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Research Article

Humanizing Cancer Care through Art-Based Psychosocial Support: A Narrative Review and the CARE-ART Framework for Supportive Oncology

Dr. Ignacio Bonasa Alzuria*

President, European Association for Well-Being, European Association of Soulful Organizations, International Association DVT, Liderarte, Madrid, Spain.
ORCID ID: 0009-0001-3940-4278

Abstract

Background: Cancer care has achieved remarkable biomedical progress, yet cancer remains a profoundly psychological, relational, social, and existential experience. Anxiety, depression, fear of recurrence, body-image disruption, family strain, loneliness, and loss of meaning may accompany diagnosis, treatment, survivorship, recurrence, and advanced disease.

Aim: This article develops a scientifically cautious and practice-oriented argument for integrating art-based psychosocial support into supportive oncology and proposes the CARE-ART Framework as an ethical and implementation-ready model.

Methods: A narrative review approach was used to synthesize selected peer-reviewed literature, clinical guidelines, institutional reports, and recent systematic reviews and meta-analyses concerning cancer-related distress, psycho-oncology, creative arts therapies, art therapy, music therapy, quality of life, and humanized care. This is not a systematic review and does not claim exhaustive retrieval.

Results: The literature suggests that creative arts therapies and art-based interventions may support anxiety and depression reduction and may improve selected dimensions of quality of life, although effects vary by modality, population, setting, duration, and methodological quality. Music therapy has stronger guideline visibility for anxiety and depression symptoms in adults with cancer, while visual art-based interventions show promising but heterogeneous evidence.

Conclusion: Art-based psychosocial support should not be presented as a cancer treatment or as a substitute for evidence-based oncology, psycho-oncology, psychiatric, palliative, or social care. Its value lies in complementing clinical care by creating spaces for expression, dignity, agency, connection, meaning, and emotional regulation. The CARE-ART Framework offers a structured pathway for ethically integrating art-based support into cancer services and for guiding future research.

Keywords

Cancer care, Supportive oncology, Psycho-oncology, Art therapy, Creative arts therapies, Music therapy, Distress, Anxiety, Depression, Quality of life, Humanized care, Dignity.

Corresponding Author Information

Ignacio Bonasa Alzuria
President, European Association for Well-Being, European Association of Soulful Organizations, International Association DVT, Liderarte, Madrid, Spain.

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Introduction

Cancer as a Biomedical and Human Experience

Cancer is one of the defining health challenges of the twenty-first century. The global burden is large and increasing: GLOBOCAN 2022 estimates reported close to 20 million new cancer cases and 9.7 million cancer deaths worldwide in 2022, with demographic projections indicating that new cases may reach approximately 35 million by 2050 [1,2]. These figures are not only epidemiological data. Behind them are millions of biographies interrupted, families reorganized, identities questioned, and healthcare teams asked to combine scientific excellence with deep human presence.

Modern oncology has transformed many cancer diagnoses through earlier detection, surgery, radiotherapy, systemic therapies, immunotherapy, targeted treatment, genomic medicine, palliative care, and survivorship programs. Nevertheless, the experience of cancer continues to exceed the purely biomedical frame. Even when treatment is technically successful, patients may live with uncertainty, fatigue, pain, disfigurement, sexual concerns, cognitive difficulties, financial toxicity, altered family roles, fear of recurrence, spiritual questions, and grief for the life that was expected but no longer feels secure.

This broader experience is the field of psycho-oncology and supportive oncology. The National Cancer Institute describes psychosocial distress as existing on a continuum, from common normal adjustment concerns to more disabling states such as depression, anxiety, panic, social isolation, and existential or spiritual crisis. The same source emphasizes that adjustment to cancer is not a single event but an ongoing process across diagnosis, active treatment, posttreatment remission, recurrence, advanced disease, and survivorship [3]. This perspective is consistent with the classic proposal to treat distress as the sixth vital sign in cancer care [4] and with ASCO guidance recommending screening, assessment, and appropriate care pathways for anxiety and depressive symptoms in adults with cancer [5].

The central thesis of this article is that cancer care must treat the tumor without forgetting the person. This is not a sentimental addition to clinical science; it is a practical, ethical, and organizational necessity. Distress can affect attention, memory, communication, adherence, shared decision-making, self-care, relationships, and quality of life. For that reason, a cancer service that ignores the emotional and symbolic dimensions of illness is not fully patient-centered, even if its biomedical protocols are excellent.

Art-based psychosocial support offers one promising pathway to humanize cancer care. Art can create a language when ordinary language is insufficient. A drawing, a song, a collage, a poem, a photograph, a gesture, a story, or a symbolic object may allow patients to express fear, anger, gratitude, loss, hope, or ambiguity without needing to produce a perfect verbal explanation. Art can make visible what the body has endured and what the person still wants to protect: dignity, identity, belonging, memory, love, and meaning.

However, this promise must be handled with scientific humility. Art-based support is not chemotherapy, immunotherapy, surgery, radiotherapy, targeted therapy, or palliative medication. It should never be marketed as curative or as an alternative to evidence-based oncology. Its proper role is complementary: to strengthen emotional regulation, expression, connection, agency, dignity, and meaning within a broader clinical ecosystem. The task, therefore, is not to replace science with art, but to ensure that science does not become emotionally sterile.

Aim, Scope, and Methodological Approach

The aim of this article is to develop a narrative, evidence-informed, and ethically cautious framework for integrating art-based psychosocial support into oncology care. It is intended for cancer centers, hospitals, survivorship programs, palliative care services, psycho-oncology teams, community cancer organizations, patient associations, healthcare leaders, art therapists, music therapists, nurses, psychologists, social workers, chaplains, and educators interested in humanized cancer care.

The article has five specific objectives: (1) to summarize the relevance of psychosocial distress in cancer care; (2) to synthesize selected evidence on creative arts therapies and art-based interventions for adults with cancer; (3) to clarify what can and cannot responsibly be claimed about art-based support; (4) to propose the CARE-ART Framework as a practical model for implementation; and (5) to identify research priorities that could strengthen the scientific, clinical, and organizational maturity of this field.

A narrative review design was used because the objective is conceptual integration rather than formal effect-size estimation. Selected literature included clinical guidelines, institutional resources, peer-reviewed systematic reviews, meta-analyses, and relevant conceptual work in psycho-oncology, supportive oncology, arts and health, art therapy, music therapy, and humanized care. The broader public-health relevance of arts-and-health approaches was considered in line with the scoping review developed by Fancourt and Finn [6] for the World Health Organization Regional Office for Europe. Searches and updating were oriented to literature available up to May 2026, with emphasis on recent reviews and guidelines. Because this manuscript is not a systematic review, it does not include PRISMA flow diagrams, formal risk-of-bias scoring, or exhaustive database reproducibility.

The interpretive stance is deliberately conservative. Findings are described as supportive, promising, or evidence-informed where appropriate, but not as definitive proof of universal benefit. The article avoids three common mistakes: exaggerating the clinical effects of art-based approaches, reducing art to entertainment, and confusing general creative activity with professionally delivered therapy. A hospital art program, a music listening intervention, a guided expressive writing activity, and formal art therapy led by a trained art therapist may overlap in spirit, but they are not methodologically identical interventions.

Psychosocial Distress in the Cancer Trajectory

Cancer-related distress may appear before diagnosis, at the moment of diagnosis, during treatment, after treatment, at recurrence, in advanced disease, and during bereavement for families. It may be emotional, cognitive, relational, practical, spiritual, physical, or existential. It may be visible through tears, insomnia, irritability, silence, avoidance, panic, anger, shame, exhaustion, or the inability to ask questions during appointments. It may also be hidden behind apparent compliance.

The NCI description of distress as a continuum is clinically useful because it avoids both minimization and pathologization. Not every frightened patient has a psychiatric disorder; fear may be an understandable response to threat. At the same time, severe anxiety, depression, panic, trauma symptoms, hopelessness, or suicidal ideation require professional assessment and intervention. Clinical reviews emphasize that depression and anxiety in cancer require careful identification and appropriate intervention rather than being normalized as inevitable suffering [7]. A humanized oncology model should recognize normal suffering while establishing robust pathways for screening, referral, and treatment when distress becomes clinically significant; practical tools such as the NCCN Distress Thermometer and Problem List can support this identification process in routine care [8].

Distress also influences communication. When a patient receives overwhelming information, heightened anxiety can narrow attention and impair processing. The person may hear the name of the diagnosis but not understand the treatment plan; may nod without remembering; may avoid asking questions in order not to appear difficult; or may leave the consultation with a family member carrying the emotional weight of translation, interpretation, and decision-making. Psychosocial support is therefore not peripheral to clinical quality. It can help create the conditions in which patients understand, participate, and adhere.

In this context, art-based support can operate as a bridge between internal experience and clinical communication. Patients may find it easier to show a visual metaphor of fear than to say, "I am terrified." A caregiver may understand the patient differently after hearing a playlist, seeing a life-map, or participating in a shared memory exercise. Clinicians may better recognize what matters to a patient when creative expression reveals identity, values, unfinished concerns, or sources of strength that are not captured by laboratory results.

Evidence on Creative Arts Therapies and Art-Based Interventions

Creative arts therapies generally include professionally facilitated approaches such as art therapy, music therapy, dance/movement therapy, drama therapy, and expressive writing or poetry-based interventions. Art-based psychosocial support is a broader category that may include structured creative activities, aesthetic environment design, community arts, patient storytelling, creative legacy work, and hospital-based arts programs. Distinguishing these categories is important for research quality and patient safety.

The evidence base has expanded in recent years. Earlier meta-analytic work by Puetz et al. [9] suggested that creative arts therapies may improve psychological symptoms and selected quality-of-life outcomes in patients with cancer. Abu-Odah et al. [10] examined creative arts therapy for adult patients with cancer and concluded that these interventions may have beneficial effects on selected health outcomes, while also indicating the need for more rigorous and better-reported trials. Unal and Erdogan Yuce [11] identified fifteen studies with 1,113 cancer patients and reported significant effects on anxiety, depression, and the physical aspects of quality of life, while finding no significant effect on fatigue, overall quality of life, or psychological and social dimensions of quality of life. Chou et al. [12] continued this line of synthesis in randomized controlled trials and supported cautious interest in creative arts therapy for anxiety, depression, and quality of life, while also confirming the need for stronger methodological designs and clearer reporting.

Visual art therapy has also been examined. Systematic reviews by Jiang et al. [13] and Bosman et al. [14] indicate that art therapy in cancer care may be associated with improvements in anxiety, depression, and quality-of-life domains, although methodological heterogeneity remains important. Zhou and colleagues [15] reported moderate-quality evidence suggesting that art therapy may improve overall quality of life and alleviate anxiety and depression among women with cancer, while evidence for somatic symptoms, fatigue, and pain remained less conclusive. This pattern supports a clinically prudent interpretation: art-based interventions may be especially relevant to emotional expression, anxiety, depression, identity, and quality-of-life domains, but they should not be overclaimed as interventions for every symptom in the cancer experience.

Music therapy and music-based interventions have comparatively strong visibility in integrative oncology guidance. Greenlee et al. [16] included evidence-based recommendations for selected integrative therapies during and after breast cancer treatment, including music-related interventions in appropriate contexts. The Society for Integrative Oncology and American Society of Clinical Oncology guideline on symptoms of anxiety and depression in adults with cancer includes recommendations for music therapy or music-based interventions in selected contexts, especially during active treatment [17]. Huang et al. [18] described music therapy as a noninvasive supportive approach for reducing anxiety, pain, and stress in patients with cancer. Xu et al. [19] reported improvements in anxiety and depression with music therapy in a meta-analysis of randomized trials in breast cancer patients, though heterogeneity between studies remained high. Because music-based interventions vary widely, reporting standards such as those proposed by Robb et al. [20] are important for specifying intervention components, dose, facilitator role, theoretical basis, and reproducibility.

Several cautions are essential. First, intervention heterogeneity is substantial: studies differ in modality, duration, frequency, facilitator qualification, setting, patient population, cancer type,

disease stage, control condition, and outcome measure. Second, many samples remain small, and blinding is often impossible. Third, culturally embedded meanings of art, body, illness, death, music, family, and spirituality vary widely. Fourth, publication bias and selective reporting may influence the field. Fifth, improvement in a psychological scale does not automatically translate into sustained functional, clinical, or organizational benefit. These cautions do not invalidate art-based support; they define the standards required for mature implementation, faithful reporting, and responsible clinical interpretation.

The CARE-ART Framework

To translate evidence, ethics, and clinical caution into practice, this article proposes the CARE-ART Framework. CARE-ART is not a therapy manual, diagnostic protocol, or replacement for psycho-oncology. It is a conceptual architecture for designing, implementing, and evaluating art-based psychosocial support in a responsible, patient-centered, and evidence-informed manner.

The acronym integrates seven dimensions: Connection, Agency, Recognition, Expression, Aesthetic safety, Resilience, and Transcendence. These dimensions were selected because they correspond to recurrent human needs in cancer care: not being alone, retaining choice, being seen as a whole person, expressing what hurts, feeling safe enough to engage, living with uncertainty, and finding meaning beyond the disease.

Connection

Cancer can isolate. Connection refers to the restoration of meaningful relational contact: with oneself, with clinicians, with family, with peers, with community, and with life beyond disease. Art-based support can create gentle forms of encounter, especially for patients who do not wish to begin with direct verbal disclosure. Group music, shared image-making, storytelling, or community exhibitions can help patients feel that their experience is witnessed rather than hidden.

Agency

Cancer treatment can make patients feel that everything is decided by scans, protocols, appointments, adverse effects, and medical necessity. Agency means restoring choice where choice is still possible. In art-based support, the patient can choose color, material, music, rhythm, level of sharing, silence, metaphor, or theme. These small choices matter because they counter the passivity that illness can impose.

Recognition

Recognition means seeing the whole person beyond diagnosis, stage, biomarker, or treatment line. A patient is also a parent, professional, friend, believer or non-believer, citizen, artist, athlete, caregiver, reader, dreamer, wounded human being, and person with a past and future. Creative activities can reveal biography, values, humor, culture, tenderness, and strength. Recognition is therefore a dignity practice.

Expression

Expression is the most visible dimension of art-based support, but it should not be reduced to emotional discharge. The purpose is not artistic performance or aesthetic excellence; it is expressive truth. Patients may externalize fear, grief, anger, gratitude, shame, love, or ambiguity in forms that are tolerable and meaningful. Expression can also protect silence: the patient may create without explaining.

Aesthetic safety

Aesthetic safety refers to environments and processes that reduce threat and support regulation. Oncology settings can be noisy, bright, crowded, procedural, and emotionally charged. Art-based design can make a space feel less dehumanizing, but safety also requires boundaries, consent, facilitator competence, cultural humility, and referral pathways. Aesthetic safety is not decoration; it is the emotional architecture of care.

Resilience

Resilience in cancer care should never be confused with forced

Table 1: Evidence-informed roles and cautions for art-based psychosocial support in oncology care.

Domain	Possible contribution	Clinical caution	Example application
Emotional expression	Helps patients symbolize fear, anger, grief, hope, uncertainty, or ambivalence.	Should not force disclosure, positivity, or emotional exposure.	Guided visual journaling after diagnosis or during chemotherapy.
Anxiety and depression support	May complement evidence-based psycho-oncology and integrative approaches.	Screening and referral remain essential for severe symptoms, trauma, or suicide risk.	Music therapy during active treatment; expressive writing in survivorship.
Identity and body image	Supports reconstruction of self-narrative after surgery, treatment effects, or visible bodily change.	Requires sensitivity to trauma, sexuality, shame, disability, and culture.	Identity collage or life-map in breast, gynecological, prostate, or head-and-neck cancer survivorship.
Family communication	Creates a shared symbolic language for experiences difficult to verbalize.	Family participation requires patient consent and privacy boundaries.	Caregiver-patient memory box or family music session.
Meaning and spirituality	Facilitates reflection on purpose, legacy, gratitude, unfinished life themes, and transcendence.	Must avoid imposing beliefs or false consolation.	Legacy letter, music biography, poem, or creative ritual in advanced disease.
Care environment	Can reduce the psychological coldness of clinical spaces and strengthen perceived dignity.	Aesthetic design must never compromise infection control or clinical workflow.	Waiting-room art, calming soundscapes, patient-created exhibitions, or nature images.

optimism. Many patients are tired of being told to fight or stay positive. A more humane definition understands resilience as the capacity to live with reality without losing all agency, dignity, connection, and meaning. Art-based support can help patients construct symbols of endurance, continuity, and adaptation without denying suffering.

Transcendence

Transcendence refers to experiences that connect the patient with something larger than immediate suffering: beauty, memory, love, faith, nature, music, family, justice, service, legacy, or future generations. In advanced disease and palliative care, art-based legacy work may support the need to leave something meaningful behind. Transcendence should remain spiritually neutral and patient-led.

Practical Integration Across the Cancer Care Trajectory

Art-based psychosocial support should be adapted to the phase of illness. At diagnosis, the priority may be containment, orientation, and safe expression of shock or uncertainty. During active treatment, interventions may focus on anxiety reduction, procedural coping, waiting-room distress, fatigue-related isolation, and preservation of identity. In survivorship, art-based support may help patients reconstruct life after treatment, address fear of recurrence, and integrate bodily or relational changes. At recurrence or progression, the focus may shift to grief, meaning, family communication, and existential resilience. In palliative care, legacy, memory, dignity, and accompaniment become especially important.

Implementation should begin modestly and evaluate carefully. A cancer center does not need to launch a large art program immediately. A realistic first step may be a weekly 60-minute professionally facilitated session for patients with elevated distress, a music-based intervention in chemotherapy areas, an expressive writing group for survivors, or a collaboration with a local museum, conservatory, university, or community arts organization. The pilot should define population, intervention, facilitator qualification, referral criteria, consent procedures, outcome measures, adverse-event protocols, and evaluation timeline before launch.

A mature program should include four levels. At the micro level, patients and families receive safe, voluntary, choice-based creative support. At the meso level, clinical teams integrate screening, referral, documentation, and interdisciplinary communication. At the macro level, healthcare organizations include arts and health within humanization, quality, equity, and patient-experience strategies. At the research level, outcomes are measured using validated quantitative instruments and qualitative methods that capture meaning, dignity, and lived experience.

Equity deserves special attention. Art-based support should not become a luxury for affluent hospitals or privileged patients. Low-cost materials, digital options, community partnerships, multilingual facilitation, culturally diverse artistic references, and accessible spaces can prevent the reproduction of health inequities. Patients in rural areas, older adults, migrants, people with disabilities, adolescents and young adults, people living in poverty, and those with advanced disease should not be excluded from the humanizing possibilities of art-based care.

Ethical and Clinical Safety Requirements

The ethical foundation of art-based psychosocial support is respect for human dignity. Patients should never be pressured to create, disclose, share, perform, or be positive. Participation must

Figure 1: CARE-ART implementation pathway for supportive oncology

1. Screen distress and needs	2. Offer choice-based art support	3. Facilitate safely	4. Monitor outcomes	5. Refer when risk emerges	6. Evaluate and improve

Implementation Matrix

Table 2: CARE-ART implementation matrix.

CARE-ART dimension	Patient need addressed	Possible intervention	Professional requirement	Suggested indicators
Connection	Loneliness, isolation, relational rupture	Peer art circle, music group, caregiver-patient creative session	Group facilitation and boundary training	Attendance, loneliness scale, qualitative feedback
Agency	Loss of control, passivity	Choice-based artmaking, patient-selected music, creative goal setting	Respect for autonomy and informed consent	Perceived control, satisfaction, engagement
Recognition	Feeling reduced to diagnosis	Life-map, identity collage, personal story object	Cultural humility and confidentiality	Patient dignity measures, narrative themes
Expression	Fear, grief, anger, unspoken emotions	Visual journaling, poetry, drama, therapeutic writing	Capacity to contain emotional activation	Distress thermometer, anxiety/depression scales
Aesthetic safety	Environmental stress and sensory overload	Calming art, music, lighting, waiting-room redesign	Collaboration with clinical and infection-control teams	Patient comfort, waiting-room anxiety, complaints
Resilience	Uncertainty, fatigue, fear of recurrence	Meaning-centered art sessions, symbolic rituals, creative coping plans	Integration with survivorship and psycho-oncology	Resilience, coping, QoL scores
Transcendence	Existential distress, legacy concerns	Legacy art, music biography, memory boxes, gratitude letters	Palliative care sensitivity and spiritual neutrality	Spiritual well-being, meaning, family feedback

be voluntary, consent-based, culturally sensitive, and clinically appropriate. Patients must be allowed to stop, remain silent, refuse interpretation, keep work private, or choose a nonverbal mode of participation.

Facilitator competence is essential. Art can open traumatic memories, unresolved grief, anger, shame, or existential despair. Programs therefore need clear professional boundaries and referral pathways for psycho-oncology, psychiatry, palliative care, spiritual care, social work, pain management, and safeguarding. When interventions are described as therapy, they should be delivered by appropriately trained and credentialed professionals according to local regulations and institutional policies.

Confidentiality requires explicit attention. Patient artworks may contain intimate information about body, family, sexuality, faith, fear, or mortality. Exhibitions, photographs, publications, videos, teaching materials, fundraising campaigns, or social media posts require specific informed consent. The fact that a patient has created something beautiful does not make it public property. Beauty can still be confidential.

Cultural humility is also necessary. Symbols of illness, hope, death, body, faith, family, music, and color vary across cultures. A white flower, a particular song, a mask, a religious image, or the act of drawing the body may have different meanings for different patients. The facilitator should not impose interpretation. The guiding question is not "What does this mean according to me?" but "What does this mean, if anything, according to you?"

Finally, art-based support must avoid false hope. The ethical message is not "art will cure cancer" but "art may help you be accompanied, express yourself, regulate distress, protect identity, and find meaning while you receive appropriate care." This distinction protects patients, professionals, institutions, and the integrity of the field.

Measurement, Outcomes, and Research Agenda

The next stage of the field should move beyond general claims that art helps and toward precise, testable, clinically meaningful questions. Which art-based interventions help which patients, at which point in the cancer trajectory, under which conditions, and measured by which outcomes? Are brief music-based interventions most useful for procedural anxiety? Are visual art therapy programs most useful for body image, identity reconstruction, or emotional processing? Which patients prefer individual work, group work, digital work, or family-based work? What level of facilitator training is required for each intervention type?

Outcomes should include both standardized measures and lived-experience data. Quantitative instruments may assess distress, anxiety, depression, pain, fatigue, sleep, loneliness, spiritual well-being, resilience, patient dignity, quality of life, patient activation, satisfaction, and healthcare utilization. Qualitative interviews, narrative analysis, arts-based evaluation, and patient-reported experience measures can capture domains that scales may miss: feeling seen, being able to speak, reconnecting with family, recovering identity, or making peace with unfinished concerns.

Implementation science is also needed. Even when an intervention is promising in a research setting, hospitals must understand feasibility, acceptability, cost, staffing, workflow, referral uptake, fidelity, equity, and sustainability. A program that is emotionally powerful but impossible to sustain will not transform cancer care. Conversely, a small, well-designed, evaluated, and scalable intervention may produce durable organizational learning.

Discussion

Treating the Tumor Without Forgetting the Person

Oncology has often been narrated through metaphors of war: battle, fight, enemy, victory, defeat. Some patients find these metaphors empowering; others experience them as exhausting or morally burdensome, particularly when disease progresses despite effort. Art-based support offers a different language. It does not demand victory as the only acceptable story. It allows tenderness, fatigue, fear, dignity, beauty, anger, humor, memory, and love to coexist.

The CARE-ART Framework contributes to supportive oncology by organizing art-based support around human needs rather than artistic products. A painting matters not because it is beautiful in an aesthetic hierarchy, but because it may hold fear safely outside

Table 3: Priority research questions for the CARE-ART Framework.

Research domain	Core question	Suggested design	Potential outcomes
Effectiveness	Does a defined art-based intervention reduce anxiety or distress in a defined cancer population?	Randomized or pragmatic controlled trial	Distress thermometer, anxiety scale, QoL, adverse events
Mechanisms	How do art-based interventions produce change?	Mixed-methods study	Emotional processing, agency, social connection, meaning
Implementation	Can the program be integrated into oncology workflow?	Implementation study	Feasibility, uptake, fidelity, staff burden, costs
Equity	Who is not reached by current arts-and-health programs?	Participatory research	Access by age, language, disability, income, geography
Palliative care	Does legacy art support dignity, family communication, or spiritual well-being?	Prospective cohort or controlled pilot	Dignity, meaning, family bereavement feedback
Clinician well-being	Can art-based reflective spaces reduce moral distress or burnout risk among oncology staff?	Cluster pilot or qualitative study	Moral distress, compassion fatigue, team cohesion

the body. A song matters not because it is technically complex, but because it may reconnect a patient with childhood, faith, homeland, romance, courage, or rest. A memory box matters not because it is an object, but because it may help a family speak about love before time becomes too short.

This framework also supports healthcare professionals. Oncology clinicians work in environments marked by suffering, uncertainty, time pressure, moral distress, and repeated exposure to loss. Art-based reflective spaces can help teams process experience, recover meaning, and remember why technical work must remain relational. Humanized cancer care is not only for patients; it is also for those who care for them.

At the organizational level, the integration of art into cancer care invites a broader cultural transformation. Hospitals should not be factories of treatment. They should be institutions of science and humanity. A hospital can be rigorous and tender, efficient and dignifying, technologically advanced and emotionally intelligent. Art does not weaken clinical excellence; rightly integrated, it reminds clinical excellence of its purpose.

The future of supportive oncology should therefore include a dual commitment: evidence and presence. Evidence protects patients from illusion; presence protects them from abandonment. Art-based psychosocial support lives in the space between these commitments. It asks oncology to remain scientifically disciplined while becoming more attentive to what cannot be fully measured: the human need to be seen, heard, accompanied, and remembered.

Limitations

This article has limitations. First, it is a narrative review and conceptual proposal, not a systematic review or meta-analysis. Second, the CARE-ART Framework has not yet been empirically tested as a unified intervention model. Third, the literature on art-based interventions is heterogeneous, and effects differ by modality, cancer type, stage, setting, cultural context, and outcome measure. Fourth, many studies in the field have small samples and varied methodological quality. Fifth, the framework is designed primarily for psychosocial and supportive care, not for direct disease treatment.

These limitations do not weaken the need for humanized cancer care. They clarify the path forward. CARE-ART should be understood as a starting architecture for pilot programs, institutional learning, and research, not as a finished evidence-based protocol. Its scientific credibility will depend on future testing, refinement, cultural adaptation, and transparent reporting.

Conclusion

Cancer care needs science, but it also needs soul. It needs protocols, but also presence. It needs treatments, but also tenderness. The growing global burden of cancer makes it urgent to strengthen not only biomedical capacity, but also psychosocial, emotional, spiritual, and relational support.

The evidence suggests that creative arts therapies and art-based interventions may support selected outcomes in cancer care, especially anxiety, depression, expression, identity, and quality-of-life domains. Yet the responsible conclusion is not that art cures cancer. The responsible conclusion is that art can help human beings live, speak, connect, remember, and make meaning while facing cancer.

The CARE-ART Framework offers a practical model for humanizing cancer care through Connection, Agency, Recognition, Expression, Aesthetic safety, Resilience, and Transcendence. It invites oncology services to design art-based support that is ethical, voluntary, evidence-informed, culturally humble, professionally bounded, and measurable. The future of oncology should be measured not only by how long people live, but also by how deeply they are seen, heard, supported, and accompanied while they live.

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