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Attitudinal and Accessibility Barriers Predict Unmet Mental Health Care Needs in Distressed Cancer Patients and Survivors

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ABSTRACT

Background: Distress affects about one-third of people with cancer, yet many never want, seek, or receive mental health care. Identifying the barriers that distinguish those who obtain help from those who do not can guide service design in psychosocial oncology.

Aims: To examine how attitudinal, stigma, instrumental, financial, and accessibility barriers predict mental-health care need status (met need, unmet need, or low perceived need or reluctance).

Methods: Survey data from 300 distressed adults in the Cancer Support Community's Cancer Experience Registry (August 2022) were analyzed. Need status reflected desire for, attempts to access, and receipt of mental health care. Multinomial logistic regression tested barrier-domain associations with need status, adjusting for sociodemographic and clinical variables.

Results: Thirty-eight percent reported met need, 25% unmet need, and 37% low perceived need or reluctance. Each one-point increase in attitudinal barrier scores was associated with a higher likelihood of reporting unmet need (relative risk ratio [RRR] = 4.21, 95% CI 1.56–11.37) and low perceived need or reluctance (RRR = 2.85, 95% CI 1.17–6.91) compared to met need. Greater accessibility barriers were also linked to a higher likelihood of unmet need (RRR = 1.73, 95% CI 1.11–2.67). Stigma, instrumental, and financial barriers were not independent predictors in multivariate analyses.

Conclusion: In oncology, help-seeking and access to mental health care appear negatively associated with patient attitudinal beliefs and system-level constraints. Interventions that normalize mental health care, provide education on its benefits, and embed providers within oncology services may reduce the distress burden more effectively than strategies focusing solely on cost or logistics.

1 | Background

Roughly one-third of patients living with cancer report clinically significant distress, yet many never receive mental health support, and desire for care varies [1–7]. Mental health barriers—attitudinal, stigma-related, instrumental, financial, and accessibility—often co-occur to suppress help-seeking and limit individuals' ability and desire to access appropriate care [8, 9].

Attitudinal barriers to mental health care influence both the perceived need for support and motivation to pursue it. Some attitudes may reduce perceived need for professional care (e.g., believing the problem will resolve on its own, preferring to

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handle it independently, or not acknowledging that a problem exists at all) [10–12]. Other attitudes may relate to skepticism about the value of professional care, such as viewing these services as ineffective, unnecessary, or untrustworthy.

Stigma involves feelings of shame and embarrassment, and in the context of mental health, may include fear of others' judgment or concern about being perceived as weak. Stigma has long been recognized as a deterrent to mental health care among cancer patients [13, 14]. The relationship between stigma and mental health appears to be bidirectionally linked: illness increases stigma, which in turn exacerbates distress [15, 16].

Instrumental barriers are logistical and can include inadequate transportation, extended travel time, or difficulty taking time off work. Frequent cancer appointments can deter patients from desiring or pursuing additional services, particularly when travel is difficult. Travel burden has been consistently documented as hindering cancer care [17]. If patients are struggling with the logistics of their care, they may be less inclined to receive mental health support, even when they recognize a need.

Financial barriers can refer to high out-of-pocket costs or fear of financial setback due to the costs of cancer care. Worry about costs and depletion of savings is termed “financial distress” among cancer patients and survivors [18]. The financial impact of cancer is a distinct source of distress, adding to anxiety and depression [19]. Beyond the emotional experiences of financial distress, a higher financial burden has been linked to poorer outcomes, including higher nonadherence, lower quality of life, and an increased likelihood of foregoing treatments [20–22].

Accessibility barriers often stem from system-level constraints, such as difficulty securing timely appointments or limited availability of mental health specialists. As of March 2025, an estimated 122 million Americans (36% of the U.S. population) lived in mental health professional shortage areas [23]. Access may be even more limited for cancer patients needing providers trained in oncology-specific concerns. Cancer care remains fragmented, underscoring the need to better integrate medical and mental health clinicians [24, 25]. When health systems implement structured processes to screen patients, identify at-risk patients, and facilitate appropriate referrals and follow-up care, access to mental health support may improve for those experiencing untreated distress.

This study explored whether attitudinal, stigma-related, instrumental, financial, and accessibility barriers influence mental health care need among distressed cancer patients and survivors. Need was categorized as met (received professional care that was wanted or sought), unmet (did not receive care that was wanted and sought), or low perceived/reluctant (neither wanted nor sought care). We hypothesized that attitudinal and stigma barriers would be reported most frequently by patients with unmet need or low perceived need; additionally, instrumental, financial, and accessibility barriers would predominate among those with unmet need.

2 | Methods

2.1 | Study Population

Cancer Support Community (CSC)—a professionally led network of cancer support services in over 200 locations in 50 markets worldwide—hosts the Cancer Experience Registry (CER), an online, community-based cohort of adults ($\geq$ 18 years) in the United States or Canada who have ever been diagnosed with any type of cancer. Participants are recruited through local CSC and Gilda's Club locations, hospital and healthcare partners, state coalitions, advocacy partnerships, and social media outreach. In August 2022, existing CER participants were invited to complete a follow-up survey that examined experiences with emotional and mental health care.

Prior to this survey, respondents completed CancerSupportSource (CSS), a psychometrically validated, 25-item multi-dimensional distress-screening tool that flags clinically significant symptoms of depression and anxiety [26]. Of the 658 participants who completed the CER and follow-up survey, 300 screened positive (anxiety only = 138 [46%], depression only = 19 [6%], or both = 143 [48%]) and comprise the analytic sample.

All procedures were approved by Ethical and Independent Review Services (IRB #22153-CSC), and informed consent was obtained from all participants.

2.2 | Measures

2.2.1 | Barriers to Accessing Mental Health Care

The following barriers to accessing mental health care were measured: (1) attitudinal, (2) instrumental, (3) stigma, (4) financial, and (5) accessibility. For each barrier, items within the respective scale were scored such that higher scores reflected a greater barrier. Attitudinal, instrumental, and stigma barriers were assessed using items from the Barriers to Access to Care Evaluation scale (BACE), which includes 30 questions related to barriers that may stop, delay, or discourage an individual from getting or continuing mental health care, including a 12-item treatment stigma subscale [10]. For each BACE item, respondents rated whether the barrier had stopped, delayed, or discouraged them *not at all (0)*, *a little (1)*, *quite a lot (2)*, or *a lot (3)*. The BACE has been validated for use in community samples. As done in prior research [27], BACE items were grouped into three indices: attitudinal, instrumental, and stigma-related barriers. Attitudinal barriers were captured by averaging 10 items (e.g., dislike of talking about feelings, emotions, or thoughts; wanting to solve the problem on my own; thinking that professional care would not help; Cronbach's α in our sample = 0.78). Instrumental barriers were measured by averaging seven items (e.g., difficulty taking time off work, unsure where to get professional care, problems with transport/travel to appointments; α = 0.75). A BACE question on the ability to afford mental health care, which has been grouped with instrumental items in previous research, was excluded, as we assessed financial barriers separately (see below). Stigma-related barriers were measured by averaging 12 items comprising the BACE treatment stigma subscale (e.g., feeling embarrassed or ashamed; concern of being seen as weak for having a mental health problem; concern about what family/friends might think, say, or do; α = 0.92).

Financial and accessibility barriers were assessed using relevant subscales from the short-form Patient Satisfaction Questionnaire (PSQ-18) [9]. For each item, participants rated their level of agreement: *strongly disagree (1), disagree (2), neither agree nor disagree (3), agree (4), and strongly agree (5)*. The financial aspect of care subscale includes two items (α = 0.81), while the accessibility and convenience of care subscale includes four items (α = 0.85). Typically, the PSQ is scored such that higher scores reflect greater satisfaction. Here, we reversed the direction of scoring so that higher scores reflect lower satisfaction, which we interpret as greater barriers to care. The items within each subscale were averaged, with scores ranging from 1 to 5.

2.2.2 | Mental Health Care Need

Participants selected all statements that applied since being diagnosed with cancer: (a) I want/wanted professional care for an emotional or mental health concern; (b) I sought professional care for an emotional or mental health concern; (c) I received professional care for an emotional or mental health concern; (d) I am still receiving professional care for an emotional or mental health concern.

Based on responses to items (a) through (d), participants were classified into one of three mutually exclusive categories: (1) Met need: participants who indicated they had received professional care—defined as endorsing either (c) or (d)—and had either wanted (a) or sought (b) care; (2) Unmet need: participants who wanted (a) or sought (b) care, but did not report having received care (neither c nor d); and (3) Low perceived need or reluctance: participants who did not report wanting (not a) or seeking (not b) care.

2.2.3 | Sociodemographic Characteristics and Clinical History

Self-reported age, gender identity, marital status, race/ethnicity, household income, region, education, employment, insurance, current treatment status, time since diagnosis, caregiver status, treatment setting, and whether they took prescription medication for anxiety and depression were included.

2.3 | Analysis

Descriptive statistics were calculated for the full sample and by mental health care need (met need, unmet need, and low perceived need or reluctance). Group differences on sociodemographic and clinical variables were examined with chi-square tests for categorical variables and ANOVA for continuous variables; only statistically significant differences are reported.

For descriptive item-level analyses, individual BACE attitudinal, instrumental, and stigma items were dichotomized (0 = "*not at all* or *a little*"; 1 = "*quite a lot* or *a lot*"). PSQ-18 financial and accessibility items were similarly dichotomized so that a value of 1 consistently reflected a greater barrier (0 = "*strongly disagree*, *disagree*, or *neither agree or disagree*"; 1 = "*agree* or *strongly agree*" for negatively worded items; 0 = "*strongly agree*, *agree*, or *neither agree or disagree*"; 1 = "*disagree* or *strongly disagree*" for positively worded items). Chi-square tests assessed between-group differences for each dichotomized item.

For multivariate regression analyses, BACE and PSQ-18 subscales were analyzed as continuous variables, calculated as the average of original item responses within each subscale. All subscales were direction-coded, so that higher values indicated greater barriers. Given the three-category outcome for need status, multinomial logistic regression was used with the met need group as the reference group. Separate relative-risk ratios (RRR) were estimated for attitudinal, stigma, instrumental, financial, and accessibility barriers. The model adjusted for age, gender identity, marital status, race/ethnicity, household income, geographic region, educational attainment, employment status, insurance status, current treatment status, time since diagnosis, caregiver status, and primary treatment setting.

Missing data on barriers and covariates were handled with multiple imputation. The Stata suite of *mi* commands created 50 imputed datasets and averaged results for final estimates. All analyses were performed in Stata/SE 17.0.

Ancillary analyses (not shown) rotated the reference category in the multinomial model and yielded substantively identical conclusions. Further, as a sensitivity check, we ran simplified multinomial logistic regression models within available subgroups (gender, education, income, geography, and employment) to explore the stability of observed associations across subgroups. These analyses were exploratory and limited by small subgroup sizes. All statistical tests were two-sided with α = 0.05.

3 | Results

3.1 | Participant Characteristics

Of the 300 distressed CER respondents, 38% had met mental health care need, 25% had unmet need, and 37% reported low perceived need or reluctance (Table 1). The mean age was 57.9 years; most participants identified as women (78%), were married (58%), and were non-Hispanic non-Latino White (86%). Nearly half were in active treatment (49%), with a median duration of 4 years since diagnosis (IQR 2–7). Primary sites included breast (32%), colorectal (16%), hematologic (13%), lung (7%), and gynecologic (7%). Most participants had a caregiver (79%), and about half used prescription medication for anxiety (49%) and depression (45%). Between-group differences in sociodemographic and clinical characteristics were modest; only

TABLE 1 | Sample characteristics.

Characteristic	Full sample ($N = 300$) *n*	%	Met need ($n = 115$) *n*	%	Unmet need ($n = 75$) *n*	%	Low perceived need or reluctance ($n = 110$) *n*	%
Age, years (range 23–88)	$M = 57.9$	SD = 12.4	$M = 56.3$	SD = 12.7	$M = 56.9$	SD = 12.5	$M = 60.2$	SD = 11.7
Age group								
18–39 years	27	9%	14	12%	7	9%	6	5%
40–64 years	176	59%	67	58%	46	61%	63	57%
65 or more years	97	32%	34	30%	22	29%	41	37%
Gender								
Man	66	22%	27	23%	11	15%	28	25%
Woman	233	78%	87	76%	64	85%	82	75%
Genderqueer/non-binary	1	0%	1	1%	0	0%	0	0%
Marital status								
Married	175	58%	68	59%	40	53%	67	61%
In relationship/dating	26	9%	11	10%	10	13%	5	5%
Divorced or separated	47	16%	15	13%	12	16%	20	18%
Widowed	14	5%	5	4%	3	4%	6	5%
Single, not in a relationship	32	11%	14	12%	9	12%	9	8%
Missing	6	2%	2	2%	1	1%	3	3%
Sexual orientation								
Straight or heterosexual	260	87%	100	87%	66	88%	94	85%
Lesbian, gay, or homosexual	11	4%	3	3%	2	3%	6	5%
Other	21	7%	10	9%	4	5%	7	6%
Prefer not to share	8	3%	2	2%	3	4%	3	3%
Race/ethnicity								
NHNL White	258	86%	95	83%	65	87%	98	89%
NHNL Black	12	4%	4	3%	5	7%	3	3%
Hispanic or Latino, any race	13	4%	6	5%	2	3%	5	5%
NHNL other/multi	15	5%	9	8%	3	4%	3	3%
Prefer not to share	2	1%	1	1%	0	0%	1	1%
Annual household income								
< $40K	74	25%	24	21%	27	36%	23	21%
$40–79.9 K	79	26%	32	28%	18	24%	29	26%
$80K or more	92	31%	44	38%	18	24%	30	27%
Prefer not to share/don't know/missing	55	18%	15	13%	12	16%	28	25%
Region								
Urban	211	70%	86	75%	45	60%	80	73%
Rural	40	13%	10	9%	14	19%	16	15%
Suburban	49	16%	19	16%	16	21%	14	13%
Education								
Less than college	95	32%	27	23%	31	41%	37	34%

(Continues)

TABLE 1 | (Continued)

Characteristic	Full sample ($N = 300$)		Met need ($n = 115$)		Unmet need ($n = 75$)		Low perceived need or reluctance ($n = 110$)	
	n	%	*n*	%	*n*	%	*n*	%
College degree	130	43%	51	44%	30	40%	49	45%
Graduate degree or higher	72	24%	36	31%	13	17%	23	21%
Prefer not to share	3	1%	1	1%	1	1%	1	1%
Employment status								
Employed (full-time, part-time, or temporary)	111	37%	46	40%	26	35%	39	35%
Retired	94	31%	34	30%	23	31%	37	34%
Not employed, disability	56	19%	19	16%	15	20%	22	20%
Not employed, other	36	12%	13	11%	11	15%	12	11%
Prefer not to share/ missing	3	1%	3	3%	0	0%	0	0%
Insurance Coverage								
Private	131	44%	55	48%	28	37%	48	44%
Government	115	38%	39	34%	35	47%	41	37%
Private and government	26	9%	11	10%	3	4%	12	11%
Not insured	4	1%	1	1%	2	3%	1	1%
Insured, other	5	2%	1	1%	2	3%	2	2%
Missing	19	6%	8	7%	5	7%	6	5%
Currently receiving treatment								
No	138	46%	60	52%	29	39%	49	45%
Yes	148	49%	53	46%	39	52%	56	51%
Missing	14	5%	2	2%	7	9%	5	5%
Time since diagnosis	median = 4	IQR 2–7	median = 5	IQR 3–10	median = 4	IQR 1–7	median = 3	IQR 1–7
Time since diagnosis group								
Less than or equal to 2 years	106	35%	28	24%	29	39%	49	45%
3–5 years	76	25%	37	32%	19	25%	20	18%
6–9 years	55	18%	21	18%	15	20%	19	17%
10–19 years	44	15%	18	16%	9	12%	17	15%
20 or more years	19	6%	11	10%	3	4%	5	5%
Most recent primary cancer diagnosis								
Breast	95	32%	41	36%	22	29%	32	29%
Colorectal	48	16%	13	11%	10	13%	25	23%
Hematologic	39	13%	16	14%	14	19%	9	8%
Lung	21	7%	5	4%	9	12%	7	6%
Gynecologic	22	7%	12	10%	4	5%	6	5%
Prostate	13	4%	4	3%	3	4%	6	5%
Other	62	21%	24	22%	13	27%	25	25%
Has a caregiver								
No	56	19%	17	15%	21	28%	18	16%
Yes	237	79%	95	83%	52	69%	90	82%
Missing	7	2%	3	3%	2	3%	2	2%

(Continues)

TABLE 1 | (Continued)

Characteristic	Full sample ($N = 300$)		Met need ($n = 115$)		Unmet need ($n = 75$)		Low perceived need or reluctance ($n = 110$)	
	n	%	*n*	%	*n*	%	*n*	%
Where received most of cancer treatment								
Large academic or comprehensive cancer center	126	42%	57	50%	30	40%	39	35%
Community hospital or cancer center	102	34%	30	26%	26	35%	46	42%
Private oncology practice	47	16%	21	18%	11	15%	15	14%
Other	4	1%	0	0%	0	0%	4	4%
Missing	21	7%	7	6%	8	11%	6	5%
Taking prescription medication for anxiety	146	49%	68	59%	34	45%	44	40%
Taking prescription medication for depression	134	45%	62	54%	31	41%	41	37%

Note: % calculated out of $n = 300$; between group differences calculated using ANOVA for continuous variables and chi-square tests for categorical variables; statistically significant ($p < 0.05$) differences across mental health experience category were observed only for taking prescription medication for anxiety; other cancer diagnoses include anal, bile duct, bladder, brain or spinal cord, head and neck, hematologic, kidney/renal cell carcinoma, melanoma, myelofibrosis, neuroendocrine, oral or oropharyngeal, sarcoma, non-melanoma skin, stomach, testicular, thyroid.
Abbreviations: IQR: inter-quartile range; M: mean; NHNL: Non-Hispanic, non-Latino; SD: standard deviation.

current use of prescription medication for anxiety differed significantly ($p < 0.05$).

3.2 | Item-Level Barriers to Care in the Complete Sample

Table 2 displays the frequency of endorsement for individual BACE and PSQ items, which include attitudinal, instrumental, stigma, financial, and accessibility barriers. Among BACE items, the most frequently endorsed barrier was the desire to solve the problem on one's own (44%). Other frequently reported barriers included attitudinal or instrumental barriers such as concerns about treatments available, like medication side effects (27%), thinking the problem would improve on its own (23%), disliking talking about emotions (22%), being unsure where to seek professional care (22%), and concern about being seen as weak for having a mental health problem (19%). For PSQ items, the most common barriers included not being confident in receiving care without a financial setback (38%), difficulty accessing care (30%), the ability to get care when needed (38%), and long wait times (28%).

3.3 | Item-Level Barriers to Care and Mental Health Care Need Category (Bivariate Analysis)

Table 2 also presents the frequency of endorsement for BACE and PSQ items by mental health care need, with statistically significant between-group differences noted. The results revealed notable differences. For example, regarding attitudinal items, only 14% of individuals in the met need group (i.e., those who wanted, sought, and received care) endorsed the belief that “the problem would get better by itself”, compared to 35% in the unmet need group (wanted and sought but did not receive care) and 25% in the low perceived need or reluctance group (neither wanted nor sought care) ($p < 0.01$). For instrumental barriers, individuals in the unmet need group more frequently reported being unsure where to obtain care and experiencing transportation challenges, compared to both the met need and low perceived/reluctance groups. Regarding stigma-related concerns, only one item—related to parenting—differed significantly across groups, though this item had an overall low endorsement rate. For financial barriers, 38% of the total sample expressed a lack of confidence in obtaining mental health care without financial hardship. This concern was most pronounced in the unmet need group (55%), relative to 33% in the met need group and 32% in the low perceived need or reluctance group ($p < 0.001$). All accessibility-related items significantly differed across the three groups, with the met need group consistently reporting fewer barriers than both the unmet need and low perceived need or reluctance groups.

Overall, multiple attitudinal, instrumental, financial, accessibility, and (to a lesser extent) stigma items differed by need category, with the met need group consistently reporting fewer barriers than the unmet need and low perceived need or reluctance groups.

3.4 | Barriers to Care by Domain and Mental Health Care Need Category (Multivariate Analysis)

Our primary aim was to examine the relationship between barriers to care and mental health care need. To address this aim, we conducted multinomial logistic regression to assess the

TABLE 2 | Item-level descriptive statistics for attitudinal, instrumental, stigma, financial, and accessibility barriers.

	Full sample ($N = 300$)		Met need ($n = 115$)		Unmet need ($n = 75$)		Low perceived need or reluctance ($n = 110$)		Between group differences
	n	%	*n*	%	*n*	%	*n*	%	
	Quite a lot to a lot								
Attitudinal									
Wanting to solve the problem on my own	133	44%	45	39%	37	49%	51	46%	
Fear of being put in the hospital against my will	36	12%	10	9%	16	21%	10	9%	*
Thinking the problem would get better by itself	69	23%	16	14%	26	35%	27	25%	**
Thinking that professional care probably would not help	42	14%	13	11%	14	19%	15	14%	
Dislike of talking about my feelings, emotions, or thoughts	66	22%	19	17%	23	31%	24	22%	
Concerns about the treatments available (e.g., medication side effects)	80	27%	30	26%	28	37%	22	20%	*
Having had previous bad experience with professional care for mental health	50	17%	17	15%	17	23%	16	15%	
Preferring to get help from family or friends	26	9%	6	5%	10	13%	10	9%	
Preferring alternative forms of care (e.g., traditional/religious healing)	27	9%	7	6%	10	13%	10	9%	
Thinking I did not have a problem	25	8%	4	3%	13	17%	8	7%	**
Instrumental									
Being unsure where to go to get professional care	65	22%	25	22%	24	32%	16	15%	*
Problems with transport or traveling to appointments	42	14%	14	12%	18	24%	10	9%	*
Professionals of my own ethnic or cultural group not being available	11	4%	5	4%	3	4%	3	3%	
Being too unwell to ask for help	28	9%	13	11%	12	16%	3	3%	**
Difficulty taking time off work	41	14%	15	13%	14	19%	12	11%	
Having problems with childcare while I receive professional care	8	3%	4	3%	3	4%	1	1%	
Having no one who could help me get professional care	34	11%	13	11%	14	19%	7	6%	
Stigma									
Concern that I might be seen as weak for having a mental health problem	57	19%	25	22%	18	24%	14	13%	
Concern that it might harm my chances when applying for jobs	19	6%	9	8%	6	8%	4	4%	
Concern about what family might think, say, do	43	14%	17	15%	11	15%	15	14%	
Feeling embarrassed or ashamed	44	15%	14	12%	16	21%	14	13%	
Concern that I might be seen as crazy	34	11%	13	11%	13	17%	8	7%	
Concern that I might be seen as a bad parent	17	6%	5	4%	9	12%	3	3%	*
Concern that people I know might find out	17	6%	7	6%	6	8%	4	4%	
Concern that people might not take me seriously if they found out	19	6%	10	9%	6	8%	3	3%	
Not wanting a mental health problem to be on my medical records	45	15%	16	14%	16	21%	13	12%	
Concern that my children may be taken into care or that I may lose access or custody	7	2%	3	3%	3	4%	1	1%	
Concern about what friends might think, say, or do	15	5%	6	5%	6	8%	3	3%	
Concern about what people at work might think, say, or do	25	8%	9	8%	9	12%	7	6%	
	Agree to strongly agree/Disagree to strongly disagree[a]								
Financial									
I feel confident that I can get the emotional and mental health care I need without being set back financially[a]	114	38%	38	33%	41	55%	35	32%	***
I have to pay for more of my emotional and mental health care than I can afford	79	26%	33	29%	12	16%	34	31%	
Accessibility									
I have easy access to the emotional and mental health specialists I need[a]	91	30%	27	23%	38	51%	26	24%	***

(Continues)

TABLE 2 | (Continued)

	Full sample ($N = 300$)		Met need ($n = 115$)		Unmet need ($n = 75$)		Low perceived need or reluctance ($n = 110$)		Between group differences
	n	%	*n*	%	*n*	%	*n*	%	
Where I get emotional and mental health care, people have to wait too long for treatment	84	28%	42	37%	12	16%	30	27%	*
I find it hard to get an appointment for emotional and mental health care right away	80	27%	43	37%	9	12%	28	25%	**
I am able to get emotional and mental health care whenever I need it[a]	91	38%	27	23%	42	56%	22	20%	***

Note: % calculated out of $n = 300$; between group differences calculated using chi-square tests.
Abbreviations: BACE: Barriers to Access to Care Evaluation scale; PSQ: Patient Satisfaction Questionnaire (PSQ-18).
*$p < 0.05$.
**$p < 0.01$.
***$p < 0.001$.
[a] For items framed positively, the frequency of responses indicating *disagree* to *strongly disagree*, reflecting a greater barrier, was reported.

association between different types of barriers (all treated as continuous) and mental health care need status (a categorial variable with three levels) while adjusting for sociodemographic background and clinical characteristics (Table 3).

Attitudinal and accessibility barriers were significantly associated with mental health care need status. Higher levels of attitudinal barriers were associated with a higher likelihood of being in the unmet need group compared to the met need group (RRR = 4.21; $p < 0.01$) as well as in the low perceived need or reluctance group compared to the met need group (RRR = 2.85; $p < 0.05$). Similarly, higher accessibility was associated with a higher likelihood of being in the unmet need group versus the met need group (RRR = 1.73; $p < 0.05$).

In contrast, stigma-related, financial, and instrumental barriers were not significantly associated with mental health care need category in the regression analysis.

Exploratory subgroup analyses (by gender, education, income, geography, and employment) yielded similar patterns of association, indicating that findings were generally stable across groups.

4 | Discussion

This study demonstrates that attitudinal barriers constitute the strongest predictors of both unmet mental health need and low perceived need in adults with cancer. Most notably, attitudinal items related to self-reliance distinguished between categories of mental health care need. While self-reliance can be viewed as a distinct barrier, it may reflect or overlap with related factors such as perceived self-efficacy, confidentiality concerns, self-stigma, and fear of being misunderstood [11, 28–30]. Accessibility constraints (e.g., long waits, limited specialists) independently predicted unmet need, whereas stigma, financial, and instrumental factors were not significant after adjustment for these constraints. Collectively, negative attitudes curb motivation to seek help, and system limitations impede care even when it is sought.

The relatively high endorsement of the idea that "the problem would get better by itself" indicates that individuals with cancer may underestimate the clinical relevance of their mental and emotional health concerns. Many cancer patients may perceive emotional and mental health struggles as a natural part of their experience, leading them to avoid seeking help. Anecdotally, this normalization of mental health struggles is often seen as part of their "new normal" rather than an issue that could be addressed with support. Furthermore, normalization is not a static experience; it may evolve. In our multivariable models, a more recent diagnosis ($\leq$ 2 years) was associated with a threefold increase in the likelihood of reporting low perceived need or reluctance to seek mental health care, suggesting that patients earlier in the course of diagnosis may experience stronger feelings of normalization.

Concerns about medication side effects were another frequently endorsed attitudinal barrier item, suggesting that perceived risks may contribute to negative attitudes toward mental health treatment. Patients may not be aware that mental health care encompasses a wide range of supportive interventions beyond medication. For instance, mindfulness, stress reduction techniques, counseling and therapy, acupuncture, exercise, and nutrition can offer significant mental health benefits with minimal to no adverse side effects. Notably, about half of the sample reported taking medication for anxiety or depression, including over one-third of those who neither wanted nor sought professional mental health care. While some of these medications may be prescribed for cancer-related symptoms such as nausea or insomnia, this finding raises questions about the context of psychotropic medication use in cancer care. The use of these medications in the absence of reported help-seeking or perceived need suggests that patients may be receiving pharmacological treatment outside of formal mental health care pathways, potentially prescribed by oncology or primary care providers.

Discussions with health care providers are critical to patients' emotional and mental well-being [31]. Through routine distress screening at each stage of the cancer journey, care teams can normalize mental health discussions, help patients recognize distress, use an opt-in/opt-out referral system to link them to

TABLE 3 | Multinomial logistic regression predicting mental health care experience by barriers to accessing care.

	Met need	Unmet need		Lower perceived need or reluctance	
	Reference	RRR	95% CI	RRR	95% CI
Barriers to accessing care					
BACE attitudinal		4.21**	(1.56–11.37)	2.85*	(1.17–6.91)
BACE instrumental		0.94	(0.40–2.19)	0.58	(0.24–1.37)
BACE treatment stigma		0.64	(0.28–1.48)	0.69	(0.37–1.68)
PSQ accessibility		1.73*	(1.11–2.67)	1.17	(0.80–1.72)
PSQ financial		1.17	(0.82–1.67)	0.91	(0.68–1.23)
Age, years		1.00	(0.97–1.04)	1.03	(1.00–1.06)
Gender					
Woman		REF		REF	
Man		0.62	(0.24–1.56)	1.26	(0.62–2.53)
Genderqueer/non-binary (*n* too small)					
Married					
No		REF		REF	
Yes		1.12	(0.46–2.76)	0.82	(0.37–1.79)
NHNL White					
No		REF		REF	
Yes		1.82	(0.65–5.11)	1.44	(0.58–3.57)
Annual household income < $60K					
No		REF		REF	
Yes		0.88	(0.35–2.19)	1.21	(0.54–2.72)
Region					
Urban		REF		REF	
Rural		2.77	(0.99–7.73)	1.52	(0.59–3.92)
Suburban		1.29	(0.50–3.30)	0.63	(0.27–1.49)
College degree					
No		REF		REF	
Yes		0.49	(0.22–1.07)	0.64	(0.32–1.29)
Not employed, due to disability					
No		REF		REF	
Yes		1.55	(0.61–3.96)	1.61	(0.71–3.62)
Insurance Coverage					
Private		REF		REF	
Government		1.53	(0.58–4.05)	0.74	(0.32–1.72)
Private and government		0.67	(0.14–3.11)	0.89	(0.29–2.73)
Not insured		1.70	(0.12–25.07)	1.38	(0.06–31.98)
Insured, other		1.77	(0.09–33.51)	1.00	(0.05–17.48)
Currently receiving treatment					
No		REF		REF	
Yes		1.53	(0.73–3.18)	1.06	(0.57–1.96)
Time since diagnosis ≤ 2 Years					
No		REF		REF	
Yes		2.22*	(1.01–4.86)	3.04**	(1.55–5.98)

(Continues)

TABLE 3 | (Continued)

	Met need	Unmet need		Lower perceived need or reluctance	
	Reference	**RRR**	**95% CI**	**RRR**	**95% CI**
Has a caregiver					
No		REF		REF	
Yes		0.57	(0.23–1.40)	1.10	(0.47–2.57)
Where received most cancer treatment					
Academic or comprehensive cancer center		REF		REF	
Community hospital or cancer center		1.21	(0.52–2.84)	1.67	(0.84–3.30)
Private oncology practice or other		0.79	(0.28–2.22)	1.09	(0.47–2.53)

Note*:* PSQ scored such that higher scores reflect lower satisfaction/greater barrier.
Abbreviations: BACE: Barriers to Access to Care Evaluation scale; CI: confidence interval; NHNL: non-Hispanic, non-Latino; PSQ: Patient Satisfaction Questionnaire (PSQ-18); REF: reference category in the multinomial model; RRR: relative risk ratio.
*$p < 0.05$.
**$p < 0.01$.

psychological services, encourage positive views of mental health care, and address concerns such as medication side effects. Educational resources and promotional campaigns can play a key role in helping patients recognize emotional distress and connect with appropriate resources and support tools. Health education can improve individuals' willingness to seek care, and educational interventions have shown some success in improving quality of life outcomes [32].

Our finding that greater reported accessibility barriers were associated with a 1.7-fold increase in the likelihood of reporting unmet mental health care needs highlights the critical role of system-level factors in preventing individuals from receiving care, even when they actively seek it. Our measure of accessibility encompassed four items, all reflecting aspects of timely and convenient access to care. As awareness of mental health has grown—particularly following the onset of the COVID-19 pandemic—the demand for licensed mental health professionals has surged. However, the U.S. currently faces provider shortages, making it increasingly difficult for people with mental health concerns to access appropriate and timely services and even more challenging for cancer patients to access mental health providers with oncology-specific training. The provider shortage is a complex and multifaceted issue. Contributing factors include a declining number of new entrants into the mental health workforce, low retention rates, and an aging and retiring provider population. Barriers to workforce entry and retention can include increasing client caseloads, high costs associated with licensure and credentialing, and inadequate reimbursement by insurance companies or government programs.

One approach to mitigating the provider shortage is to increase awareness and utilization of a multidisciplinary workforce in addressing mental health concerns. This includes referring and connecting patients to professionals beyond psychiatry and psychology—such as social workers, counselors, and other trained providers—who can offer non-pharmacological support for managing symptoms of anxiety, depression, and psychological distress. Research suggests that system-level supports (such as patient navigators and structured inter-professional collaboration) can buffer fragmented care pathways and increase engagement with mental health services [33].

Furthermore, routine distress screening in oncology [34, 35] is an important step toward timely emotional support [36]. Current distress screening protocols in oncology settings rely on patients' self-reporting their level of distress. In this study, all participants met criteria for elevated distress and would have been flagged through standard screening procedures. However, one in three individuals reported neither wanting nor seeking support—a group we classified as having "low perceived or reluctance for mental health care." A frequently cited challenge with distress screening is the limited availability of mental health professionals to follow up with all patients identified as at risk [37, 38]. To address resource constraints, one potential strategy is to integrate a stepped or patient-centered model, allowing patients to indicate the type of support they would prefer (e.g., digital educational resources or direct contact with a staff member). This "opt-in" approach could help prioritize care for those who express a desire for support and, in turn, expand access for individuals who want mental health care but have been unable to receive it due to resource limitations.

However, our findings also highlight a critical tension: many individuals in the "low perceived or reluctance" group endorsed beliefs such as expecting their problems to resolve on their own. Thus, some patients with actual need may forgo care, risking persistent distress that is associated with poorer treatment adherence, worse clinical outcomes, higher costs, and diminished quality of life.

Contrary to our hypotheses, instrumental, financial, and stigma-related barriers were not independently, significantly associated with mental health care need, though perceived financial barriers were highly endorsed across all mental health care groups. However, the analytical sample was predominantly women, non-Hispanic White, well-educated, and adequately insured. Less than 4 in 10 were currently employed, and approximately 25% had annual household incomes under $40,000. The sociodemographic composition of the sample may have contributed to fewer perceived instrumental and financial barriers, as we would not expect work, childcare, or insurance-related challenges, for example, to be prominent in this group. Additionally, while efforts to reduce stigma and discrimination around mental health care have intensified in recent years [39], experiences with stigma are likely to vary by sociodemographic factors [40].

Although sensitivity analyses suggested that the association between stigma and mental health care need was consistent across subgroups, small sample size in subgroups remains a consideration, and the non-significant role of stigma may in part be attributed to the limited diversity in our sample. Still, several contemporary explanations rooted in the evolving context of oncology and mental health integration could make this finding genuine rather than spurious. Stigma has historically been a major barrier to mental health care among individuals with cancer; however, its diminished role may reflect progress in normalizing psychosocial care. As distress screening, embedded counseling, and multidisciplinary models become routine, mental health engagement may be viewed less as a sign of vulnerability and more as standard survivorship care. The expansion of telehealth and digital mental health supports also enables patients to seek care more privately, reducing self- and public stigma. Lastly, broader cultural shifts, including public campaigns, media portrayals, and survivor advocacy, have further normalized help-seeking. Future research should test whether these patterns hold in more diverse and underserved populations.

5 | Implications

5.1 | Clinical Implications

Clinicians and health-system leaders can take immediate action to improve supportive care uptake. First, normalize help-seeking early. Clear, routine conversations at diagnosis that frame distress as a common, treatable aspect of cancer can counter low perceived need and increase willingness to engage. Second, improve access. Integrating mental health professionals into oncology—whether in person, virtually, or through scheduled warm handoffs—can reduce delays and drop-off after referral. When a full-time psychologist is not feasible, brief, evidence-based interventions can be delivered by supervised trainees, social workers, or counselors within a stepped-care model. Patient navigators can play a key role by monitoring electronic distress screens and reaching out to those who ask for help but have not yet connected to care. Offering trusted self-help tools, such as mindfulness or online therapy programs, as a first step respects patient choice and preserves clinical resources for those with greater needs. These practical strategies address the gap between wanting help and receiving it and can be adopted without major changes to existing workflows. Because attitudinal and accessibility barriers often extend beyond the clinic, practical strategies are also needed to broaden engagement and reach individuals less likely to pursue traditional mental health care.

5.2 | Practical Implications

Beyond clinical integration, scalable and sustainable models of supportive care are needed to reduce attitudinal and accessibility barriers. Group-based programs that deliver evidence-based approaches—such as relaxation training, mindfulness, stress management, and emotional coping skills—within a supportive, non-threatening environment can help address attitudes such as believing distress will resolve on its own or that professional help is unnecessary. Because participants often join these programs for connection, skill-building, or wellness rather than for "therapy," they can reach individuals who might otherwise decline traditional mental health services. Such programs can be delivered at low cost and implemented flexibly across diverse care settings.

Digital mental health interventions (DMHIs) also represent a promising avenue to expand access to care. These tools adapt evidence-based interventions for online or mobile delivery, offering flexible, scalable options that can be accessed privately and on demand. DMHIs help overcome common barriers among cancer survivors, including attitudinal resistance to formal therapy, limited availability of trained providers, and geographic constraints that make in-person sessions difficult.

For health systems with limited behavioral-health infrastructure, partnering with trusted community-based organizations that provide free or low-cost psychosocial programming can further extend the continuum of care and create a safety net for those experiencing unmet need. Together, these strategies promote equitable access to supportive care and position mental health support as a routine and integral part of comprehensive cancer care.

5.3 | Research Implications

Our results highlight several priorities for future inquiry. First, longitudinal studies are needed to determine how attitudinal barriers and perceived accessibility evolve from the point of diagnosis through long-term survivorship and how these trajectories affect psychological outcomes. Mixed-methods implementation research can isolate which components of stepped-care or opt-in triage models most effectively convert "unmet need" into "met need." Rigorously designed trials should compare interventions that directly target attitudes (e.g., self-reliance-focused psychoeducation) against those that remove practical constraints (e.g., rapid-access scheduling) to establish causal pathways. Sensitivity analyses conducted within subgroups suggested that the direction and magnitude of associations were generally consistent with the full-sample findings, although statistical significance varied due to smaller sample sizes. These results support the overall robustness of the main findings but underscore the need for replication in larger, more diverse samples. For example, because our sample was predominately White, female, and insured, oversampling racial/ethnic minorities, rural residents, and under-insured populations is essential to clarify whether the non-significant role of financial and stigma-related barriers generalizes to more diverse groups. Economic evaluations of workforce innovations (e.g., embedding master-level counselors or social workers) can help guide policymakers to weigh the costs against reductions in distress and downstream healthcare use. Finally, incorporating patient-reported outcome measures and ecological momentary assessment will enable more granular tracking of when and why perceived needs shift during the cancer journey.

6 | Limitations

Limitations related to the sociodemographic composition of the sample also affect the generalizability of our results. Further, the data are cross-sectional and based on self-report. Respondents were selected from the Cancer Experience Registry, which required internet access. As a result, our findings may not be representative of the experiences of all cancer patients and survivors. Longitudinal, prospective data collection and more rigorous experimental study designs would provide further insight into the association between barriers to care and mental health care needs throughout the cancer continuum.

7 | Conclusion

In this national sample of 300 cancer patients and survivors who self-reported elevated levels of distress, 25% indicated an unmet need for mental health care. Attitudinal barriers were a key factor distinguishing those whose mental health care needs were met from those who either did not receive the support they desired or who did not want or seek care. Accessibility barriers were also significantly associated with not receiving desired mental health services.

Efforts to address negative attitudes that deter patients from seeking or engaging in care—through patient education and provider communication—may benefit from emphasizing the normalization of mental health challenges during the cancer experience and increasing awareness of non-pharmacological options for managing symptoms of anxiety, depression, and emotional distress. These approaches can also help patients recognize when a mental health issue may be present and reinforce the message that such challenges do not have to be faced—or solved—alone. Enhancing the efficiency of distress screening and promoting awareness of a broader, multidisciplinary mental health workforce may help alleviate pressure on an already strained healthcare system, which is facing a shortage of mental health providers.

Author Contributions

M. F. Miller: conceptualization, data curation, formal analysis, funding acquisition, investigation, methodology, project administration, writing (original draft, review, and editing). **J. S. Olson:** formal analysis, methodology, writing (original draft, review, and editing). **E. E. Fortune:** funding acquisition, supervision, writing (review and editing). All authors read and approved the final manuscript.

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Conflicts of Interest

E. E. Fortune: Reports institutional funding from: Gilead Sciences, Lilly Oncology, Merck. All other authors declare no conflicts of interest.

Data Availability Statement

The dataset analyzed during the current study is available from the corresponding author on reasonable request.

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