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Analysis of Psychiatric Illness among Breast Cancer Patients: An Institutional Based Study

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Abstract

Background: Breast cancer is one of the most common malignancies among women and is often associated with considerable psychological distress. In addition to the physical burden of the disease and its treatment, patients frequently experience emotional, social, and functional challenges that may contribute to psychiatric morbidity. Psychiatric illness in breast cancer patients can adversely affect quality of life, treatment adherence, coping ability, and overall clinical outcome. Recognition of these problems in routine oncology practice is therefore essential for comprehensive patient care.

Aim: To analyze psychiatric illness among breast cancer patients.

Materials and Methods: This hospital-based observational study was conducted among 85 adult female patients with histopathologically confirmed breast cancer. Patients were recruited by consecutive sampling. Data were collected through structured interviews in a private clinical setting. Sociodemographic variables, including age, marital status, educational level, occupation, socioeconomic status, and family support, were recorded. Clinical variables such as stage of disease, treatment modality, metastasis, medical comorbidity, pain severity, and sleep disturbance were also assessed. Psychiatric evaluation was carried out using standardized screening tools for depression, anxiety, and psychological distress, followed by clinical psychiatric assessment to establish diagnosis. Data were analyzed using descriptive and inferential statistics, and associations were tested for statistical significance.

Results: Among the 85 breast cancer patients, psychiatric illness was identified in 46 patients, giving an overall prevalence of 54.12%. Depressive disorder was the most common diagnosis, seen in 16 patients (18.82%), followed by anxiety disorder in 11 (12.94%), mixed anxiety-depressive disorder in 9 (10.59%), adjustment disorder in 6 (7.06%), and insomnia disorder in 4 (4.71%). Clinically significant depressive symptoms were present in 19 patients (22.35%), while clinically significant anxiety symptoms were observed in 18 patients (21.18%). Severe overall psychological distress was found in 22 patients (25.88%). Psychiatric morbidity was significantly associated with advanced stage of disease ($p=0.044$), metastasis ($p=0.008$), moderate to severe pain ($p=0.007$), and inadequate family support ($p=0.002$). Age did not show a statistically significant association with psychiatric illness ($p=0.206$).

Conclusion: Psychiatric illness is highly prevalent among breast cancer patients and represents a major but often under-recognized component of disease burden. Depression and anxiety were the predominant psychiatric disorders. Advanced disease, metastasis, pain, and poor family support significantly increased the risk of psychiatric morbidity. Routine psychiatric screening and integrated psychosocial intervention should be incorporated into breast cancer care for early identification and better management of mental health problems.

Key words: Breast cancer; Psychiatric illness; Depression; Anxiety; Psychological distress.

INTRODUCTION

Breast cancer is one of the most common malignancies affecting women and remains a major public health problem because of its long clinical course, repeated hospital visits, demanding treatment schedules, and persistent impact on everyday life. Beyond its physical consequences, the diagnosis of breast cancer often produces a profound psychological reaction. For many patients, the illness is experienced not only as a threat to survival but also as a threat to femininity, body integrity, family role, social functioning, and future security. As a result, the emotional burden of breast cancer extends far beyond the period of diagnosis and treatment and may continue during recovery, remission, or recurrence. Psychiatric illness in women with breast cancer has therefore emerged as an important area of clinical concern in oncology practice.[1]

The experience of breast cancer is often accompanied by intense uncertainty, fear, and disruption of normal life. Patients must cope with the shock of diagnosis, the need for multiple investigations, and the possibility of surgery, chemotherapy, radiotherapy, or hormonal therapy. Each phase of management can create new stressors, including fear of death, fear of recurrence, concerns about disfigurement, altered body image, loss of independence, and interruption of family and occupational responsibilities. These stressors may interact with pre-existing vulnerabilities and can precipitate psychological distress or more clearly defined psychiatric disorders. The emotional response to breast cancer is therefore multifactorial and may be influenced by disease-related, treatment-related, and psychosocial circumstances.[2]

Among the psychiatric problems seen in breast cancer patients, depression and anxiety are the most frequently discussed. These may range from transient emotional symptoms to clinically significant disorders that interfere with coping, adherence to treatment, and overall quality of life. In addition, adjustment problems, sleep disturbance, excessive worry, hopelessness, irritability, and somatic preoccupation are commonly reported in this group. Such disturbances are important because they may remain unrecognized in busy oncology settings, particularly when emotional symptoms overlap with physical symptoms of cancer or adverse effects of treatment. The need to identify psychiatric illness early is therefore central to comprehensive breast cancer care.[3] The psychological impact of breast cancer is also closely tied to quality of life. A woman's sense of well-being after diagnosis is shaped not only by the biological severity of disease but also by pain, fatigue, sleep problems, treatment burden, social support, communication with caregivers, and the ability to maintain meaningful daily roles. Quality of life in breast cancer is now understood as a multidimensional concept that includes emotional, physical, social, and functional domains. Psychiatric morbidity can adversely affect all of these domains, while poor quality of life may in turn intensify emotional suffering. This close interrelationship makes the study of psychiatric illness especially relevant in women undergoing treatment for breast cancer.[4]

Another important dimension of psychological morbidity in breast cancer is the effect of illness and treatment on body image and self-perception. The breast has strong symbolic significance in relation to femininity, sexuality, and personal identity, and treatments such as mastectomy, breast-conserving surgery, chemotherapy-related hair loss, and other bodily changes may deeply affect self-esteem. Even when treatment is medically successful, women may continue to

experience dissatisfaction with appearance, altered sexuality, embarrassment, and distress related to their changed body. Such concerns can contribute substantially to emotional suffering and may coexist with depression, anxiety, and reduced social confidence. For this reason, body image must be regarded as a central psychological issue in breast cancer patients rather than a purely cosmetic concern.[5]

Psychiatric morbidity in breast cancer is further influenced by the social and cultural context in which illness occurs. Women often face expectations related to caregiving, marital roles, child rearing, and household responsibilities even while undergoing treatment. In many settings, limited awareness about mental health, financial difficulties, stigma related to cancer, and reduced access to psychosocial services can worsen emotional outcomes. Coping style, family support, communication patterns, educational background, and health beliefs may all affect how a patient interprets the illness and adapts to treatment. These concerns may be particularly relevant in tertiary care hospitals where patients present with varying disease severity and diverse social backgrounds. Understanding psychiatric illness in such settings is therefore essential for planning integrated and culturally sensitive care.[6]

MATERIALS & METHODS

This hospital-based observational study was conducted to analyze psychiatric illness among breast cancer patients. The study was designed to evaluate psychological morbidity in a clinical oncology setting, ensuring comprehensive assessment alongside routine cancer care services. A total of 85 patients diagnosed with breast cancer were included in the study. Patients were selected irrespective of cancer stage, treatment modality, or disease duration. All participants were adult females who were aware of their diagnosis and capable of providing reliable responses during psychiatric evaluation.

Inclusion and Exclusion Criteria

Patients aged 18 years and above with histopathologically confirmed breast cancer were included. Participants who provided informed consent and were able to comprehend and respond to assessment tools were recruited. Patients with a prior history of major psychiatric disorders diagnosed before the onset of breast cancer, those with severe cognitive impairment, neurological disorders, or critically ill patients unable to participate were excluded from the study.

Methodology: A consecutive sampling method was used to recruit eligible patients attending the oncology outpatient and inpatient departments. This approach ensured that all patients meeting inclusion criteria during the study period were considered, minimizing selection bias and providing a representative sample of breast cancer patients in the tertiary care setting.

Data were collected through structured interviews conducted in a private and comfortable clinical setting. Sociodemographic variables such as age, marital status, educational level, occupation, socioeconomic status, and family support were recorded. Clinical variables included stage of breast cancer, duration since diagnosis, type of treatment received (surgery, chemotherapy, radiotherapy, hormonal therapy), presence of metastasis, comorbid medical conditions, and pain severity.

Psychiatric evaluation was performed using standardized and validated screening tools. Depression and anxiety symptoms were assessed using commonly accepted scales such as the Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder scale (GAD-7). Stress levels were evaluated using perceived stress

measures, while overall psychological distress was assessed using appropriate screening instruments. In addition, a clinical psychiatric interview based on standard diagnostic criteria was conducted to confirm psychiatric diagnoses.

Psychosocial variables including social support, coping mechanisms, body image disturbance, fear of disease progression, and treatment-related side effects were assessed. Sleep disturbances, fatigue levels, and quality of life indicators were also recorded. Substance use history, adherence to cancer treatment, and impact on daily functioning were evaluated to understand broader mental health implications.

Statistical Analysis: Data were entered into a structured database and analyzed using appropriate statistical software. Descriptive statistics such as mean, standard deviation, frequencies, and percentages were used to summarize sociodemographic and clinical variables. Inferential statistics were applied to assess associations between psychiatric morbidity and clinical or demographic factors, with significance levels determined using appropriate statistical tests.

RESULTS

Table 1 shows the sociodemographic characteristics of the study participants. The largest proportion of patients belonged to the 50–59 years age group, comprising 31 patients (36.47%), followed by patients aged 60 years and above, who accounted for 22 patients (25.88%). Patients in the 40–49 years age group constituted 20 cases (23.53%), while the least represented group was those aged below 40 years, with 12 patients (14.12%). This indicates that breast cancer patients in the present study were predominantly middle-aged to elderly. With regard to marital status, the majority of participants were married, numbering 63 (74.12%), whereas 15 patients (17.65%) were widowed, separated, or divorced, and only 7 patients (8.24%) were unmarried.

In terms of educational status, 38 patients (44.71%) had studied up to the primary or secondary level, making this the most common educational category. Twenty-eight patients (32.94%) were graduates or had education above the graduate level, while 19 patients (22.35%) had no formal education. These findings suggest that although a fair proportion of the patients had at least basic schooling, a considerable number still had limited or no formal education. Regarding occupation, the majority of the participants were homemakers, accounting for 58 cases (68.24%), while 17 patients (20.00%) were employed and 10 (11.76%) were retired. This indicates that most women in the study were not engaged in formal paid employment, which may have implications for dependency, caregiving roles, and psychosocial stressors. Socioeconomic distribution revealed that 43 patients (50.59%) belonged to the middle socioeconomic class, 29 (34.12%) were from the lower socioeconomic class, and 13 (15.29%) were from the upper socioeconomic class. Family support was reported as adequate by 49 patients (57.65%), whereas 36 patients (42.35%) experienced inadequate family support.

Table 2 summarizes the clinical characteristics of the breast cancer patients. The most common stage of disease at presentation was Stage III, seen in 31 patients (36.47%), followed by Stage II in 28 patients (32.94%). Stage IV disease was present in 15 patients (17.65%), while Stage I disease was the least common, noted in 11 patients (12.94%). These findings suggest that a large proportion of the study population had relatively advanced breast cancer, with Stage III and Stage IV together accounting for more than half of the cases. With respect to treatment modality, 29 patients (34.12%) had undergone surgery combined with

chemotherapy, which was the most frequent treatment pattern. Twenty patients (23.53%) received a combination of surgery, chemotherapy, and radiotherapy, while 18 patients (21.18%) each were on chemotherapy alone and hormonal or targeted therapy combinations.

Metastatic disease was present in 24 patients (28.24%), whereas 61 patients (71.76%) had no metastasis. Thus, although the majority had non-metastatic disease, more than one-fourth had evidence of metastatic spread, which may increase psychological burden. Medical comorbidities were documented in 34 patients (40.00%), while 51 patients (60.00%) had no associated medical illness, indicating that a substantial minority were dealing with additional physical health problems alongside breast cancer. Pain severity assessment revealed that 45 patients (52.94%) had moderate to severe pain, while 40 (47.06%) reported mild pain or no pain. This suggests that pain was a significant issue in more than half of the sample. Sleep disturbance was present in 37 patients (43.53%) and absent in 48 patients (56.47%), showing that disturbed sleep affected a large proportion of breast cancer patients and may have contributed to emotional and functional impairment.

Table 3 describes the prevalence and pattern of psychiatric illness among the participants. Out of the 85 patients studied, 46 were found to have some form of psychiatric illness, giving an overall prevalence of 54.12%, while 39 patients (45.88%) had no psychiatric illness. This means that more than half of the breast cancer patients in the present study were suffering from a diagnosable psychiatric condition, highlighting the substantial mental health burden in this population. Among the various diagnoses, depressive disorder was the most common and was identified in 16 patients (18.82%). Anxiety disorder was the second most frequent diagnosis, present in 11 patients (12.94%), followed by mixed anxiety-depressive disorder in 9 patients (10.59%). Adjustment disorder was observed in 6 patients (7.06%), and insomnia disorder in 4 patients (4.71%).

Table 4 presents the severity distribution of psychiatric symptoms based on screening scales. For depressive symptoms, 49 patients (57.65%) fell in the normal range, 17 patients (20.00%) had borderline or mild depressive symptoms, and 19 patients (22.35%) had clinically significant depressive symptoms. Thus, nearly one in every five patients had mild depressive symptoms and more than one-fifth had depression severe enough to be considered clinically significant. Regarding anxiety symptoms, 52 patients (61.18%) were in the normal range, 15 patients (17.65%) had borderline or mild anxiety, and 18 patients (21.18%) had clinically significant anxiety symptoms. This shows that anxiety, similar to depression, was a common psychological problem in this population. In relation to overall psychological distress, 39 patients (45.88%) had no distress, 24 patients (28.24%) had mild to moderate distress, and 22 patients (25.88%) had severe distress.

Table 5 evaluates the association between psychiatric illness and selected clinicopsychosocial variables. Psychiatric illness was present in 14 out of 32 patients aged 50 years or below (43.75%) and in 32 out of 53 patients aged above 50 years (60.38%). Although psychiatric morbidity was numerically higher in the older age group, the association was not statistically significant ($p = 0.206$). This suggests that age alone did not have a significant influence on psychiatric illness in this study population. In contrast, stage of disease showed a statistically significant association with psychiatric morbidity. Among patients with early-stage disease (Stage I–II), psychiatric illness was present in 16 of 39 cases (41.03%), whereas among

those with advanced-stage disease (Stage III–IV), psychiatric illness was present in 30 of 46 cases (65.22%). The p value of 0.044 indicates that psychiatric morbidity was significantly more common in patients with advanced disease.

Metastasis also showed a strong and statistically significant association with psychiatric illness. Among patients without metastasis, 27 out of 61 (44.26%) had psychiatric illness, while among those with metastasis, 19 out of 24 patients (79.17%) had psychiatric illness. The p value of 0.008 confirms that this difference was statistically significant. This finding suggests that metastatic spread of disease markedly increases psychological vulnerability, likely because of increased fear, disability, treatment complexity, and uncertainty regarding survival. Pain severity was another significant factor. Psychiatric illness was present in only 15 of 40 patients (37.50%) with mild or no pain, compared to 31 of 45 patients (68.89%) with moderate to severe pain. This association was statistically significant (p = 0.007), indicating that uncontrolled or severe pain may substantially contribute to the development or worsening of psychiatric symptoms. Similarly, family support demonstrated a highly significant association with psychiatric illness. Among patients with adequate family support, 19 of 49 (38.78%) had psychiatric illness, whereas among those with inadequate family support, 27 of 36 patients (75.00%) had psychiatric illness. The p value of 0.002 shows a strong statistically significant relationship.

Table 1. Sociodemographic profile of study participants (n = 85)

Variable	Category	Frequency (n)	Percentage (%)
Age group	<40 years	12	14.12
	40–49 years	20	23.53
	50–59 years	31	36.47
	≥60 years	22	25.88
Marital status	Married	63	74.12
	Widowed/Separated/Divorced	15	17.65
	Unmarried	7	8.24
Educational status	No formal education	19	22.35
	Primary/Secondary	38	44.71
	Graduate and above	28	32.94
Occupation	Homemaker	58	68.24
	Employed	17	20.00
	Retired	10	11.76
Socioeconomic status	Lower	29	34.12
	Middle	43	50.59
	Upper	13	15.29
Family support	Adequate	49	57.65
	Inadequate	36	42.35

Table 2. Clinical characteristics of breast cancer patients (n = 85)

Variable	Category	Frequency (n)	Percentage (%)
Stage of breast cancer	Stage I	11	12.94
	Stage II	28	32.94
	Stage III	31	36.47
	Stage IV	15	17.65
Treatment modality	Surgery + Chemotherapy	29	34.12
	Chemotherapy alone	18	21.18
	Surgery + Chemotherapy + Radiotherapy	20	23.53
	Hormonal/Targeted therapy combination	18	21.18
Metastasis	Present	24	28.24
	Absent	61	71.76
Medical comorbidity	Present	34	40.00
	Absent	51	60.00
Pain severity	Mild/None	40	47.06
	Moderate/Severe	45	52.94
Sleep disturbance	Present	37	43.53
	Absent	48	56.47

Table 3. Prevalence and pattern of psychiatric illness among breast cancer patients (n = 85)

Psychiatric status / diagnosis	Frequency (n)	Percentage (%)
Any psychiatric illness present	46	54.12
No psychiatric illness	39	45.88
Depressive disorder	16	18.82
Anxiety disorder	11	12.94
Mixed anxiety-depressive disorder	9	10.59
Adjustment disorder	6	7.06
Insomnia disorder	4	4.71

Table 4. Distribution of psychiatric symptom severity on screening scales (n = 85)

Screening domain	Category	Frequency (n)	Percentage (%)
Depressive symptoms	**Normal**	49	57.65
	Borderline/Mild	17	20.00
	Clinically significant	19	22.35
Anxiety symptoms	**Normal**	52	61.18
	Borderline/Mild	15	17.65
	Clinically significant	18	21.18
Overall psychological distress	**Absent**	39	45.88
	Mild to Moderate	24	28.24
	Severe	22	25.88

Table 5. Association of psychiatric illness with selected clinicopsychosocial variables (n = 85)

Variable	Category	Psychiatric illness present n (%)	Psychiatric illness absent n (%)	p value
Age	**≤50 years (n=32)**	14 (43.75)	18 (56.25)	0.206
	>50 years (n=53)	32 (60.38)	21 (39.62)	
Stage of disease	**Stage I–II (n=39)**	16 (41.03)	23 (58.97)	0.044*
	Stage III–IV (n=46)	30 (65.22)	16 (34.78)	
Metastasis	**Absent (n=61)**	27 (44.26)	34 (55.74)	0.008*
	Present (n=24)	19 (79.17)	5 (20.83)	
Pain severity	**Mild/None (n=40)**	15 (37.50)	25 (62.50)	0.007*
	Moderate/Severe (n=45)	31 (68.89)	14 (31.11)	
Family support	**Adequate (n=49)**	19 (38.78)	30 (61.22)	0.002*
	Inadequate (n=36)	27 (75.00)	9 (25.00)	

*Statistically significant.

DISCUSSION

In the present study, most patients were middle-aged or elderly, with 36.47% in the 50–59 year group and 25.88% aged ≥60 years, while 74.12% were married, 44.71% had primary/secondary education, and 68.24% were homemakers. This broadly agrees with the profile reported by Kissane et al. (1998), who studied 303 women with early-stage breast cancer with a mean age of 46 years and showed that psychosocial burden was concentrated in women who were still socially and familiarly active; however, our cohort appears somewhat older and more socially dependent, which may partly explain the higher emotional burden seen in our sample. The large proportion of homemakers and women with only basic education in our study may also indicate greater economic and caregiving dependency, making adaptation to cancer more difficult in a tertiary-care setting.[7]

Clinically, our patients had a substantial burden of disease, with Stage III disease in 36.47%, Stage IV disease in 17.65%, metastasis in 28.24%, moderate to severe pain in 52.94%, and sleep disturbance in 43.53%. This suggests that more than half of the sample was dealing with advanced local or metastatic disease and significant symptom load. Fallowfield et al. (1990) reported that treatment policy and the manner in which treatment decisions were made influenced psychiatric morbidity in women with early breast cancer, and women undergoing breast conservation generally had less psychiatric morbidity than those undergoing mastectomy or less participatory decision pathways. Compared with that earlier early-stage cohort, our patients appear more clinically complex because many were receiving multimodal treatment and were already in advanced stages, which likely increased both physical symptom burden and vulnerability to psychiatric illness.[8]

The overall prevalence of psychiatric illness in our study was 54.12% (46/85), which is high and indicates that more than half of the breast cancer patients had a diagnosable psychiatric condition. This rate is somewhat higher than that reported by Kissane et al. (2004), who found an overall DSM-IV psychiatric diagnosis in 45.00% of women with early-stage breast cancer and 42.00% of women with advanced breast cancer, with no statistically

significant difference between the two groups. Our higher prevalence may reflect the fact that our sample combined substantial psychosocial adversity with a higher proportion of advanced-stage disease, pain, and inadequate family support. Nevertheless, both studies consistently show that psychiatric morbidity in breast cancer patients is common enough to warrant routine mental health screening as part of standard oncologic care.[9]

With regard to the pattern of psychiatric diagnoses, depressive disorder was the most common diagnosis in our study (18.82%), followed by anxiety disorder (12.94%), mixed anxiety-depressive disorder (10.59%), adjustment disorder (7.06%), and insomnia disorder (4.71%). This pattern is comparable to that reported by Burgess et al. (2005), who observed that nearly 50.00% of women with early breast cancer had depression, anxiety, or both during the first year after diagnosis, with a point prevalence of 33.00% at diagnosis that fell to 15.00% after one year; 45.00% of women with recurrence again experienced depression, anxiety, or both. Our findings similarly place depressive and anxiety-spectrum disorders at the center of psychiatric morbidity, although our cross-sectional prevalence figures are lower than Burgess et al.'s first-year cumulative burden, likely because their cohort specifically captured the period around diagnosis and recurrence, when emotional symptoms are known to peak.[10]

The screening-scale findings in our study further support the presence of considerable emotional morbidity. Clinically significant depressive symptoms were seen in 22.35% and clinically significant anxiety symptoms in 21.18% of patients, while 25.88% had severe overall psychological distress and another 28.24% had mild to moderate distress. These results are close to the observations of Hegel et al. (2006), who found that 41.00% of newly diagnosed breast cancer patients rated distress in the clinically significant range on the Distress Thermometer and 47.00% screened positive for one or more distress or psychiatric disorder measures; they also reported major depression in 11.00% and post-traumatic stress disorder in 10.00% of patients. Compared with that presurgical cohort, our patients demonstrated a similarly high burden of distress, but with a somewhat greater proportion showing severe distress, probably because our sample included many women with ongoing treatment, pain, and advanced disease rather than only newly diagnosed cases.[11]

In our study, psychiatric illness was more frequent in women aged >50 years (60.38%) than in those aged ≤50 years (43.75%), but this difference was not statistically significant (p=0.206). This differs somewhat from the findings of Compas et al. (1999), who studied 80 women aged 36–80 years with newly diagnosed breast cancer and found that age was negatively correlated with anxiety/depression near the time of diagnosis, meaning younger women had greater emotional distress initially; however, that age effect was no longer significant at 3 and 6 months. This comparison is important because it suggests that the effect of age may vary with the phase of illness. Our lack of significant association may therefore reflect the mixed clinical stages and treatment phases in our sample, where disease severity and social factors may have overshadowed age as an independent predictor.[12]

A major finding of our study was the significant association of psychiatric illness with disease severity. Psychiatric morbidity was present in 65.22% of patients with Stage III–IV disease compared with 41.03% in Stage I–II disease (p=0.044), and in 79.17% of those with metastasis compared with 44.26% without metastasis

(p=0.008). This indicates that progression of disease markedly increased psychological burden in our sample.

Pinder et al. (1993), in a study of 139 women with advanced breast cancer, found that 25.00% were probable cases of anxiety and/or depression on the HADS, and clinical depression was significantly more common among those in lower socioeconomic classes and with poor performance status. Although the absolute prevalence in our study is higher, both studies support the same interpretation: as disease becomes more advanced and function worsens, the risk of psychiatric morbidity rises appreciably.[13]

Pain severity and family support emerged as especially important correlates in our study. Psychiatric illness was present in 68.89% of patients with moderate/severe pain compared with 37.50% in those with mild or no pain (p=0.007), and in 75.00% of patients with inadequate family support compared with 38.78% among those with adequate family support (p=0.002). These findings are strongly supported by Lueboonthavatchai et al. (2007), who reported anxiety disorder in 16.00%, anxiety symptoms in 19.00%, depressive disorder in 9.00%, and depressive symptoms in 16.70% of 300 breast cancer patients, and showed that poor family relationship/functioning, maladaptive coping, pain, and fatigue were significant predictors of anxiety and depression. Thus, our data and older literature both indicate that psychiatric morbidity in breast cancer is shaped not only by tumor burden but also by symptom severity and the quality of the family environment, underscoring the need for psycho-oncologic care that includes pain control and family-based support.[14]

CONCLUSION

In conclusion, psychiatric illness was highly prevalent among breast cancer patients in this tertiary care hospital, affecting more than half of the study population. Depressive and anxiety disorders were the most common psychiatric conditions identified. Psychiatric morbidity was significantly associated with advanced stage of disease, metastasis, greater pain severity, and inadequate family support. These findings highlight the need for routine psychiatric screening and integrated psychosocial care as an essential part of comprehensive breast cancer management.

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