Mental Health Burden After Cancer Diagnosis: A Rapid Review of Anxiety, Depression, and Determinants of Distress

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Abstract. Introduction: Cancer diagnosis is a highly stressful event, frequently associated with significant psychological distress, particularly anxiety and depression, representing a major public health concern. This rapid review aimed to synthesize the psychological consequences experienced by adults recently diagnosed with cancer and to identify factors associated with increased or reduced distress.

Methods: Following WHO guidance for rapid reviews, selected databases were searched using predefined eligibility criteria, resulting in the inclusion of four cross-sectional studies comprising 8,743 patients from diverse countries and clinical settings.

Results: Findings revealed high prevalence rates of anxiety (up to 57.1%) and depression (up to 60.2%), with greater vulnerability among patients with poor social support, low performance status, severe pain, multiple physical symptoms, inpatient care, palliative care, and chemotherapy. Protective factors included higher functional status and better quality of life. Gender differences were observed, with women reporting greater emotional distress. Overall, evidence indicates that anxiety and depression are distinct yet correlated dimensions of psychological distress.

Conclusions: The review concludes that early identification and targeted psycho-oncological interventions are essential to mitigate suffering and enhance quality of life from the moment of diagnosis.

Keywords: Psychological · Cancer · Consequences · Oncology · Diagnostic · Hospital · Psychological distress · Anxiety · Depression

1 Introduction

A cancer diagnosis represents one of the most challenging and traumatic events in the human experience and is globally recognised as a major public health problem, being the second leading cause of morbidity and mortality worldwide. Receiving an oncological diagnosis triggers a myriad of complex emotions, inherent to the perceived threat to life and the profound lifestyle changes that are anticipated [1]. In this context, psychological distress (also referred to as psychosocial distress), defined as the totality of negative subjective experiences caused by the disease and its treatments, constitutes a reactive and situational form of suffering whose intensity is highly variable [2].

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The extensive literature on this topic confirms that the psychological burden associated with cancer is substantial, with approximately 30% of all oncology patients experiencing psychosocial distress [3], and around half of these individuals presenting with conditions such as anxiety and depression [1]. The early identification and detailed characterisation of this distress are priorities for both psycho-oncology research and routine clinical practice [2]. Among the most extensively studied and clinically relevant manifestations of psychological distress are anxiety and depression, which, although distinct constructs, are frequently correlated.

The experience and intensity of psychosocial distress are significantly modulated by sociodemographic, clinical, and contextual factors. With regard to gender, women generally report higher overall distress, exhibiting greater scores in the psychological dimension of distress, whereas men tend to report higher levels of distress in the physical dimension [3]. These gender differences have been observed in anxiety, though not consistently in depression. Concerning age, findings are sometimes divergent: some studies indicate that younger patients (18–39 years) may experience lower levels of anxiety and depression compared with older patients (60–84 years), while other investigations suggest that younger individuals—particularly during the first six months following diagnosis—may experience higher levels of distress [2].

Social support emerges as a key protective factor. Evidence demonstrates that patients with inadequate social support face a significantly increased risk of developing anxiety, with scores up to 4.43 times higher compared with those who benefit from robust support networks. Such support is crucial, as it provides both physical and psychological benefits in stressful situations, helping to alleviate distress [1].

The manner and context in which the diagnosis is communicated, as well as the referral pathway to psychological support, also highlight the clinical relevance of distress. Lower levels of distress have been observed among patients recruited through routine contact, whereas those who actively sought psychosocial support or were referred by the medical team exhibited the highest distress scores. This finding underscores the association between the mode of engagement and pre-existing levels of suffering. It is particularly relevant when considering the impact of an unexpected diagnosis, which may lead to an immediate increase in distress and therefore requires especially sensitive communication by healthcare professionals.

Furthermore, treatment modality influences psychological distress; for example, chemotherapy is frequently perceived as the most distressing intervention, whereas surgery or radiotherapy are sometimes no more stressful than the absence of treatment and may even be associated with hope for survival [3].

Given the complexity and high prevalence of psychological distress throughout the cancer trajectory, and the need to understand the factors that modulate patients' responses—particularly in highly vulnerable contexts such as an unexpected diagnosis—this Rapid Literature Review aims to: assess the psychological consequences in patients receiving unexpected cancer diagnoses; examine the evolution of psychological status six months after diagnosis; analyse the influence of factors such as age, gender, and family support on patients' psychological well-being; evaluate the impact and manner of healthcare professionals' communication at the time of diagnosis; and assess patients' quality of life following diagnosis.

By synthesising the most up-to-date evidence on these factors, this review seeks to delineate profiles of psychological vulnerability and to provide valuable insights for the implementation of more targeted and effective psycho-oncological support interventions from the point of diagnosis.

2 Methods

We conducted this rapid systematic review to address a specific need in a timely manner, enabling the production of evidence with an efficient use of resources.

2.1 Eligibility Criteria

The eligibility criteria were defined according to the PCC framework (Population, Concept, and Context) as follows. Population (P): participants aged 18 years or older with a diagnosis of cancer. Concept (C): participants who received a cancer diagnosis following diagnostic investigations. Context (C): eligible studies included participants who received a cancer diagnosis in healthcare settings, both in hospital environments and in primary healthcare services.

The literature review included studies published up to December 2025 and was conducted across three databases: PubMed, CINAHL, and Web of Science. The search strategy combined Medical Subject Headings (MeSH) and relevant free-text terms related to cancer diagnosis. The final search string was: mental health AND (oncological OR cancer) AND diagnostic.

Eligible study designs comprised observational studies—cohort, cross-sectional, and case–control designs—as well as secondary analyses of existing databases. Studies published in Portuguese or English were included.

The exclusion criteria were as follows: (1) participants with a prior history of oncological diagnosis, in order to ensure that the sample consisted exclusively of individuals in the initial phase of the disease; (2) lack of explicit information regarding breast cancer diagnosis; (3) inclusion of specific clinical populations (e.g. participants with neurological impairment); and (4) absence of original data (e.g. editorials, commentaries, and narrative reviews).

2.2 Methodological Quality Assessment

The methodological quality of included studies was assessed using the Joanna Briggs Institute's recommendations, and the classification was presented in both narrative and tabular formats. One reviewer conducted the initial assessment, which was then verified by a second reviewer to ensure validity and rigor. In line with these recommendations, the total score was classified from a threshold of 70% of the checklist items. Between 70 and 79% were considered medium quality, those between 80 and 90% were rated as high quality, and scores above 90% were classified as excellent quality [10, 11]. Due to methodological variability and inconsistent metrics, meta-analysis was not conducted.

2.3 Data Extraction and Analysis

Study selection was conducted in two stages by two independent reviewers to minimize bias. Titles and abstracts were first screened, followed by full-text reviews of potentially eligible studies [1–9]. Disagreements were resolved through discussion or consultation with a third reviewer. Data extraction was performed using a standardized form capturing author and publication year, country, study design, data collection period, setting, sample size, follow-up duration, comparator, outcomes, objectives, main findings, effect direction, and practical implications.

A descriptive summary first presented key study characteristics - geographical setting, design, sample size, factores psicológicos, implicações práticas. Results were then organized by themes of interest, including. Prevalência e Intensidade do Stress, Fatores Físicos; Fatores Clínicos; Fatores sociodemográficos. This rapid review was conducted following the WHO Rapid Review Guide and in compliance with the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) reporting standards [12].

3 Results

The initial search across electronic databases identified 451 records. After removing duplicates (25), 426 titles and abstracts were screened for eligibility. During this screening phase, 411 studies were excluded for not meeting the predefined inclusion criteria. Full-text articles (15 studies) were then assessed in detail, leading to the exclusion of six additional papers. In the end, 9 primary studies fulfilled all PCC criteria and were included in the synthesis. The flow of information through the different phases of the review is mapped in Fig. 1.

3.1 Physical Factors

Across the studies analysed, as we can see in Table 1, physical factors were primarily associated with symptom burden and loss of functional capacity. Severe weakness, limitations in activities of daily living, and impaired overall performance status were frequently reported, alongside common symptoms such as pain and fatigue. In certain contexts (e.g. intracranial neoplasms and hospitalised patients), greater intensity of somatic symptoms and physical limitations tended to co-occur with poorer emotional outcomes, suggesting a "cascade" effect whereby physical discomfort amplifies psychological distress.

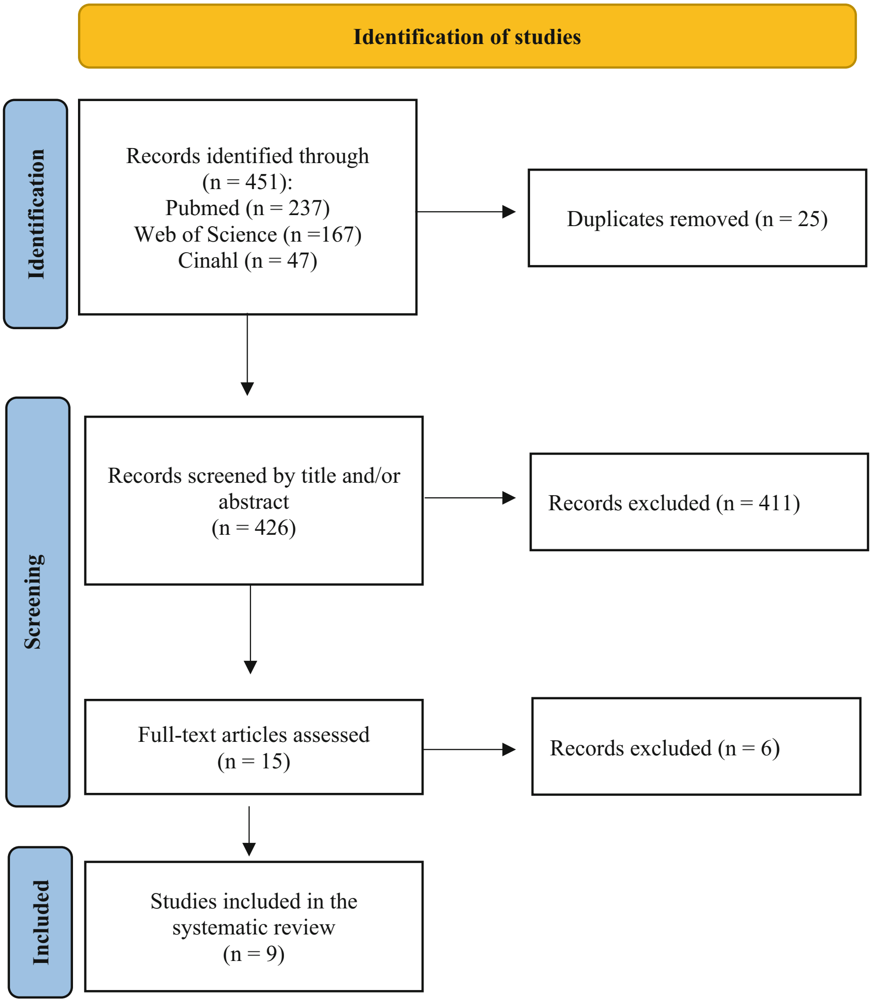

Fig. 1. Flowchart of the article selection and inclusion process.

3.2 Psychological Factors

Psychological factors were consistently reported across the included studies, with a high prevalence of anxiety, depression, and emotional distress. Emotional reactions to the diagnosis and treatment trajectory were also described, including denial, anger, crying, and emotional instability, as well as, in some cases, symptoms compatible with post-traumatic stress. Beyond symptomatology, key psychosocial determinants emerged, notably low levels of social support (or fragile support networks) and the quality of communication with healthcare professionals (e.g. insufficient information provision and inadequate active listening). These factors were associated with poorer emotional adjustment and increased psychological suffering.

3.3 Clinical Factors

From a clinical perspective, the findings indicate significant associations between mental distress and greater disease severity and complexity, including advanced or metastatic stages and the presence of comorbidities. Cancer treatments and their consequences (for example, mastectomy, chemotherapy, and visible side effects such as hair loss) were also identified as clinically relevant factors influencing well-being and the subjective experience of illness. Furthermore, the care setting (inpatient oncology wards, outpatient services, or palliative care) appeared to shape both the profile of patient needs and the factors associated with distress, underscoring the importance of tailoring assessment and interventions to the specific clinical context.

Table 1. Characterization of the studies.

Author, year	Country	Sample size	Study design	Context of Study	Physical Factors	Psychological Factors	Clinical Factors
Iddrisu et al., 2020	Ghana	12	Qualitative exploratory descriptive	Young women with breast cancer; recruited shortly after diagnosis (3 hospitals)	Severe physical weakness; limitations in activities of daily living; impaired global functioning	Depression and emotional instability; crying; denial	Impact of treatments (mastectomy; chemotherapy; visible treatment effects)
Endeshaw et al., 2022	Ethiopia	392	Cross-sectional	Oncology patients undergoing treatment or follow-up (outpatient and inpatient settings)	Pain; fatigue; poorer physical functioning	Low social support; marital status (divorced)	Advanced disease stage; comorbidities
Gontijo Garcia et al., 2023	Brazil	70	Cross-sectional	Adults with cancer receiving palliative, outpatient, or inpatient care	Fatigue (and other assessed symptoms)	Emotional functioning (associated with anxiety); psychological suffering	Palliative care status; global functional status; tumour type
Raoui et al., 2025	Morocco	100	Cross-sectional	Oncology patients following disclosure of the cancer diagnosis	Not the primary focus; study includes disease stage and functional status	Poor quality of communication (e.g. "poor listening" by healthcare professionals)	Female sex; urban residence; low educational level
Herschbach et al., 2008	Germany	6,365	Large multi-centre observational study	Patients recruited across 105 institutions/services for distress screening	Physical symptoms (e.g. pain, fatigue)	Emotional items (e.g. anxiety, depression)	Institutional and organisational factors evaluated
Fehrenbach et al., 2021	Germany	31	Cross-sectional	Patients with intracranial neoplasms (benign and malignant)	Greater burden of somatic symptoms and physical limitations	Depression and anxiety; post-traumatic stress symptoms	Diagnosis (benign vs malignant); comorbidities
Muzzatti et al., 2022	Italy	1,990	Large sample descriptive / screening study	Hospitalised oncology inpatients; distress screening during admission	Specific "associated factors" related to hospitalisation	Anxiety and depression (HADS; defined cut-off scores)	Inpatient oncology setting

(*continued*)

Table 1. (*continued*)

Author, year	Country	Sample size	Study design	Context of Study	Physical Factors	Psychological Factors	Clinical Factors
Zhang et al., 2025	Australia	142,682	Population-based cohort study	Men with metastatic prostate cancer; incident cases	Not detailed in the text	Depression and anxiety following diagnosis of metastatic disease	Clinical and sociodemographic factors included in modelling
Deenadayalan et al., 2023	India	754	Cross-sectional	Users of palliative care services (patients and/or caregivers)	Not detailed in the text	Distress associated with limited understanding of the diagnosis	Palliative care context

The literature shows that anxiety and depression, although related, represent distinct entities in the oncological context. In studies conducted with inpatients, a prevalence of 26.6% for anxiety and 28.6% for depression was observed, with 17.2% of patients presenting both conditions. These findings support the existence of two independent dimensions of psychological distress, and the mean intensity of symptoms has been found to be higher for anxiety than for depression [5, 8].

The prevalence of anxiety and depression varies according to clinical and sociodemographic context: in the study by Endeshaw in Ethiopia, rates were particularly high, with 57.1% for anxiety and 60.2% for depression. In palliative care, as reported by Gontijo Garcia in Brazil, prevalence reached 44.3% for depression and 25.7% for anxiety, with 52.9% of patients exhibiting both conditions. Among hospitalized patients in Italy, Muzzatti identified prevalence rates of 26.6% for anxiety and 28.6% for depression [2].

Gender shapes the emotional experience related to cancer, with women exhibiting higher overall and psychological suffering, whereas men tend to report greater physical suffering. Findings regarding age are less consistent: some studies suggest that younger patients show lower anxiety and depression, whereas others indicate that younger people and adolescents may experience higher levels of distress in the first months after diagnosis. This inconsistency underscores the need to investigate distress in the initial phase following diagnosis [5, 8].

4 Discussion

This review examined the psychological, clinical, and physical consequences experienced by oncology patients at the time of cancer diagnosis, with particular attention to the influence of sociodemographic characteristics, social support, treatment modalities, and the process of diagnostic disclosure. Overall, the findings confirm that psychological distress constitutes a substantial and highly prevalent burden following a cancer diagnosis. Consistent with previous literature, approximately 30% of oncology patients experience clinically relevant psychosocial distress [3]; however, when specific manifestations such as anxiety and depression are considered, prevalence rates vary widely according to clinical context, population characteristics, and methodological approaches [1].

Across the included studies, anxiety and depression emerged as the most prominent indicators of psychological distress. In several oncology settings, particularly among patients undergoing active treatment, prevalence rates were notably high, reaching up to 57.1% for anxiety and 60.2% for depression [1]. While these estimates are consistent with findings from low- and middle-income settings and from samples with greater clinical complexity, they tend to exceed those reported in some high-income countries. Such discrepancies may reflect differences in performance status, disease stage, availability of psychosocial care, and cultural factors influencing symptom reporting and help-seeking behaviour. These findings reinforce the importance of contextualising prevalence data within the healthcare and sociodemographic environments in which studies are conducted [1].

The review also supports the conceptual distinction between anxiety and depression in the oncological context. Although these conditions frequently co-occur, evidence indicates that they represent related but independent dimensions of psychological distress. Studies conducted in hospitalised populations reported moderate prevalence of anxiety and depression individually, with a smaller yet clinically significant proportion of patients presenting with comorbid symptoms. Notably, anxiety symptoms were often more intense than depressive symptoms, which may reflect the acute uncertainty and anticipatory fear associated with diagnosis and treatment initiation [5, 8]. This distinction has important implications for clinical assessment and intervention, as it underscores the need for multidimensional screening tools rather than reliance on global distress measures alone.

Sociodemographic factors were found to meaningfully shape emotional responses to cancer diagnosis. Gender differences were consistently observed, with women reporting higher levels of overall and psychological distress, while men tended to exhibit greater physical distress [13]. These findings align with broader psychosocial oncology literature and may reflect gender-related differences in emotional expressiveness, coping strategies, and social roles. In contrast, evidence regarding age was less consistent. While some studies suggested lower anxiety and depression among younger patients, others indicated heightened distress during the first months following diagnosis, particularly among adolescents and young adults [14]. This variability highlights the need for further investigation into age-specific vulnerability, especially during the early diagnostic phase.

Social support emerged as one of the most robust protective factors against psychological distress. Patients with limited or fragile support networks were found to have up to a fourfold increased risk of anxiety, underscoring the buffering role of interpersonal relationships in mitigating emotional suffering. Additionally, the mode of access to psychosocial care was closely linked to distress severity. Patients identified through routine clinical contact generally reported lower distress levels, whereas those who actively sought support or were referred by healthcare professionals exhibited higher anxiety and depression scores [15]. This pattern reinforces the importance of universal distress screening at diagnosis, rather than reliance on patient-initiated help-seeking, which may occur only once distress has already become severe.

Physical symptom burden was another key determinant of psychological outcomes. Symptoms such as pain, fatigue, nausea, vomiting, and appetite loss were consistently associated with increased risk of anxiety and depression. These findings support a bidirectional relationship between physical and psychological suffering, whereby unmanaged somatic symptoms exacerbate emotional distress, which in turn may heighten symptom perception [15]. This interdependence highlights the clinical value of integrated care models that address both physical symptom control and psychological support from the outset of the diagnostic process.

Clinical and treatment-related factors further influenced distress levels. Poor performance status and higher pain intensity were identified as strong predictors of both anxiety and depression, with risk increasing proportionally as functional capacity declined. Patients receiving palliative care were particularly vulnerable, reflecting the cumulative impact of advanced disease, symptom burden, and existential concerns. Among treatment modalities, chemotherapy was consistently perceived as the most distressing, likely due to its systemic side effects and visible physical changes. In contrast, surgery and radiotherapy were sometimes associated with lower distress, possibly because they are perceived as curative or as offering greater disease control, thereby fostering hope [15]. This dimension highlights the importance of investing in integrated education within the oncological clinical context, ensuring differentiated care for these patients [16].

Several methodological limitations within the included studies point to important directions for future research. The predominance of cross-sectional designs limits causal inference and precludes examination of temporal relationships between distress and associated factors. Other studies are therefore essential to clarify how psychological distress evolves following diagnosis and to identify early predictors of persistent or worsening symptoms [15]. Moreover, key variables such as illness perceptions, fear of recurrence or progression, family and financial support, treatment-related side effects, and early rehabilitation interventions were not consistently assessed [17–22]. Given that maladaptive cognitive appraisals are amenable to change through targeted psychological interventions, their inclusion in future research is particularly warranted. From an analytical perspective, the use of path analysis or structural equation modelling may offer advantages over traditional regression approaches by capturing the complex, multilevel pathways through which physical, psychological, and social factors interact to influence distress.

5 Conclusion

In conclusion, this review highlights the high prevalence and multifactorial nature of psychological distress at the time of cancer diagnosis. Anxiety and depression are common, closely linked to physical symptom burden, social support, clinical severity, and treatment characteristics. These findings underscore the need for early, systematic distress screening and for tailored psycho-oncological interventions integrated into routine cancer care from the moment of diagnosis, with particular attention to patients at heightened risk of psychological vulnerability.

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