportive counseling appointment, in order to save money (CancerCare 2016, p. 56). Oncology social workers and their multidisciplinary health care team members are often greatly concerned when patients forego either medical treatment and/or psychosocial appointments as cost-cutting strategies, at a time when these are most needed.

Maslow's Hierarchy of Needs: A Theoretical Pathway

Given the prevalence of FT in the U.S. as well as its impact on quality of life and mental health, clinical social workers are increasingly encountering its effects on the people they serve. Helping clients manage their cancer-related distress often includes a thorough evaluation of their financial distress. As Lethborg and Harms (2015) argue, there is great value in being able to understand how someone conceptualizes and makes sense of one's cancer, which includes an assessment of that person's socioeconomic, as well as familial and cultural, context. Exploring the financial dimension in greater detail may lead to a deeper understanding of how to help patients cope more effectively with their cancer.

If someone is struggling with basic socioeconomic needs, how can she begin to engage in the coping process? How does she start to make sense of her experience? Cancer represents an existential threat, a reminder of our mortality (Frankl 1968; Yalom 1980). Financial toxicity may compound that threat.

According to Maslow's theory of the hierarchy of needs (1970), humans are motivated to fulfill four main ascending levels of needs—physiological (food, water, sleep), safety (home, family, stability), love (belongingness, acceptance), and esteem (mastery, recognition)—before being able to focus on the 5th (peak) level of self-actualization. For someone whose bodily integrity has already been threatened by cancer, a lack of financial security can be particularly challenging. For example, Ben, a 65-year-old man who cannot afford the cost of his chemotherapy, may fear that missing treatments will cause the cancer to grow and hasten his death. His sense of physical security is impeded. Understandably, Ben may be preoccupied with his mortality and not able to invest emotionally in his relationships, communicate with his loved ones, or develop a sense of mastery or fulfillment.

Or, Ben may prioritize his chemotherapy copayments over buying adequate groceries, because his income is not sufficient to cover both, which compromises his basic needs in another way. Not only can he not meet his nutritional needs, but Ben is deprived of the feelings of safety and stability that might allow him to process and reflect on his cancer experience. It follows that patients burdened by both cancer and FT may find it difficult to self-actualize, or realize their fullest individual potential (Maslow 1970), when unable to meet fundamental needs on the hierarchy.

One could argue that part of self-actualization is the ability to engage in meaning-making. Meaning-making requires the ability to reflect, to make sense of an experience, to organize the parts of one's life into a coherent whole, and to attribute purpose to certain events or one's existence (Lichtenthal et al. 2015). Those clients whose existence is made more fragile by both cancer and FT may never get to that point, reflecting the crucial premise of Maslow's theory: it is more difficult to fulfill higher-order needs until more fundamental ones (oriented toward survival) are met (Maslow 1970). In psychosocial oncology, a critical practice domain for social workers is to conduct a thorough assessment of our clients' FT—in both its objective and subjective forms—in addition to exploring the emotional and social sequelae of a cancer diagnosis. Identifying patients' fundamental financial needs, locating essential resources, advocating for the removal of any barriers, and validating and normalizing their financial stress all may pave the way for other core clinical interventions.

Implications for Practice: Addressing Financial Toxicity

To facilitate our clients' coping, we may utilize multiple evidence-based interventions, such as problem-solving, cognitive-behavioral therapy, family and group support, and meaning-focused approaches. These practices are helpful in alleviating cancer-related distress, but they may also help our clients cope with financial toxicity. Even when FT makes it harder for patients and caregivers to manage the emotional and practical challenges of cancer, these interventions may facilitate adjustment to their cancer experience.

For example, the problem-solving approach may build clients' sense of self-efficacy: they may learn that they are capable of handling their illness by using inner and outer resources (Nezu et al. 2003; Zabora 2015). A strengths-based assessment may elicit a patient's skill in mobilizing social support or in organizing information and making plans. Oncology social workers assist patients in applying these skills to their current crisis. Providing psychoeducation around common concerns is another important component of problem-solving (Zabora 2015). As social workers, we may help the patient sift through an overwhelming amount of medical information and identify which sources are reliable or not, manage expectations around medical bills and how to negotiate payment or ask for assistance from the hospital, and provide guidance on getting accurate information from the insurance company about what it will or will not cover. To address financial obstacles, social workers may also help their patients locate grants from national or community programs, discuss medical leave options with an employer, and rehearse a conversation about financial concerns with their doctors, who can potentially recommend less costly treatments or those with fewer side effects that would allow patients to continue working (Zabora 2015). Thus even when our clients experience significant financial stress, some basic but crucial problem-solving may give them back a measure of hope and control (Zabora 2015).

Problem-solving may be a key intervention within the context of couples counseling, family therapy, or group support, which have all been shown to reduce cancer-related distress (Manne et al. 2006; Damaskos and Parry 2015). By providing psychoeducation around both the patient's and caregiver's experiences and facilitating effective communication around cancer *and* FT, family and interpersonal conflict may be reduced (Manne et al. 2006). For example, when 30-year-old client Emily came to see the author with her mother, the client expressed considerable distress about her inability to continue working and support herself while she underwent chemotherapy and radiation. Emily was worried not only about her own loss of financial stability but about the extra expenses she was incurring for her mother, who was paying her rent and monthly insurance premiums. With psychoeducation about the impact of cancer and FT on family roles and a patient's sense of self, Emily's mother began to understand that her daughter was mourning her independence and certain parts of her identity. At the same time, Emily learned to communicate more clearly with her mother about her need to retain some autonomy while also accepting her mother's desire to help her financially. Through some basic problem-solving, Emily and her mother identified ways to minimize some expenses.

Emily also attended a support group for other young adults with cancer, which normalized her guilt about relying on her mother for financial assistance, as other group members faced similar challenges. The group members validated Emily's experience with both cancer and FT and provided a safe space for her to authentically express her feelings. Support groups help reduce patients' feelings of isolation as well as provide a forum for information exchange and resource-sharing (Ussher et al. 2006; Damaskos and Parry 2015). Despite her considerable stress about her financial situation, Emily developed a greater sense of self-efficacy, which is often an important of predictor of how well patients will cope with illness (Lorig and Holman 2003). With the help of her peers in the group, Emily realized that she could take certain steps to partially resolve her FT (e.g., apply for small grants from charities and enroll in a free meal delivery service for patients).

Cognitive behavioral therapy (CBT) is another approach that has shown utility in alleviating cancer-related distress, especially during diagnosis and initial treatment (Nezu et al. 2003; Boesen et al. 2005; Cagle and Loscalzo 2015). Techniques such as identification of unhelpful thoughts about their illness, reframing and reconstruction of those thoughts into more adaptive beliefs, and relaxation training to promote emotional regulation may all be helpful ways to reduce anxiety and depression in people with cancer (Boesen et al. 2005). These interventions may also be useful in addressing financial toxicity.

For example, a patient's belief that he must always be strong and never ask for help may interfere with his ability to access financial resources from friends or family. With the guidance of a social worker, he learns to more closely examine the belief that seeking help makes him weak and needy. He engages in reality-testing and eventually develops a more balanced perspective: "Asking for help does not mean I am weak; it means I need support in a difficult situation. I still show strength in many different ways, including how I cope with my cancer. I would not judge my friends or family if they asked *me* for help." Through the CBT process, financial toxicity may be reduced.

Of course, not all financial toxicity can be fully or even partially resolved. In these instances, cognitive or problem-focused coping strategies (such as CBT and problem-solving interventions) may be less useful. Instead, when challenges are largely out of one's control or even unsolvable, we may turn to meaning-focused coping, which improves psychological adjustment to illness (Folkman and Greer 2000; Lethborg and Harms 2015). Meaning-focused coping involves finding meaning in life despite obstacles such as a major illness, which is the premise of Breitbart et al.'s (2010) Meaning-Centered Group Psychotherapy (MCGP). Based on Viktor Frankl's (1968) logotherapy, Breitbart et al. (2010) demonstrated the ability of MCGP to enhance a personal sense of meaning and purpose in people with advanced cancer, even at the end of life. MCGP, as well as the individual-based Meaning-Centered Psychotherapy (MCP), may thus be important interventions for improving quality of life and spiritual well-being in patients (Breitbart and Poppito 2014).

Other examples in the psychosocial health literature support the value of using meaning-making interventions with patients at any stage of cancer. For instance, one systematic literature review found that guided meaning-focused techniques are effective in alleviating patients' "holistic suffering," or their comprehensive sense of hopelessness and helplessness (Best et al. 2015, p. 886). Another comprehensive literature review cited the capacity of meaning-focused therapies to help patients cope better with various types of cancer, suffer less anxiety, and experience renewed hope (Ownsworth and Nash 2015). Finally, meaning-making interventions have been positively correlated with higher levels of self-esteem and self-efficacy in people newly diagnosed with breast or colon cancer (Lee et al. 2006).

Jackie was a 55-year-old woman with stage 3 breast cancer who had guardianship of her young granddaughter. They had been living in a homeless shelter for the past 9 months after Jackie lost her job. She did not have a significant source of income, although she did receive food stamps and Medicaid. Although she felt very overwhelmed by her lack of financial stability and had difficulty getting to her hospital due to high transportation costs, she felt strongly about trying to keep as many treatment appointments as possible. Without the prospect of major resources to alleviate her financial burden, Jackie focused on the things that still gave her life meaning. She derived great joy in caring for her granddaughter and she was an active member of her local faith community. Jackie also took pride in the way she carried herself—with dignity and perseverance—as a role model for her granddaughter.

Research has not yet focused on the potential application of meaning-centered interventions to the experience of financial toxicity. Still, one may argue that learning to reconnect with or create new sources of meaning in one's life may be useful here as well. However dismal the circumstances of either one's cancer diagnosis or financial circumstances, the opportunity for meaning-making exists.

A Case Example[1]

A 42-year-old, African American woman with metastatic colon cancer, Deborah began her cancer journey as terrified as anyone else. Three weeks after her diagnosis, she walked into my office with two main questions: "Am I going to die? Can I pay for my cancer treatment?" For Deborah, the two questions were inextricably linked. Feeling shocked and numb by her cancer diagnosis, she wondered aloud if she should start writing her will and in the next moment asked me if I knew anything about health insurance. I asked her to take a deep breath, told her that we could discuss both, and I started the assessment process.

After completing the short depression module of the Patient Health Questionnaire (PHQ; Kroenke et al. 2001)—which indicated that she was moderately depressed—Deborah explained that she did not start to feel that way until she realized how expensive it was to have cancer. Although she had just started chemotherapy and had not yet received any medical bills, she knew that her health insurance only covered a certain percentage of her care. She was anxious about paying off her high deductible, and her doctor warned her that she would probably have to take time off work. Deborah was anticipating awful side effects from chemotherapy treatment in addition to the financial toxicity of her cancer. I acknowledged that there was a difficult road ahead, but that she did not have to travel it alone.

The financial toxicity that Deborah experienced was her biggest initial impediment to accepting and processing her cancer diagnosis. Over time, Deborah often told me, "Money stresses me out more than cancer." She needed me to hear and understand that her financial obstacles were significant. Once she felt that I was taking her immediate financial

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[1] Please note: The details of Deborah's case are a composite of several clients with whom the author has worked.

concerns seriously—as seriously as her advanced cancer diagnosis—we began to develop a working alliance.

Our subsequent counseling sessions focused on alleviating her depressive symptoms, which could not happen without simultaneously addressing her financial burden. She was an independent, single woman who was proud of never having to ask for help. Her reluctance to do so was partly a result of her personal history as a caregiver for both of her elderly parents; she had nursed them both through long illnesses before they died. For Deborah, requesting help meant that she was no longer the person in charge, the person who took care of everyone else. The role reversal represented a partial loss of her identity.

Now Deborah lay awake at night trying to figure out how she would afford her care on her own. Because she did have to miss several days of work after each treatment and eventually exhausted her sick time, her income was greatly reduced. Because she could no longer take public transportation (due to a compromised immune system), she relied on expensive car service to get to her medical appointments. Could she still pay her rent each month? Would she become homeless? How much debt could she carry? Would she go bankrupt? These were the questions that consumed her.

After an initial identification of Deborah's financial strain, we could engage in some basic problem-solving: partialization of her burden into more manageable and actionable pieces; identification of realistic sources of support; and rehearsal of proactive behavior (Nezu et al. 2003). Using her considerable inner resources—creativity, affability, and confidence—she decided to look for external resources. By challenging her belief that she should never rely on other people for help, Deborah eventually was able to see that this way of thinking was too extreme and reflective of unreasonable standards she had set for herself. She reframed her need for support: "This is only temporary. Everyone needs help at times and I've helped many people in my life. It's only natural that others want to help me now. People feel good when they are useful."

Indeed, Deborah was delighted to find that her friends and family members were eager to support her however they could. Knowing that they all had their own financial challenges, she chose to barter rather than accept direct financial assistance from them: she would help her beloved nieces with a big school project in exchange for rides to treatment from their parents. Deborah decided to apply to local and national charity organizations for small grants to help with living expenses, and we located a community program that offered free meal delivery, which offset the cost of her other daily expenses.

Tapping into her social support network was an important part of Deborah's coping process. By asking her best friend to call her at a certain time each morning as a reminder to take her medications and to confirm she had a ride to treatment, Deborah also ensured that they had a chance to connect and socialize, no matter how she was feeling. This consistent opportunity for connection is especially important given de Souza et al.'s (2017) finding that social isolation exacerbates financial toxicity by increasing the risk of missed appointments and treatment non-adherence.

To increase Deborah's sense of self-efficacy and control, we role-played a conversation she wanted to have with her oncologist, to ask him if there were less expensive medications she could take; there were not, so we found a non-profit organization that provided copayment assistance for her treatment. Feeling more empowered and hopeful about the possibility of help, she scheduled an appointment with her hospital billing department to work out a monthly payment plan for her accumulating medical bills. Applying her excellent communication skills to the problem-solving process, Deborah identified what was and was not in her control and used that information to identify financial coping strategies.

Gradually, Deborah reported feeling less anxious and depressed, as was reflected in her post-counseling PHQ score. Financial toxicity made it more difficult for her to cope with having cancer, but Deborah was able to overcome some of her main financial obstacles while she simultaneously managed her feelings about cancer. As she felt less overwhelmed and paralyzed by her financial burden, she gained the emotional and mental energy to grapple with some deeper existential questions triggered by her cancer diagnosis: "Who am I? What matters to me? How will I die? How should I live?" She began to process the heightened awareness of her mortality and take advantage of her new sense of urgency to live a more meaningful life, for whatever time she had left.

Discussion

Deborah's story illustrates some of the common psychosocial challenges of cancer and demonstrates how financial toxicity may compound the emotional distress of a cancer diagnosis (Klimmek et al. 2010; Sharp et al. 2013; Delgado-Guay et al. 2015). Well-researched clinical interventions such as problem-solving, CBT, and family and group support are all effective ways to reduce depression and anxiety in people with cancer (Zabora 2015; Cagle and Loscalzo 2015; Damaskos and Parry 2015), and social workers have a critical role to play on the frontlines of psychosocial oncology. Importantly, the same interventions that are used to alleviate cancer distress may be used to address financial strain. From initial diagnosis through the treatment period and even at end of life, we have the opportunity to identify and reduce financial stress. When financial toxicity cannot be resolved, meaning-centered approaches may be particularly valuable by shifting the focus from problem-solving to meaning-making and purpose-finding, which may facilitate greater coping (Breitbart et al. 2010; Lethborg and Harms 2015).

Given the prevalence of both cancer and financial strain in the U.S. (Chino et al. 2014; NCI 2016), more research is needed to identify and develop effective interventions for managing financial toxicity. There is a special role here for qualitative studies, which can give voice to those who carry the double burden of cancer and financial strain, so that we may better understand their experience. The challenge is to do this without overlooking the structural flaws in our healthcare system that contribute to patients' financial burden. By placing the responsibility on people with cancer to first overcome their financially-induced anxiety and depression, and then to adjust more smoothly to their situation, we risk "blaming the victim." Enhancing coping and resilience is a worthwhile goal, but research should further demonstrate the psychosocial cost—for both individuals and society—of *not* removing financial obstacles from the cancer experience. However, until systemic inequities are resolved, we would be remiss in not helping our clients adapt to their circumstances. Deborah made a conscious choice to live her life as fully as possible, despite any limitations posed by cancer *or* financial toxicity. Knowing that the path was shorter (due to her advanced diagnosis) did not diminish the value of her life; it increased it. But she also had to cope with financial toxicity.

Conclusion

The rising incidence of cancer and its concurrent decline in mortality in the U.S. leave more survivors to manage its long-term side effects, including financial toxicity. Financial toxicity may contribute to diminished mental health and quality of life in cancer survivors and subsequently adds to the burden of cancer. Oncology social workers often assess for and address the objective and subjective manifestations of financial stressors using established psychosocial interventions. When the obstacle of financial toxicity is identified and reduced, patients and their caregivers may more readily process the deeper meaning and impact of cancer on their lives.

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Compliance with Ethical Standards

Conflict of interest The author declares that she has no conflict of interest.

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