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Identification of Mental Disorders in Oncology Patients

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RESUMO

OBJECTIVE

To analyze how mental disorders influence mortality, quality of life and adherence to oncological screening.

METHODS

An integrative review of the literature was conducted using DeCS/MeSH descriptors, searched in the main indexed databases: PubMed, SciELO, Cochrane, and LILACS. The results were analyzed descriptively, and grouped into categories.

RESULTS

Patients with severe mental disorders faced significant difficulties in early diagnosis and effective treatment of cancer. Low participation rates in screening programs, delayed diagnoses, and challenges in accessing treatment were common. During treatment, disorders such as anxiety and depression were frequently identified as the most common disorders, further complicating the management of the disease.

CONCLUSION

The intersection between the themes of mental disorders and cancer is crucial and highlights the need to expand research that addresses different types of neoplasms and mental disorders.

KEYWORDS

Mental Disorders; Oncology Patients; Adherence.

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INTRODUCTION

Every year, approximately 18 million new cases of cancer are diagnosed on a global scale, with a significant proportion, estimated at 9.6 million, resulting in death. [1] Projections indicate an increase in cancer mortality in the Americas, reaching around 2.1 million deaths by the year 2030, with around 70% of these deaths occurring in low- and middle-income nations, including Brazil.[2]

It is estimated that approximately one in eight people worldwide is affected by some kind of mental disorder, which equates to around 450 million individuals.[3,4] In addition, approximately one third of patients diagnosed with cancer in hospitals have some kind of mental disorder.[5]'

Cancer treatment may have significant side effects on the individual, making it difficult to adhere to treatment, both in surgical, radiotherapeutic and chemotherapeutic approaches.[6] In turn, mental disorders require the use of medication which, on occasion, can also have side effects that negatively impact the individual, making it difficult to adhere to treatment in both contexts oncological and psychiatric. [7] These psychiatric disorders affect at least 30 to 35% of cancer patients at all stages of the disease trajectory.[8]

In addition, screening actions for the early detection of cancer are considerably less frequent among vulnerable groups, such as individuals with severe mental disorders. [9] This low adherence is associated with various barriers, including difficulties in accessing health services, cognitive limitations, social instability and lack of support for follow-up care. [10]

Thus, this study aims to analyze how mental disorders influence mortality, quality of life and adherence to cancer screening. This study is of great relevance, as it addresses an interface that is still little explored between mental health and oncology, highlighting the vulnerability of a population group that is often neglected: cancer patients with mental disorders. By highlighting how psychiatric disorders interfere with quality of life, adherence to cancer screening and treatment, as well as clinical outcomes and mortality, this study will help to broaden understanding of the multiple barriers faced by these individuals.

Furthermore, by gathering current scientific evidence, the research supports the development of more humanized clinical strategies, the creation of integrated public policies, and the awareness of healthcare professionals regarding the importance of psychological screening and interdisciplinary care. It also promotes essential reflections for building a more equitable model of care— one that acknowledges the biopsychosocial complexity of these patients and aims to ensure comprehensive, personalized, and evidence-based care.

METHODS

This is an integrative review that was carried out by surveying information and bibliographic materials on the topic: "Identification of Mental Disorders in Oncology Patients". Bibliographic research is an effective strategy for gathering and synthesizing information, enriching understanding of the subject under study, through existing materials such as books and scientific articles. [11]

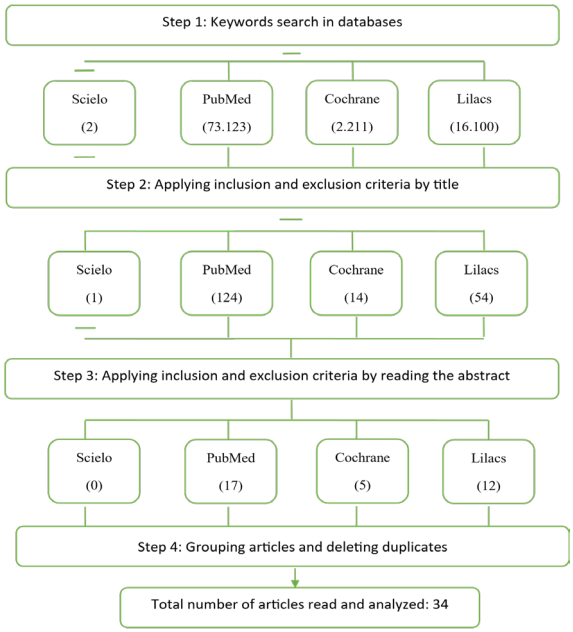
Indexed databases including PubMed, SciELO, Cochrane and LILACS were used to prepare this study. The Decs/Mesh platform, Descriptors in Health Sciences, was used to identify the descriptors present in the research. The descriptors were identified and the respective Boolean operators were added to insert them into the databases: "Cancer" OR "Oncology" OR "Neoplasm" AND "Mental disorder" OR "Psychopathology" OR "Mental illness" AND 'Treatment' OR "Intervention". In addition, the following English descriptors were used: "Cancer" OR "Neoplasm" OR "Oncology" AND "Mental disorders" OR "Psychopathology" AND 'Treatment' OR "Intervention".

With regard to inclusion/exclusion criteria, the following were included: articles indexed in the aforementioned scientific databases, considering a search period of the last[10] years (2014 to 2024), written in Portuguese, English or Spanish, and covering a population aged 18 or over. In addition, it was essential that the articles were available in full. The exclusion criteria included not meeting the inclusion criteria. In order to consider 18 as the adult population, the research was based on Article 5° of the Brazilian Civil Code (2002).[12]

The results were interpreted based on the previously defined inclusion criteria. The data was analyzed descriptively, without the use of statistical tests or thematic categorization. Interpretation was carried out by reading all the articles included, considering only the information related to the sample population that met the established criteria.

In the first stage, a search was made for articles in the databases described in the method (initially only articles that dealt with patients with an oncological diagnosis and the presence of an associated mental disorder were selected), using the descriptors together with the corresponding Boolean operators. In the second stage, the inclusion and exclusion criteria were applied, followed by reading the titles of the selected articles. Finally, in the third stage, the abstracts of each article were analyzed in order to select those that best suited the purpose of this research. Figure 1 shows the three stages of the methodological procedure.

Figure 1. Flowchart of the Stages of the Methodological Procedure in Relation to the Result Articles.



Fonte: The authors (2025).

Source: The authores (2025)

RESULTS

This research identified 34 articles with results that corresponded to the predetermined objective (table 1).

Table 1. Results articles identified in this research separated by category.

Quality of life	Tracking/screening	Mortality
Vivanco Muñoz et al.[16] (2022)[1]	Kerrisson et al.[34] (2023)[2]	Grassi et al.[51] (2021)[2]
Mathias et al.[18] (2022)[1]	Murphy et al.[35] (2021)[2]	Mahar et al.[54] (2020)[2]

Mathias et al.[18] (2022)[1]	Murphy et al.[35] (2021)[2]	Mahar et al.[54] (2020)[2]
Gutiérrez-Gómez et al.[24] (2021)[1]	Ouk et al.[36] (2020)[2]	Irwin et al.[53] (2019)[2]
Roy et al.[17] (2021)[1]	Schouten et al.[47] (2019)[1]	Lee et al.[58] (2019)[1]
Pereira et al.[26] (2020)[1]	Eriksson et al.[37] (2018)[2]	Cunningham et al.[52] (2015)[2]
Coutiño-Escamilla et al.[29] (2019)[1]	Chen et al.[41] (2018)[2]	
Boing et al.[19] (2019)[1]	Fujiwara et al.[38] (2017)[2]	
Shirama et al.[15] (2017)[1]	Irwin et al.[42] (2017)[2]	
Javier Cejuro et al.[20] (2017)[1]	Woodhead et al.[43] (2016)[2]	
Villar et al.[24] (2017)[1]	Barley et al.[40] (2016)[2]	
Unal et al.[14] (2016)[1]	Clifton et al.[39] (2016)[2]	
Andreia Ferreira et al.[13] (2015)[1]	Reinert et al.[48] (2015)[1]	
Cormanique et al.[23] (2015)[1]	Unal et al.[14] (2016)[1]	
Jassim et al.[30] (2015)[1]	Shirama et al.[16] (2017)[1]	
Schuster et al.[30] (2015)+		
Cristiane Decat et al.[27] (2014)[1]		
Carvalho et al.[22] (2015)[1]		
Caption: Results articles categorized by theme: a. Quality of life, b. Screening and c. Mortality. Table 1 also shows the separation between authors who studied mental disorder acquired after cancer diagnosis (superscript number 1) and mental disorder acquired before cancer diagnosis (superscript number 2).		

Source: The authors (2025)

Table 2 summarizes the results of the articles identified in this research.

Table 2: Outcome articles included in the review in relation to year of publication, authorship, mental disorder investigated and associated neoplasm.

YEAR	AUTHOR	STUDY DESIGN	CANCER	MENTAL DISORDER
2023	Kerrison RS, Jones A Peng J, Price G, Verne J, Barley EA, Lugton C[34]	Cross-sectional analytical observational study	Intestine, cervical, breast	Bipolar disorder, schizophrenia, psychosis and other SMI prior to cancer diagnosis
2022	Vivanco Muñoz KE, Ibañez Limaico JL, Estévez Montalvo LE[16]	Systematic review	All cancers in general	Anxiety, depression, stress and trauma disorders following cancer diagnosis
2022	Mathias AS, Gomes FK, Chagas PD, Campos DA, Leão MA[18]	Literature review	Breast cancer	Depression and anxiety after cancer diagnosis

2022	Mathias AS, Gomes FK, Chagas PD, Campos DA, Leão MA[18]	Literature review	Breast cancer	Depression and anxiety after cancer diagnosis
2021	Gutiérrez-Gómez T, Peñarrieta-de Cordova MI, Malibrán-Luque DJ, Piñones-Martínez MS, Cosme-Mendoza M, Gaspar Meza-de Nalvarte[25]	Cross-sectional study	All cancers in general	Depression and anxiety after cancer diagnosis
2021	Grassi L, Stivanello E, Belvederi Murri M, Perlangeli V, Pandolfi P, Carnevali F, Caruso R, Saponaro A, Ferri M, Sanza M, et al, [51]	Retrospective cohort study	Stomach, central nervous system, respiratory system and pancreas	Schizophrenia or other functional psychosis, mania or bipolar affective disorders, prior to cancer
2021	Roy DC, Lun R, Wang TF, Chen Y, Wells P[17]	Cross-sectional study	All cancers in general	Depression, bipolar disorder, mania and dysthymia Anxiety disorder, phobia, obsessive-compulsive disorder or panic disorder
2021	Murphy KA, Stone EM, Presskreischer R, McGinty EE, Daumit GL, Pollack CE[35]	Mixed methods study with retrospective quantitative and qualitative analysis	Breast, prostate, cervical and colorectal cancer	Schizophrenia, bipolar disorder and major depressive disorder. Prior to cancer
2020	Pereira AAC, Passarin NP, Coimbra JH, Pacheco GG, Rangel MP[26]	Quantitative cross-sectional study	Breast, gynecological, head and neck, protate, skin, gastrointestnal tract, bone, lung, central nervous system, gastrointestinal, penis and pancreas	Depression, post cancer
2020	Mahar AL, Kurdyak P, Hanna TP, Coburn NG, Groome PA[54]	Retrospective cohort study	Câncer colorretal	Schizophrenia, schizoaffective disorders,other psychotic disorders, bipolar disorders or major depressive disorders prior to cancer
2020	Ouk M, Edwards JD, Colby-Milley J, Kiss A, Swardfager W, Law M[36]	Retrospective case-control study	Cervical cancer	Schizophrenia and bipolar disorder prior to cancer
2019	Coutiño-Escamilla L, Piña-Pozas M, Guimaraes--Borges G,Tobías-Garcés A, López-Carrillo L[29]	Systematic review	Breast cancer	Depression after cancer diagnosis
2019	Boing L, Pereira GS, Araújo CDCR, Sperandio FF, Loch MDSG, Bergmann A, Borgatto AF, Guimarães ACA[19]	Cross-sectional study	Breast cancer	Depression after cancer diagnosis
2019	Schouten B, Avau B, Bekkering GTE, Vankrunkelsven P, Mebis J, Hellings J, Van Hecke A[47]	Trebuchet MS	Breast, lung, head and neck, colorectal and prostate cancer	.....
2019	Irwin KE, Steffens EB, Yoon Y, Flores EJ,Knight HP, Pirl WF, Freudenreich O, Henderson DC, Park ER[42]	Cross-sectional study	Lung cancer	Schizophrenia, prior to cancer
2019	Eriksson EM, Lau M, Jönsson C, Zhang C, Risö Bergerlind LL, Jonasson JM, Strander B.[37]	Cohort study	Cervical cancer	Schizophrenia, Schizotypal Disorders and Delusional Disorders, Neurotic Disorders, Stress-Related Disorders and Somatoform Disorders and mood disorders prior to cancer

2018	Chen LY, Hung YN, Chen YY, Yang SY, Pan CH, Chen CC, Kuo CJ[41]	Cohort study	Cancer of the oral cavity, esophagus, larynx, liver, lung, nasal cavity and paranasal sinuses, pancreas, stomach, kidney, urinary bladder, myeloid leukemia, colon and rectum, skin, brain tumor and thyroid	Schizophrenia, before cancer diagnosis
2018	Lee JH, Ba D, Liu G, Leslie D, Zacharia BE, Goyal N[58]	Retrospective cohort study	Cancer of the oral cavity, trachea, oropharynx, larynx, head and neck	After cancer diagnosis
2017	Shirama; Flávio H[15]	Cross-sectional cohort study	Not specified (all types)	Common mental disorders (CMD), especially anxiety and depression after cancer diagnosis
2017	Javier C, Sagrario GM, Delgado MLL[20]	Randomized clinical trial	Breast	Anxiety
2017	Villar RR, Fernández SP, Garea CC, Pillado MTS, Barreiro VB, Martín CG[24]	Prospective observational study	Breast	Anxiety after cancer diagnosis, before and after treatment
2017	Irwin KE, Park ER, Shin JA, Fields LE, Jacobs JM, Greer JA, Taylor JB, Taghian, AG, Freudenreich O, Ryan DP, Pirl WF[42]	Observational cohort study	Colorectal	pre-existing MIS
2017	Fujiwara M, Inagaki M, Nakaya N, Fujimori M, Higuchi Y, Hayashibara C, So R, Kakeda K, Kodama M, Uchitomi Y, Yamada N[38]	Cross-sectional descriptive study	Colorectal, gastric, lung, breast and cervical	Schizophrenia
2016	Woodhead C, Cunningham R, Ashworth M, Barley E, Steart RJ, Henderson MJ[43]	Observational population-based cohort study	Breast and cervical	MIS, including schizophrenia and bipolar disorder
2016	Clifton A, Burgess C, Clement S, Ohlsen R, Ramluggun P. Sturt J, Walters P, Barley EA[39]	Qualitative interview study	Breast, neck and intestine	Bipolar disorder, schizophrenia, other psychoses, borderline personality disorder, major depression and severe anxiety
2016	Barley EA; Borschmann RD; Walters P; Tylee A[40]	Literature review of randomized clinical trials	Any cancer screening program (e.g. cervical, breast, prostate, colorectal)	SMI, i.e., schizophrenia or other related psychotic disorders and bipolar disorder
2016	Unal D, Eroglu C, Ozsoy SD, Besirli A, Orhan O, Kaplan B[14]	Prospective observational study	Head and Neck	Depression, anxiety, adjustment disorder and sleep after cancer diagnosis
2015	Ferreira AS, Bicalho BP, ODA JMM, Duarte SJH, Machado RM[13]	Descriptive cross-sectional study	Breast	Depression and Anxiety after cancer diagnosis
2015	Reinert CA, Ribas MR, Zimmerman NPR[48]	Cross-sectional observational study	Not specified (All types)	Depression after cancer diagnosis
2015	Carvalho SMF; Bezerra IMP, Freitas TH;Rodrigues RCS, CIOC, et al[22]	Cross-sectional observational study	Breast	Major depression after cancer diagnosis

2015	Cormanique TF;Almeida LEDF, Rech, CA, Rech D, Herrera ACSA, Panis C[23]	Observational cohort study	Breast- infiltrating reast carcinoma	Chronic psychological stress after cancer diagnosis
2015	Schuster JT, Feldens VP, Iser BPM, Ghislandi GM[31]	Cross-sectional observational study	Not specified (all types)	Depression after cancer diagnosis
2015	Jassim GA, Whitford DL; Hickey A, Carter, B[30]	Systematic review of randomized clinical trials	Non-metastatic breast	Depression and anxiety after cancer diagnosis
2015	Cunningham R, Sarfati D, Stanley J, Peterson D, Collings S[52]	Observational cohort study	Breast and colorectal	Schizophrenia or bipolar affective disorder and others using mental health services before cancer diagnosis
2014	Cristiane DB, Laros JA, TC, Araujo TCCF[27]	Cross-sectional observational study	Predominantly Breast and Hematological	Anxiety and Depression after cancer diagnosis
Caption: SMI: Severe Mental Disorder				

Source: The autors (2025)

DISCUSSION

The discussion was divided into five topics, namely: 1. Quality of life in patients with cancer and mental disorders; 2. Adherence to cancer screening in patients with severe mental disorders; 3. Screening in cancer patients who developed mental disorders; 4. Mortality of patients with mental disorders prior to cancer; 5. Mortality of cancer patients with mental disorders.

Quality of life in patients with cancer and mental disorders

The studies analyzed indicated that the diagnosis of cancer in people with a history or predisposition to mental disorders compromises quality of life, worsening physical, emotional and social aspects. In addition, symptoms such as depression, anxiety and psychological distress are common and intensify after diagnosis and during treatment. [13-17] Furthermore, factors such as altered body image, loss of femininity, sexual dysfunction and impacts on self-esteem have been strongly associated with a poorer perception of quality of life, especially in women with breast cancer.[18-23] Similarly, socioeconomic aspects such as low income and less schooling are important aggravating factors, increasing the psychological and social vulnerability of these individuals.[15,24]

Physical symptoms such as fatigue, pain, insomnia, dyspnea and loss of appetite are also often associated with psychological distress, forming a cycle that compromises self-care and accentuates the decline in quality of life.[25,26] These problems have a significant impact on adherence to treatment, prognosis and even survival.[14,27] These findings are in line with scientific literature, which points out that cancer imposes a significant stress burden not only on the patient, but also on the family and health professionals involved. Throughout the course of the disease, physical and emotional factors interact and negatively influence therapeutic outcomes and quality of life.[28]

On the other hand, psychosocial interventions such as cognitivebehavioral psychotherapy, development of emotional intelligence, yoga and meditation have been shown to be effective in reducing anxious and depressive symptoms, as well as improving body image perception, self-esteem and quality of life. 20,29,30 In addition, hope emerges as a protective factor, with an inverse relationship to levels of depression, standing out as a relevant element in coping with the disease. 31 In this sense, the literature also corroborates these results, highlighting the effectiveness of Cognitive-Behavioral Therapy (CBT) in favoring more adaptive interpretations of events, which contributes to healthier emotional responses and a better quality of life.[32] Spirituality, in turn, appears as a complementary resource, offering emotional support throughout treatment and the course of the disease.[33]

Adherence to cancer screening in patients with severe mental disorders

Consistent studies show that people with severe mental disorders (SMD), such as schizophrenia and bipolar disorder, have significantly lower rates of participation in cancer screening programs - including breast, cervical, prostate and bowel screening - compared to the general population. [34-40] Among the main obstacles to adherence are psychotic symptoms, apathy, disorganized thinking, fear of diagnosis, previous traumatic experiences, lack of motivation and logistical barriers. [35,38,41] Socioeconomic status, ethnicity and limited access to health services are additional barriers, which add to the vulnerabilities imposed by the mental disorder. [34,37] In addition to unequal access, studies show that patients with GTM often receive lower quality cancer care, with fewer therapeutic options and less adherence to clinical guidelines, which makes outcomes more serious.[42]

Social stigma and the resistance of some professionals o making shared decisions with these patients also hinder access to preventive care.[35,43] People with mental illnesses undergo cancer screening tests at much lower rates than the general population, which may contribute to higher cancer mortality rates among this group.[44]

Another relevant aspect refers to the fact that individuals with schizophrenia have a higher risk of certain types of cancer, with variations according to gender: women tend to develop more breast and bladder cancers, while men have a higher incidence of colorectal cancer, which suggests the need for gender-sensitive screening programs. [41] This evidence dialogues with the literature on gender differences in the incidence and location of colorectal cancer, reinforcing the need for specific and gender-sensitive screening strategies. While men tend to develop more rectal tumors, women have a higher prevalence of proximal tumors, often associated with microsatellite instability. These distinctions, combined with variations in adherence to screening by gender, age and ethnicity, reinforce the importance of personalized guidelines that increase the effectiveness of preventive strategies and promote better outcomes.[45]

In addition, the literature confirms that the development of screening protocols based on predictive variables and nomograms contributes to a more accurate estimate of risk, by incorporating relevant sociodemographic and clinical factors.

These models help, above all, to define objective criteria for referring patients to mental health services. With accuracy indicators higher than 0.68, demonstrating greater performance than traditional screening instruments. In this way, by integrating multiple risk factors, these protocols allow for more refined screening, allowing for the prioritization of cases, the appropriate targeting of interventions and the personalization of care.[46]

Screening cancer patients who have developed a mental disorder

Some studies have shown that depressive symptoms are significantly more prevalent in cancer patients than in the general population. In addition, underdiagnosis of mental disorders is also a recurring barrier, especially in men, who tend to hide their emotional symptoms. [47,48] The literature reinforces the importance of systematic screening for mental disorders in the oncology context, especially given the high prevalence of depression and anxiety among cancer patients, which are often associated with the emotional impact of the diagnosis, the side effects of treatment, uncertainty about the prognosis and fear of recurrence. Lack of proper identification and management of these symptoms can significantly compromise quality of life, reduce adherence to treatment and contribute to worse clinical outcomes.[49,50]

Mortality of patients with pre-cancer mental disorders

The literature reviewed consistently shows that cancer mortality is significantly higher in individuals with CMD, such as schizophrenia and bipolar disorder, compared to the general population.[51,52] This disparity does not necessarily stem from a higher incidence of cancer in this population, but rather from a complex interaction of clinical, psychosocial and structural factors that compromise early detection and the effectiveness of cancer treatment. Irwin et al. (2019) [53] observed that patients with schizophrenia tend to underestimate their cancer risk, due to cognitive deficits that make it difficult to understand the seriousness of the disease and the need for prevention. This distorted perception compromises adherence to smoking cessation and screening programs, especially in cases of lung cancer. In addition, Grassi et al., (2021)[51] pointed out that the low participation of these patients in screening programs contributes to diagnoses at more advanced stages, when therapeutic possibilities are more limited and the prognosis is unfavorable. This condition is aggravated by difficulties in accessing specialized treatments such as surgery, chemotherapy and radiotherapy, as well as the adverse effects of psychotropic drugs and the high risk of suicide. Corroborating these findings, Mahar et al.[54] (2020) [54] reinforce that individuals with a history of psychiatric hospitalization are less likely to receive adequate cancer treatment and have a higher risk of mortality, especially those in situations of social vulnerability. The study by Cunningham (2015)[52] complements this analysis by showing that, although the incidence of cancer in people with mental illness is similar to that of the general population, the mortality is higher, which indicates failures at different stages of the line of care. It also highlights that the worsening of outcomes varies according to the type of cancer and psychiatric diagnosis, reinforcing the importance of specific strategies for each subgroup.

These findings corroborate the literature and reinforce that patients with a history of severe mental disorders have a higher risk of cancer mortality, especially when the severity of the psychiatric condition requires more intense levels of care.[55] This association is related to multiple factors, including lower adherence to screening, the presence of comorbidities, drug interactions and cognitive limitations that hinder adherence to treatment. [56] Moreover, the stigma associated with mental health can result in clinical negligence, delaying diagnosis and contributing to worse prognoses, such as an increased risk of metastasis.[57]

Mortality of cancer patients with a mental disorder Depressive symptoms are significantly associated with lower adherence to treatment in patients with head and neck cancer (HNC), contributing to worse clinical outcomes and increased mortality.[58] These results reinforce consolidated evidence in the literature, which points to depression as an independent risk factor for mortality in cancer patients, regardless of the type or stage of cancer. This impact is even more pronounced in elderly patients, who often face additional barriers to mental health treatment, such as stigma, the presence of comorbidities and limited access to specialized care.[59]

CONCLUSION

The findings of this research showed that patients with severe mental disorders face substantial obstacles to adhering to cancer screening. In addition, they have a poorer quality of life and lower survival rates when compared to those without a history of mental disorders.

Despite the relevance and topicality of the subject, this review has some important limitations. Firstly, there is a scarcity of studies that take an integrated approach to oncological aspects and mental disorders, which restricts the scope of the analysis and makes it difficult to generalize the findings. In addition, the methodological heterogeneity between the studies included - with different diagnostic criteria, target populations and assessment instruments - limits direct comparison between the results. Another relevant point is that many of the articles available focus on specific populations, such as women with breast cancer or individuals with schizophrenia, which may not reflect the diversity of experiences present in other subgroups. The predominance of observational studies and the scarcity of randomized clinical trials also compromise the strength of the evidence regarding the effectiveness of psychosocial interventions.

It is also important to consider that this review is subject to selection bias, since only studies available in certain databases and languages were included, which may have resulted in the exclusion of relevant evidence. Finally, the social stigma surrounding mental health and cancer can influence both the underreporting of symptoms and scientific production on the subject, which highlights the need for more interdisciplinary research that is sensitive to the psychosocial complexities of these patients.

In view of the limitations identified, it is recommended that future research deepen the investigation into the intersection between mental health and oncology through studies with more robust designs, such as randomized clinical trials and longitudinal research, capable of establishing more precise causal relationships. It is also essential to increase the diversity of the samples, including different types of cancer, various mental disorders and different sociodemographic profiles, in order to increase the representativeness and applicability of the results. It is also necessary to promote an interdisciplinary scientific agenda that tackles stigma and promotes the inclusion of mental health as an essential component of comprehensive cancer care.

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