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NARRATIVE AND ARTS-BASED INTERVENTIONS IN ONCOLOGY SUPPORTIVE CARE: A NARRATIVE REVIEW OF EVIDENCE AND IMPLICATIONS FOR BRIDGING THE DISTRESS SCREENING–RESPONSE GAP

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ABSTRACT – Psychological distress is a core dimension of oncology care and has long been described as the "sixth vital sign". Although distress screening is widely recommended and increasingly embedded in oncology services, translation of screening results into structured supportive responses remains inconsistent.

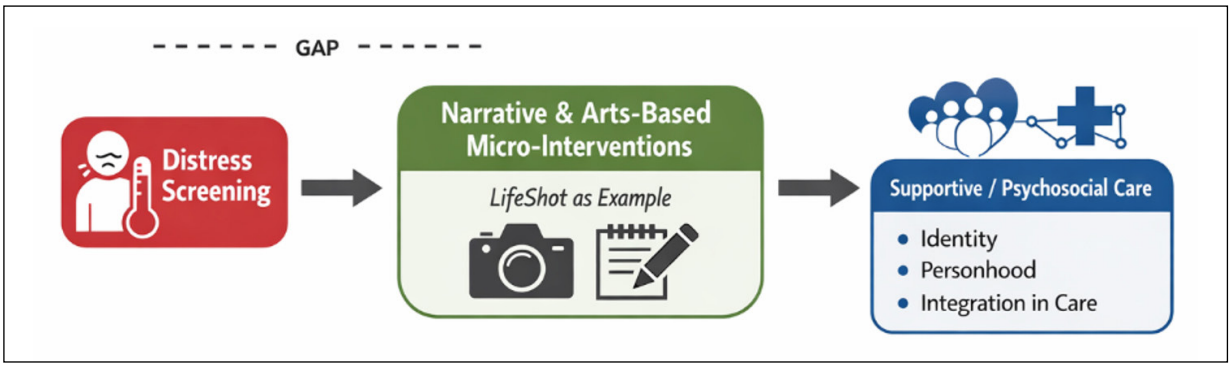
The aim of the study is to synthesize the literature on narrative and arts-based interventions in adult oncology supportive care and to examine how implementation science can clarify the persistent gap between distress screening and timely supportive action.

This manuscript was developed as a targeted narrative review. PubMed and Scopus were searched for systematic reviews, meta-analyses, landmark randomized trials, and implementation science papers relevant to distress screening, narrative medicine, art therapy, creative arts therapy, music interventions, dignity therapy, meaning-centered psychotherapy, and participatory visual methods in oncology. Priority was given to high-quality secondary evidence, seminal conceptual papers, and practice guidelines.

Across visual art therapy, creative arts therapy, music interventions, dignity therapy, meaning-centered psychotherapy, and participatory visual approaches, the literature generally shows modest but consistent improvements in anxiety, emotional well-being, quality of life, existential outcomes, and patient experience. However, the same literature repeatedly reveals structural limitations: specialist dependency, multi-session intensity, heterogeneous outcome measurement, short follow-up, and sparse reporting of adoption, fidelity, penetration, cost, and sustainability. These constraints help explain why many psychosocial and arts-based interventions remain peripheral to routine oncology pathways despite favorable therapeutic signals.

The central challenge in supportive oncology is no longer only whether distress can be detected, but whether detected distress is followed by a visible, scalable, and person-centered response. The literature supports renewed attention to brief, identity-centered conceptual models that can complement specialist psycho-oncology services and strengthen the connection between screening and supportive care within multidisciplinary cancer systems.

KEYWORDS: Distress screening, Psycho-oncology, Narrative medicine, Arts in health, Supportive oncology, Implementation science, Patient-centered care, Cancer supportive care.



Graphical Abstract. The figure illustrates the gap between distress screening and structured psychosocial response in routine oncology care. While screening tools effectively identify patient distress, they often do not translate into timely and personalized supportive interventions. Narrative and arts-based micro-interventions, exemplified by LifeShot, are positioned as pathway-compatible approaches that can function as a relational bridge. By enhancing visibility of patient identity and personhood, these approaches may facilitate integration with multidisciplinary supportive care and contribute to bridging the screening-response gap.

INTRODUCTION

Psychological distress affects a substantial proportion of patients across the cancer continuum. Prevalence estimates vary according to cancer site, stage, treatment phase, and measurement strategy, but clinically significant distress has consistently been reported in approximately one-third of patients, with even higher rates in some high-burden tumor groups such as lung cancer[1]. Distress in oncology is multidimensional. It includes anxiety, depressed mood, uncertainty, practical burden, family concerns, social vulnerability, altered body image, and disruption of personal identity. This breadth explains why distress cannot be reduced to a narrow psychiatric category. In cancer care, it is better understood as a clinically relevant expression of human vulnerability under conditions of biological threat, high information load, and frequent confrontation with prognosis.

The clinical importance of distress extends beyond patient comfort. Meta-analytic evidence has linked depressive symptoms and depressive disorders in cancer with adverse outcomes, including poorer quality of life and higher mortality risk, even though the causal pathways are complex and undoubtedly shaped by confounding, disease severity, and treatment factors[2,3]. Distress also influences communication, treatment adherence, decision making, symptom amplification, family functioning, and help-seeking behavior. For these reasons, psycho-oncology has argued for decades that emotional suffering should not be managed as a secondary issue or a discretionary add-on, but as a constitutive part of high-quality cancer care[4].

The idea that distress deserves routine attention became especially influential with the formulation of emotional distress as the "sixth vital sign" in cancer care[4]. In parallel, short, validated tools such as the Distress Thermometer were developed and tested for use in busy clinical settings[5,6]. Contemporary guidelines, including the NCCN Distress Management guideline, continue to recommend systematic distress screening linked to triage, assessment, and supportive intervention rather than isolated data collection[7]. Reviews of implementation efforts have nevertheless shown that distress programs often succeed in measuring distress more reliably than in organizing what happens next[8,9]. As a result, many oncology services have addressed the first part of the problem (detection) but not the second (response).

This "screening-to-response gap" is especially salient in thoracic and other high-burden cancers. Patients with lung cancer often confront heavy symptom loads, rapid diagnostic pathways, treatment urgency, prognostic uncertainty, and social stigma. The landmark trial of early palliative care in metastatic non-small-cell lung cancer showed that when supportive care is structurally integrated into the routine pathway, meaningful improvements in quality of life and mood can follow[10]. At the same time, stigma studies have shown that lung and head-and-neck cancers can expose patients to shame, blame, social withdrawal, and role disruption, deepening the experiential impact of disease[11,12]. These observations matter because they suggest that supportive oncology is not only about symptom control but also about preserving narrative continuity and personhood under clinical pressure.

The conceptual background for such an approach is not new. Engel's biopsychosocial model challenged reductionist medicine by arguing that illness cannot be adequately understood without considering psychological and social dimensions alongside biology[13]. Narrative medicine later added a more explicitly interpretive and relational emphasis, arguing that clinicians require "narrative competence" – the capacity to recognize, absorb, interpret, and be moved by the stories of illness[14]. Psycho-oncology developed from precisely these insights: cancer generates not only biological pathology but also psychiatric morbidity, existential threat, family burden, and disruption of selfhood[15,16]. In this framework, supportive interventions that address emotional meaning and patient identity are not peripheral to medicine; they are part of medicine when practiced comprehensively.

Over the last decade, arts-in-health literature has added further depth to this field. The World Health Organization's broad evidence synthesis concluded that arts-based activities can support health and well-being through multiple mechanisms, including emotional expression, cognitive reframing, social connection, meaning-making, and embodied engagement[17]. Within oncology, the relevant modalities are diverse: visual art therapy, multimodal creative arts therapy, music therapy and music medicine, dignity therapy, life review, meaning-centered psychotherapy, and participatory visual methods such as photovoice. These interventions differ in intensity and setting, but many share a common ambition: to help patients articulate, preserve, or reconstruct meaning when illness threatens coherence.

Yet the question facing contemporary oncology is not simply whether such interventions can help selected patients in protected contexts. The more pressing question is whether the field can learn from this literature to design supportive responses that are compatible with real multidisciplinary workflows. Many effective psychosocial interventions remain dependent on specialist facilitators, repeated sessions, or stand-alone referral pathways. Those features may be entirely appropriate for patients with significant psychiatric, existential, or palliative needs. However, they can also limit reach in high-volume systems where the majority of distressed patients will never access a specialist intervention. This review therefore starts from the literature rather than from a single program. Its aims are twofold: first, to synthesize the evidence on narrative and arts-based interventions in adult oncology supportive care; second, to interpret that evidence through an implementation lens in order to clarify what kinds of conceptual models may help bridge the persistent distress screening-response gap in routine cancer care.

METHODS

This manuscript is a targeted narrative review intended to synthesize current evidence on narrative and arts-based interventions in oncology supportive care and to examine structural barriers that limit their integration into routine practice. This study was not designed as a systematic review and therefore does not include exhaustive literature identification or quantitative pooling. Instead, it prioritizes high-quality secondary evidence, landmark randomized trials, seminal conceptual papers, and implementation science frameworks particularly relevant to supportive oncology.

Searches were undertaken in PubMed and Scopus using combinations of the terms "distress screening", "distress thermometer", "psycho-oncology", "narrative medicine", "art therapy", "creative arts therapy", "music therapy", "music interventions", "dignity therapy", "meaning-centered psychotherapy", "photovoice", "oncology", and "implementation". Priority was given to systematic reviews, meta-analyses, Cochrane reviews, randomized controlled trials, and authoritative guidelines or policy documents. Foundational conceptual references were also included where necessary to frame the literature, particularly in relation to the biopsychosocial model, narrative medicine, and implementation science. The literature search covered studies published between 2000 and March 2026.

Evidence was synthesized thematically with attention to four domains: (i) reported psychosocial and patient-centered outcomes; (ii) intensity and resource profile of the intervention; (iii) degree of fit with routine oncology workflows; and (iv) explicit reporting – or omission – of implementation outcomes such as feasibility, adoption, fidelity, penetration, and sustainability. Any conceptual framework discussed in the later sections is presented only as an illustrative model derived from the reviewed literature and not as an implementation protocol or study proposal.

VISUAL ART THERAPY

The visual art therapy literature suggests that structured art-making can support emotional expression, symptom processing, and aspects of quality of life in patients with cancer. The most comprehensive recent meta-analysis by Jiang et al[18] included 12 studies and reported significant improvements in anxiety, depression, fatigue, and quality of life. These findings are clinically encouraging because they support the intuition that art-making can offer patients a non-verbal or pa-

ra-verbal route for processing distress when direct clinical conversation is difficult. At the same time, the evidence base remains constrained by modest sample sizes, heterogeneous interventions, and varying comparators. Studies included in the meta-analysis by Jiang et al[18] frequently combine several artistic tasks, use local quality-of-life scales, or rely on short follow-up periods, making it difficult to determine which elements are essential and how durable the observed benefits may be. The delivery model also matters; most visual art interventions are facilitated by trained therapists or highly engaged staff, which may enhance quality but can limit scalability.

CREATIVE ARTS THERAPY

Broader creative arts therapy literature, encompassing painting, drawing, sculpting, mixed-media expressive work, and related modalities, similarly points to psychosocial benefit but with methodological complexity. Abu-Odah et al[19] recently reviewed 25 studies and found significant quality-of-life benefits, with narrative evidence suggesting possible improvements in depression, anxiety, hope, self-image, and emotional processing. However, the same review underscored substantial variation in study design, intervention dose, patient populations, and risk of bias. This is a recurrent problem in arts-in-health research: interventions are often clinically rich but methodologically nonuniform. For oncology readers, the implication is not that the evidence should be discounted, but that it should be interpreted proportionately. Creative arts therapy appears promising, especially for emotional expression and relational engagement, yet its implementation burden may remain high if services depend on bespoke programs rather than routinized pathway integration.

MUSIC INTERVENTIONS

Music-based interventions are among the most extensively synthesized arts modalities in cancer care. The updated Cochrane review by Bradt et al[20] concluded that music interventions may improve anxiety, depression, hope, pain, and fatigue in adults with cancer, although the certainty of evidence was mostly low and the pooled studies were heterogeneous. One particularly important distinction analyzed in that study is between music therapy delivered by trained music therapists and music medicine based on structured listening or recorded music. The former showed more consistent outcome signals, especially for quality of life and fatigue, whereas the latter produced less uniform effects[20]. This distinction is important for implementation because it highlights a trade-off between fidelity to the therapeutic model and ease of scale-up. Music therapy may offer greater depth, but music medicine may be easier to deploy. For oncology systems, the literature therefore raises a practical question: should supportive care be optimized for intensity or for reach? The answer will likely differ by setting and patient need, but the question itself is central.

DIGNITY THERAPY AND STRUCTURED LIFE REVIEW

Dignity therapy occupies a special place in supportive oncology because it is simultaneously narrative, psychotherapeutic, and closely tied to end-of-life concerns. In the original feasibility study, Chochinov et al[21] described dignity therapy as a brief psychotherapeutic intervention that invites patients to discuss what matters most and what they wish to be remembered for. The subsequent randomized trial showed less effect on traditional distress endpoints than originally hoped, but important benefits in patients' self-reported end-of-life experience and perceived helpfulness[22]. These findings remain highly relevant. Dignity therapy demonstrates that structured narrative recognition can have meaningful clinical value even when symptom reduction is not dramatic. It also shows that outcomes such as meaning, dignity, legacy, and family usefulness matter to patients and may not be fully captured by conventional anxiety or depression scales. However, dignity therapy is generally positioned in advanced illness and usually requires trained professionals, careful interviewing, transcription, editing, and dedicated time. It is therefore powerful but not easily generalizable as a universal first-line response to distress screening.

MEANING-CENTERED PSYCHOTHERAPY

Meaning-centered psychotherapy extends similar concerns into the domain of existential well-being in advanced cancer. In their pilot randomized trial, Breitbart et al[23] showed that meaning-centered group psychotherapy improved spiritual well-being and sense of meaning, with additional favorable effects on anxiety and desire for death over time. Subsequent randomized work with the individual format provided further evidence of benefit for quality of life, spiritual well-being, meaning, and anxiety in patients with advanced cancer[24]. This literature is conceptually important because it makes explicit what many other interventions

imply only indirectly: cancer threatens not only comfort and mood, but a person's sense of coherence, value, and continuity. Meaning-centered psychotherapy also reminds oncology that existential suffering is not a vague adjunct to "real" care; it is often one of the central clinical realities. The limitation, again, is structural. These interventions require specific training, multiple sessions, and substantial therapeutic commitment. Their relevance to routine screening programs is therefore less about direct scalability and more about identifying what core principles – meaning, identity, values, personhood – should not be lost when designing lighter-touch models.

PARTICIPATORY VISUAL APPROACHES

Participatory methods such as photovoice shift the focus from therapist-led care to patient-generated representation. In photovoice, participants document aspects of their lived reality through images that become material for reflection, dialogue, and social communication. Halvorsrud et al[25] found that photovoice can improve health knowledge and community-related outcomes, although effects on longer-term health outcomes and behavior were less clear. In oncology, participatory visual methods are especially compelling because they can make illness experience visible without requiring patients to translate everything into conventional clinical language. They may support agency, voice, and social recognition – themes that are highly relevant when diagnosis or treatment threatens identity. At the same time, photovoice is usually embedded in project-based, group-based, or community-facing settings rather than mainstream clinic flow. It is therefore more useful as a conceptual resource for supportive oncology than as a directly exportable workflow solution.

CROSS-CUTTING INTERPRETATION OF THE THERAPEUTIC LITERATURE

When considered together, these modalities reveal several clear patterns. First, the evidence is not absent: across interventions, consistent benefits are observed in anxiety, emotional distress, quality of life, spiritual well-being, meaning, dignity, and patient experience[18-25]. Second, the effect sizes are usually modest rather than transformative, which means real-world population impact depends heavily on reach and continuity. Third, much of the literature is more sophisticated in describing what the intervention does therapeutically than in explaining how it might become routine care. Many studies[18-20] focus primarily on therapeutic outcomes, with comparatively limited attention to implementation aspects such as workflow burden, staffing requirements, documentation processes, referral pathways, and long-term sustainability. As a consequence, the field has often produced interventions with strong human value but weak architectural fit.

This pattern matters for oncology services because most patients with elevated distress will not enter an intensive psychotherapeutic pathway. They will instead encounter brief visits, multidisciplinary transitions, and repeated points at which emotional suffering is recognized but not always metabolized into action. The literature does not suggest that specialist interventions are excessive or misplaced. On the contrary, dignity therapy, meaning-centered psychotherapy, and arts-based therapies remain essential for many patients. Instead, the evidence highlights a substantial gap: patients whose distress is clinically significant and observable often lack an immediate, structured, and person-centered response bridging routine screening and formal specialist referral (Table I).

IMPLEMENTATION CHALLENGES IN ONCOLOGY SUPPORTIVE CARE

The implementation challenge in oncology supportive care is not best understood as a failure of compassion. It is better understood as a mismatch between what services are asked to do and how pathways are actually built. Distress screening can be standardized, digitized, audited, and reported. Supportive response is more difficult. It relies on personnel, culture, triage confidence, communication routines, local referral capacity, and institutional willingness to treat psychosocial care as a pathway obligation rather than an optional enrichment.

Reviews of distress screening programs show that implementation is most successful when screening is embedded in a broader system that includes staff training, clear thresholds, referral pathways, and accountability for follow-up[8,9]. Without these components, screening may still increase awareness, but it risks becoming performative – a procedural confirmation that distress exists without an assured relational or therapeutic consequence. This is one reason why implementation findings in this field have been mixed. Programs can improve communication and sometimes referral patterns, yet they do not always improve quality of life or emotional outcomes at the population level[8,9]. The screening instrument is rarely the limiting factor. The limiting factor is usually what the system can reliably do once the instrument identifies a need.

Table I. Summary of the reviewed intervention modalities.

Modality	Representative evidence	Main reported benefits	Main limitations	Implication for routine oncology
Visual art therapy	Systematic review and meta-analysis[18]	Lower anxiety, depression and fatigue; better quality of life	Small samples, heterogeneous tasks, short follow-up, therapist dependency	Promising for emotional expression but difficult to standardize at scale
Creative arts therapy	Systematic review and meta-analysis[19]	Potential improvements in quality of life, hope, emotional processing and self-image	Moderate-to-high risk of bias; broad intervention heterogeneity	Conceptually rich, but implementation burden remains substantial
Music interventions	Updated Cochrane review[20]	Benefits for anxiety, pain, fatigue, hope and selected quality-of-life outcomes	Low-certainty evidence; large variation between music therapy and music medicine	Potentially scalable, but benefit depends on format and facilitator expertise
Dignity therapy	Feasibility study and randomized trial[21,22]	Improved sense of dignity, meaning and end-of-life experience	Advanced-illness focus; trained staff; transcription/ editing burden	Highly valuable for selected patients, less suited as a universal first response
Meaning-centered psychotherapy	Randomized studies[23,24]	Improved meaning, spiritual well-being, anxiety and quality of life	Multi-session format, specialist training, advanced disease populations	Clarifies existential targets that lighter interventions should preserve
Photovoice / participatory visual methods	Systematic review and meta-analysis[25]	Health knowledge, engagement, agency and voice	Project-based design; uncertain long-term health effects	Useful as a conceptual resource for identity and visibility rather than direct workflow transfer

Implementation science helps clarify this problem. The RE-AIM framework reminds us that effectiveness alone does not determine public health impact; reach, adoption, implementation, and maintenance are equally decisive[26]. Proctor's taxonomy further distinguishes acceptability, appropriateness, feasibility, fidelity, cost, penetration, and sustainability as specific implementation outcomes rather than secondary afterthoughts[27]. CFIR adds a practical map of barriers and facilitators by highlighting the importance of intervention complexity, inner setting, leadership engagement, available resources, and process[28]. These frameworks are highly relevant to oncology supportive care because they explain why an intervention can be clinically meaningful yet still fail to become routine.

Viewed through this lens, many arts-based and narrative interventions encounter three recurring implementation barriers. The first is specialist dependency. Interventions led by art therapists, psychotherapists, music therapists, or specially trained facilitators may have strong internal coherence, but they remain vulnerable to workforce limitations and referral bottlenecks. The second is multi-session intensity. Repeated visits are often therapeutic strengths, yet they can restrict reach in services already burdened by treatment schedules, staffing pressure, and patient fatigue. The third is peripheral positioning. Many psychosocial or arts-based interventions sit outside the core clinic flow and therefore depend on extra effort, discretionary referral, or unusual patient motivation.

Another challenge concerns how outcomes are defined and measured in oncology studies. Many oncology studies[26-28] measure proximal changes in distress, anxiety, or quality of life, but fewer examine whether interventions improve the architecture of supportive care: for example, whether they increase uptake of psycho-oncology referral, strengthen communication in multidisciplinary teams, reduce depersonalization, or improve continuity across disease transitions. This omission is understandable from a traditional efficacy perspective, but it is limiting from a pathway perspective. In actual oncology systems, a modest intervention that is routinely delivered and visible to the whole team may generate more real-world benefit than a deeper intervention that reaches only a small subset of patients.

The literature on unmet supportive care needs after treatment underscores that psychosocial burden often persists or evolves over time rather than disappearing once acute treatment ends[29]. This is another reason implementation matters. If supportive care is organized only around discrete specialist encounters, many moments of need

will remain structurally unattended. In contrast, if supportive responses are designed as repeatable pathway components, the service may be better able to address the fluctuating nature of distress across diagnosis, treatment initiation, response assessment, progression, survivorship, and palliation.

For review purposes, the practical conclusion is clear: the next conceptual step in supportive oncology is not to replace specialist psychosocial care with lighter interventions, but to think more carefully about how the space between detection and specialist care is structured. The literature justifies interest in interventions that are briefer, more scalable, and more visibly tied to identity recognition, provided they are presented with proportional claims. What is needed is not a grand alternative to psycho-oncology, but a better architectural bridge between numeric distress and relational response[14,21-24].

A related issue is visibility inside multidisciplinary systems. Tumor boards, pathway meetings, and treatment planning conferences are designed to optimize technical decisions, but their communication style can unintentionally depersonalize the patient[14-16]. The more technologically advanced the pathway becomes, the greater the risk that the individual is represented chiefly through stage, imaging, molecular markers, or performance status. Narrative and visual interventions matter here not because they make the team less scientific, but because they reinsert biographical meaning into a setting optimized for technical precision[14]. The oncology setting also differs from many other chronic care contexts because transitions are frequent and often abrupt. Patients may move quickly from suspicion to diagnosis, from staging to multimodal treatment, from remission to progression, or from disease-directed care to palliation. Each transition can reconfigure identity, control, and hope[10,29]. Supportive care models that depend on lengthy intake processes or optional referral pathways may therefore miss the moments when distress is most acute and when acknowledgment may be most needed. By contrast, pathway-proximal supportive responses can in principle accompany these transitions without claiming to solve all psychosocial needs. Their value lies in continuity: they help ensure that the person remains visible while the disease trajectory changes[26-28] (Table II).

CONCEPTUAL MODELS FOR BRIDGING THE DISTRESS SCREENING-RESPONSE GAP

Conceptual models for bridging the distress screening-response gap begin from a simple proposition: if distress is screened routinely, then some form of immediate acknowledgment should be available before or alongside escalation to more intensive support. Such acknowledgment does not need to be a full psychotherapy session, nor should it be mistaken for one. Its function is different. It is to ensure that screening is not experienced as a one-way extraction of data but as an opening into recognition.

Table II. Implementation synthesis: from recurrent barriers to design principles.

Implementation issue	What the literature shows	Why it matters	Resulting design principle
Specialist dependency	Many arts and psychotherapeutic models require trained facilitators[18-24]	Workforce limitations reduce reach	Use specialist services for depth, but design pathway-near responses that do not always depend on specialist availability
Multi-session intensity	Several effective interventions are delivered over multiple sessions[20-24]	Repeated sessions can limit uptake in fatigued or heavily scheduled patients	Preserve meaning-focused principles while allowing lower-dose entry points
Peripheral positioning	Interventions are often referred outside routine clinic flow[8,9,26-28]	Optional pathways increase attrition after screening	Place supportive response closer to routine milestones and team communication
Heterogeneous outcomes	Literature emphasizes symptom change more than pathway performance[18-25]	Difficult to judge system-level value	Assess supportive models also through reach, feasibility, adoption and continuity
Identity disruption and stigma	Cancer can intensify shame, blame, role loss and depersonalization[11,12]	Numeric screening alone may not restore personhood	Include explicit acknowledgment of patient identity, roles and values

The reviewed literature suggests three principles for such models. First, the response should be identity-centered. Narrative medicine and existential interventions repeatedly show that suffering in cancer is intensified when the person feels reduced to a diagnosis, a scan, or a treatment line[14,21-24]. A supportive response should therefore, even briefly, acknowledge the patient as a person—recognizing their roles, values, strengths, and life beyond the illness. Second, the response should be workflow compatible. An intervention that cannot coexist with routine oncology timing, documentation, and multidisciplinary communication is unlikely to achieve meaningful reach[26-28]. Third, the response should be complementary. It should not compete with psycho-oncology, palliative care, or specialist arts therapies, but instead function as an early relational layer that may facilitate those services when indicated.

These principles help explain why the literature points toward interest in micro-interventions. The term should not be understood as trivializing patient suffering. It simply denotes low-dose, focused interventions designed for broad reach and minimal disruption. In supportive oncology, a micro-intervention can be particularly valuable because it takes place within routine care – during screening, intake, treatment reviews, or other standard touchpoints – rather than requiring patients to enter a separate therapeutic setting. The goal is not therapeutic maximalism; the goal is reliable human recognition built into ordinary care[26-28].

ILLUSTRATIVE IDENTITY-CENTERED MICRO-INTERVENTIONS IN SUPPORTIVE ONCOLOGY

One illustrative conceptual model with potential relevance to addressing the gap identified in the literature between distress screening and supportive response is LifeShot. In this review, it is presented solely as an example of a narrative- and arts-informed micro-intervention positioned between distress screening and supportive care, rather than as an operational program or implementation proposal.

Conceptually, it combines a brief identity-oriented prompt, a visual element, and a concise patient-generated caption reflecting a meaningful role, value, or strength. Its purpose is not aesthetic production, but to transform an abstract distress score into a visible reminder of personhood.

Its relevance lies in timing and visibility. While screening quantifies vulnerability, it does not necessarily convey identity. A brief narrative-visual acknowledgment may therefore serve as an intermediate relational layer, complementing referral-based services and enhancing multidisciplinary awareness.

The claim is intentionally modest: not to replace specialist psychosocial care, but to make the transition from screening to supportive response more legible. Future research should therefore focus on the implementation and evaluation of such pathway-compatible, identity-centered approaches to determine their effectiveness in bridging the screening-response gap in routine oncology care.

DISCUSSION

This review yields four main conclusions. First, narrative and arts-based interventions in oncology are supported by a meaningful, though methodologically heterogeneous, evidence base. Across modalities, the literature consistently reports improvements in anxiety, emotional well-being, quality of life, meaning, dignity, and patient experience[18-25]. While effect sizes are generally modest and not uniform across studies, the overall signal is sufficiently robust to support their clinical relevance. The key question is therefore no longer whether such approaches have value, but how their value can be integrated into routine cancer care. Second, the literature highlights a persistent mismatch between therapeutic depth and implementation feasibility. Interventions such as dignity therapy, meaning-centered psychotherapy, and specialist-led arts therapies derive much of their impact from time, expertise, and relational intensity. However, these same features can limit reach in high-volume oncology settings. This does not diminish their importance; rather, it underscores the need for a layered model of supportive care in which specialist interventions coexist with more accessible, pathway-compatible responses.

Third, implementation science provides a useful framework to interpret this gap. In supportive oncology, impact depends not only on effectiveness but also on reach, adoption, and sustainability[26-28]. This is particularly relevant when effect sizes are modest, as interventions with broader coverage may have greater system-level impact than more intensive approaches reaching fewer patients. From this perspective, the central challenge is not whether an intervention works in principle, but whether it can be reliably incorporated into routine care pathways.

Fourth, identity recognition emerges as a central dimension of supportive oncology. Across narrative medicine, dignity therapy, meaning-centered psychotherapy, and participatory visual approaches, a consistent finding is that

cancer threatens not only physical well-being but also coherence of self[14,21-25]. Approaches that incorporate narrative and expressive elements help restore visibility of the person beyond the disease, complementing biomedical care rather than opposing it.

Limitations

Several limitations should be acknowledged. This is a narrative review rather than a systematic synthesis with formal risk-of-bias assessment. Although priority was given to high-quality evidence, interpretation remains influenced by the review's translational focus. In addition, the modalities considered differ substantially in scope, population, and intent, and should not be interpreted as directly comparable. Finally, the heterogeneity of outcomes and limited long-term data constrain conclusions regarding durability and comparative effectiveness.

Despite these limitations, the implications are clear. Oncology services require not only effective screening tools but also reliable mechanisms to respond to identified distress. The literature supports a shift from viewing narrative and arts-based interventions as optional adjuncts toward recognizing them as sources of design principles for person-centered care. In this sense, their value extends beyond individual interventions to the broader architecture of supportive oncology.

Future research should prioritize greater consistency in outcome measures, clearer reporting of implementation variables, and attention to equity, particularly for populations affected by social vulnerability, stigma, or limited access to care[11,12,27]. Ultimately, supportive oncology is strongest when measurement, meaning, and multidisciplinary care are structurally integrated rather than sequentially disconnected.

CONCLUSIONS

Narrative and arts-based interventions represent a credible and conceptually important domain of supportive oncology. The reviewed literature indicates that they can improve emotional well-being, aspects of quality of life, existential outcomes, and patient experience, while simultaneously illuminating dimensions of suffering that purely biomedical pathways often miss. Their main challenge is not a lack of relevance, but the difficulty of integration.

When interpreted through implementation science, the field points toward the value of brief, complementary, identity-centered models that can sit closer to routine workflow without replacing specialist psycho-oncology or palliative care. In this review, LifeShot is offered only as an illustrative example of such a model. More broadly, the evidence suggests that the future of distress care in oncology will depend less on screening alone than on whether cancer systems can make person-centered response visible, timely, and structurally routine.

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The authors declare no competing interests.

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Authors' Contributions
S. Cafarotti: Conceptualization; Methodology; Investigation; Writing – original draft; Writing – review & editing; Supervision. P. Perretta: Data curation; Writing – review & editing. D. Salafia: Data curation; Writing – review & editing.

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