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Exploring the Perceived Impact of Stigma on the Cancer Experience of People with Severe Mental Illness.

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Abstract

Purpose

People with severe mental illness (SMI) experience disparities in cancer care, including delayed diagnosis, poorer symptom management, and reduced quality of life. This study aimed to explore the lived experiences of individuals with SMI who have also been diagnosed with cancer.

Methods

A qualitative, grounded theory study was conducted with 11 adults in England with lived experience of both SMI and cancer. Participants were recruited via NHS and voluntary organisations. Semi-structured interviews, conducted via telephone or video call were transcribed verbatim. Coding progressed through initial, focused and theoretical coding alongside constant comparative methods and memoing.

Results

Stigma emerged as a main theme, derived through participant explanations of limited information sharing, restricted involvement in decision making, and the misattribution of physical symptoms to mental illness. These perceived forms of stigma contributed to delays in cancer diagnosis, reduced opportunities for informed decision making, and feelings of disempowerment. Collectively, they reinforced existing health inequities and negatively affected participants' mental and physical wellbeing throughout their cancer care and beyond.

Conclusions

Structural and public stigma intersect, resulting in health-related stigma, creating barriers across cancer care pathways for people with SMI. Stigma may compromise quality care and contribute to poorer clinical and experiential outcomes in people with cancer and SMI.

Implications for Cancer Survivors

Interventions are needed to reduce stigmatising behaviours and beliefs in healthcare settings, to distribute power within clinical settings, and promote shared, person-centred decision making to ensure comprehensive information provision and recognition of patient expertise. Collectively, these actions may improve early diagnosis, cancer symptom management, recovery, and overall quality of life for cancer survivors with SMI.

Keywords

Cancer, comorbidity, diagnostic overshadowing, severe mental illness, stigma

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Introduction

The term severe mental illness (SMI) remains contested within the literature [1], and the absence of an agreed definition [2] led this study to adopt a working description based on seminal papers [3-4]. For the purposes of this research, *SMI refers to experiencing emotional, behavioural, or mental health problems, other than addiction or developmental issues, that substantially limit one or more major life activities and have a service duration of two years or more. Individuals should also be accessing services related to their mental health.*

Individuals with SMI face a significantly reduced life expectancy, living on average 15 years less than the general population [5]. Premature mortality among people with SMI is driven largely by cancer, cardiovascular disease, liver disease, and respiratory conditions [6]. Disparities are experienced across the cancer trajectory, where people with SMI are less likely to receive optimal treatment and are more likely to experience increased interruptions and delays to treatment [7]. People with a pre-existing SMI are also known to present unique cancer survivorship challenges [8]. Stigma further compounds these inequalities. Individuals with SMI are known to experience discrimination, marginalisation, and stereotyping, all of which limit access to employment, stable housing, supportive relationships and high-quality healthcare [9, 10, 11] Stigmatising experiences are also recognised within cancer care more broadly [12] and individuals report fears of judgement, tendencies to conceal their diagnosis, and delays in seeking care, all of which can negatively influence treatment engagement and psychosocial wellbeing [12]. This evidence indicates that stigma in cancer care is an existing and systemic concern, which may be further exacerbated when a pre-existing SMI is also present.

People living with comorbid mental and physical health conditions experience multiple forms of stigma that shape their healthcare experiences and outcomes. A consistent finding within the existing literature is that people with SMI experience stigma in relation to how physical symptoms are perceived and treated in healthcare [13-14]. The misattribution or dismissal of physical symptoms, describes the concept of diagnostic overshadowing, which is recognised as an attributing factor to underdiagnosis and undertreatment of physical illness in people with mental illness [15]. Despite growing recognition of these inequalities, there remains limited research exploring how stigma is experienced by people living with SMI and cancer, particularly from a lived experience perspective.

It is important to also recognise that the stigma associated with SMI, in the context of cancer care does not occur in isolation, and there is a growing body of evidence focused on how a number of social and structural categories also interact, further compounding health disparities [16]. There is emerging literature in both physical and mental health to demonstrate that people who experience multiple intersecting societal and structural categories, such as socioeconomic status, ethnicity, gender, often encounter more complex and intensified forms of stigma within healthcare settings. Although intersectionality was not a specific focus of the current study, this perspective is relevant in interpreting how stigma might be experienced among people with SMI and cancer, and highlights the importance of considering intersectionality in future research.

In this study, people with SMI and cancer specifically described challenges in healthcare settings that might be attributed to stigma. Although such challenges are often described in the literature as diagnostic overshadowing, communication barriers, or reduced shared decision making, they collectively reflect established mechanisms of stigma within healthcare settings. Negative attitudes, assumptions, and a lack of awareness among health and care staff are known to contribute to stigma within healthcare environments. This can result in poorer experiences and outcomes for people with cancer and pre-existing SMI [17] and stigma may therefore have a role in the elevated mortality seen among this population [18]. Although stigma is recognised as a major barrier to high quality care [19], interventions to address it remain insufficient, highlighting the importance of understanding and tackling health-related stigma for individuals with SMI and cancer.

Stigma operates across several interrelated levels that can influence how individuals are treated within health and care systems. *Structural stigma* is embedded in organisational norms, policies, and routine practices [20] that disadvantage people with pre-existing mental health conditions [21]. *Public stigma* reflects the broader cultural stereotypes and negative assumptions circulating within society [20], which shape how health professionals may perceive and interact with those accessing care [21]. These processes may create and sustain power imbalances in clinical encounters, enabling decisions to be made about people rather than in partnership with them. Such mechanisms align with Link and Phelan's conceptualisation of stigma as the convergence of labelling, stereotyping, separation, status loss, and discrimination within contexts of social power [22]. Scambler's (2009) analysis of health-related stigma [23] offers further insight into how these dynamics operate. He differentiates between enacted stigma - the discriminatory treatment individuals experience, and felt stigma - the shame, fear of rejection and heightened vulnerability produced by stigma. Importantly, both forms are rooted not only in individual prejudice in the form of *public stigma* but in broader social hierarchies and power relations in the form of *structural* stigma. This distinction reinforces the interplay between public and structural stigma in that societal beliefs generate stereotypes that influence interpersonal behaviour, while health system structures may allow such patterns to be reproduced and sustained.

However, while these frameworks emphasise the role of social and structural power in producing stigma, there remains limited exploration and understanding of how intersectional social categories shape healthcare experiences, including SMI. This gap limits understanding of how multiple overlapping inequalities may compound stigma within cancer care pathways. Therefore, it is vital to understand the experiences of people living with both cancer and SMI directly from those with lived experience. Their accounts offer insight into how stigma, discrimination, and systemic barriers can shape care at every stage from recognising symptoms to navigating treatment and survivorship. Lived experience provides knowledge that is often absent from clinical or policy perspectives, and through greater consideration may contribute to a reduction in stigmatising behaviours and beliefs that impact on people with SMI and cancer.

Methods

Study Aim

This study aimed to provide a theoretical analysis of how individuals with a pre-existing SMI perceive their needs when they are diagnosed with, receive treatment and live with and beyond cancer.

Study Design

A constructivist grounded theory approach was employed [24]. The study design was shaped by patient and public involvement (PPI). PPI contributed to the design and modification of the study, including the development of study materials. Initial feedback was sought from mental health professionals and cancer professionals who reviewed study documents and advised on terminology and content. This was followed by consultation with two PPI groups who provided input into the recruitment materials, interview topic guide and the recruitment strategy. Contributors included people with lived experience of cancer and of SMI. Modifications were made to language and formatting as a result of the feedback.

Data Collection

Recruitment involved purposive sampling of adults (≥18 years) in England with lived experience of both SMI and cancer through engagement with health services and voluntary organisations specialising in cancer or mental health. Eligible participants had a SMI lasting more than two years and a clinically confirmed cancer diagnosis made between six months and ten years before the study. Exclusion criteria were: age under 18 years, lack of capacity to provide informed consent, current inpatient status, detention under the Mental Health Act [25], and not living independently. Recruitment materials followed plain-English guidance. Interested individuals were contacted for an initial telephone conversation to explain the study and confirm eligibility; those who consented returned signed forms before an interview was arranged. Interviews lasted between 45 and 90 minutes and were conducted via telephone or video call, depending on the participant's preference. A structured interview guide, tested with patient and public involvement groups, was used. All interviews were recorded and transcribed verbatim. Participants were assigned randomly generated pseudonyms to preserve confidentiality.

Data Analysis

Data were analysed using grounded theory methods, progressing through initial, focused and theoretical coding. Initial coding was performed line by line for the first three transcripts and paragraph by paragraph thereafter, following Charmaz's constructivist approach [24] with adaptations from Glaser and Strauss [26] to emphasise participants' actions and reduce researcher assumptions. Gerund coding captured processes, and in vivo codes retained participants' language; some of these codes were subsequently elevated to subcategories. Constant comparison, recording of written and audio analytical reflections (memoing) and diagramming supported iterative development of concepts [24 -25]. Focused coding consolidated the most prominent initial codes into more abstract categories, and theoretical coding examined relationships between categories. Saturation was judged to have been reached after 11 in depth interviews, defined as the absence of new relevant data for a category, rich development of categories with clear properties and variation, and well-established relationships between categories [26]. Reflexivity was a core component of the study, reflecting the constructivist grounded theory methodology. Reflexivity was embedded through regular supervision meetings and the use of audio and written memoing which facilitated the development on early analytical insights and provided a documented record of the development of categories and sub categories. These processes enabled ongoing critical reflection on assumptions and interpretations to ensure that analysis remained grounded in participants' experiences yet recognised the role of the researcher in the construction of the research findings.

Ethical Considerations

Ethical approval was granted by Sheffield Hallam University (ER5430039), the NHS Health Research Authority London Surrey Research Ethics Committee (20/HRA/3177), and local research and development teams across four participating health organisations. Participants received detailed information sheets, provided written consent prior to interview, and verbally confirmed consent at the start of the interview.

Results

To uphold confidentiality and anonymity and as a requirement of the ethics review process, demographic data collection was minimal. All 11 participants self-identified as white British citizens. The study included individuals who identified as male or female, with the majority identifying as female. Among those who disclosed their age, participants fell within the 30–39, 40–49, 50–59, and 60–69 age groups. No specific details regarding cancer type or SMI diagnosis were collected to reduce the potential for participant recognition as required from the ethics review process, however throughout interviews participants described a range of SMI and cancer diagnoses.

Stigma

Stigma was a main theme from analysis of experiences of people with lived experience of cancer and SMI. This theme was formed from three subcategories of participants' explanations of limited sharing of information, lack of involvement in decision making, and the misattribution of physical symptoms to mental illness. Although described sequentially, each sub category was not expressed as single discrete experiences but as a set of interconnected factors that shaped experiences across the cancer pathway. These factors were reflected in participants' experiences of receiving limited information or the withholding of information, lack of shared decision making and misattribution or dismissal of physical symptoms – diagnostic overshadowing. Collectively these factors illustrate how stigma was encountered within healthcare settings, shaping the experiences of care in the study population. Restricting the information provided limited the ability for people with SMI and cancer to actively participate in informed and shared decision making which may also have been underpinned by diagnostic overshadowing which resulted in delays to recognition of physical symptoms further limiting opportunities for timely sharing of information. Stigma was described through participant encounters of perceived power imbalances between patients and healthcare professionals, where decisions were made with dialogue, appraisal or collaboration. Participants described how diagnostic overshadowing, where physical symptoms were dismissed or attributed to mental illness contributed to delayed cancer diagnoses. Participants reported that their cancer symptom concerns were perceived to be minimised, or their capacity to make decisions was questioned, sometimes without their awareness, which impacted on timely access to treatment, and compassionate care. Through these factors, stigma functioned as an underlying mechanism that structured how people with SMI and cancer experience cancer care. Although this analysis centres on stigma within healthcare structures and practices, it is important to recognise that public stigma toward mental illness also shapes the beliefs and behaviours of health professionals. The negative stereotypes circulating in wider society influence how staff interpret and respond to people with SMI, likely to be a factor in reinforcing the observed inequities in this population. Consequently, the theoretical category of stigma in this study was formed from three interlinked processes of the withholding of information, unequal decision making power, and diagnostic overshadowing.

Withholding of Information

In oncology settings, participants with SMI described receiving limited information or having information withheld about their cancer including details about available treatment options, the sequencing and timing of diagnostic tests and treatments, and potential acute and chronic treatment related sequela. These explanations suggest that information provision was shaped not only by clinical practice processes but also by stigma associated with SMI, which may have influenced assumptions about participants' capacity to understand, process, or act on complex medical information. Although participants emphasised the importance of receiving information tailored to their specific cancer histology and circumstances, they explained that informational needs and preferences were rarely actively discussed. Many explained needing to self-advocate or rely on family members or friends to obtain further information about their diagnosis and treatment. While participants generally assumed that healthcare professionals were acting in their best interests, they described feeling inadequately informed and excluded from decision making processes.

> *"My consultant, I think he was… Yes, I think he was trying to save me from getting more depressed by not telling me the full details… I think it would have been useful to know more about ---. More about, you know, what was going to happen. Not to be sort of kept in the dark." Selina*

Participants reported that they were not provided with comprehensive information about the potential risks and side effects of cancer treatment. This lack of information significantly limited their ability to evaluate options and make informed decisions, leaving them unprepared for the effects of treatment.

> *"… Conversations about what's actually going to happen to my body because you know, I signed a consent form and I wasn't aware of half of the things that were going to happen, but that were going to happen to me and how I would be affected." Maggie*

This participant later explained:

> *"No, it should be a part of where I should be, a massive part of it. I should have been having those conversations at the beginning you know. How could it impact on my relationships and intimacy? It's just not talked about you know." Maggie*

The withholding or minimising of treatment related information sometimes became apparent only after they experienced significant long-term effects. One participant described this sense of belated realisation and a discussion that later took place with a health professional:

> *"…and they reckon it's gone now but it's left me scarred, like…so I'll never be able to have kids and he said that if I needed to get an erection I wouldn't be able to without medical assistance, you know, like pills or something like that. So it's left me where I can't do anything you know what I mean, it's left me like that." Michael.*

These experiences may reflect broader stigma related assumptions within cancer care for people with SMI, particularly regarding the extent to which people with SMI are perceived as able to engage with and retain complex medical information. This outlines that this issue cannot be understood only by the absence of good communication but as a process that is shaped by expectations about the perceived capacity and needs of people with SMI.

Power imbalance in decision making

Participants described a perceived power imbalance in which healthcare professionals retained control over care decisions, limiting patients' ability to actively engage in their treatment. This issue extended beyond immediate decisions to a broader lack of access to the information required for informed choices. The unequal consideration of physical versus mental health needs created additional barriers to shared decision making, with choices sometimes made without participants' input or awareness. These experiences reflect the earlier discussion of health-related stigma, demonstrating how structural and public stigma may shape professional assumptions and behaviour, reinforcing inequitable power dynamics in clinical encounters.

> *"I found out later that the --- care team (cancer) had delayed my surgery because of my mental health." Amanda*

Participants explained how health professionals sometimes presented a single, preferred treatment option without offering opportunities to explore alternatives or fully appraise the efficacy and potential acute or long-term effects. This approach left participants feeling that they were poorly informed and restricted their ability to engage meaningfully in decision making.

> *"They said I had to have surgery… Well, all he said to me when I sat in front of him was, 'I'll give you a better quality of life' and that's all he said." Michael*

> *"Perhaps not, no. Because I think that was just because I'd gone into a sort of trance like state, and it was always offered to me that surgery would cure it was absolutely curable by surgery alone." Judy*

In contrast, one participant described an experience in which she contributed actively to decisions about her treatment plan. Through the presentation of multiple treatment options and sufficient time to discuss these with her health professional, she perceived a sense of control, even though treatment timelines were largely dictated by the healthcare professional and her preferences were assumed. She also reflected positively on interactions with professionals who treated her as an individual, listened attentively, and considered her unique circumstances. These encounters enabled informed, shared decision making and had a beneficial impact on her experience of entering treatment and coping throughout the cancer care pathway.

> *"…and he gave me three choices. He said we could leave it and just watch it because it is very small, which was never an option you know, we discussed it and then something called --- … or we can just have the surgery, and for me I just thought, even with the risks, I've got to have the surgery it's got to be gone… then he said "well I assume you won't want to be operated on over Christmas" he said "to wait until January won't cause any problems", to be honest I would have it over Christmas, but anyway." Jennifer*

The same participant also shared an interaction with a health professional who she felt had treated her like an individual. She felt listened to, empowered, and as though her unique circumstances were understood, enabling her to make informed shared decisions. This had a positive impact on her experience of entering the treatment phase of her cancer and helped her to cope throughout.

> *"People who have a psychiatric diagnosis need listening to you know, and even if a psychiatrist or a medical professional thinks, 'Well I don't actually believe her, but I'll test for it anyway.'" Jennifer*

The negative experiences of perceived power imbalance appeared to originate from a paternalistic approach to care, in which professionals, often intending to protect patients from distress, inadvertently contributed to feelings of disempowerment and mistrust. These findings highlight the critical importance of asset-based care that values the knowledge, priorities, and capabilities that individuals bring to their own care, fostering shared decision making and promoting trust, autonomy, and engagement.

Diagnostic Overshadowing

Participant interviews revealed how diagnostic overshadowing appeared to operate as a mechanism through which stigma shaped clinical interpretation of physical symptoms in the context of a pre-existing SMI. Experiences of dismissal of physical symptoms or interpretation of symptoms through the lens of SMI, was perceived to delay cancer detection and early diagnosis.

In several interviews, participants described how concerns were not investigated, with limited follow-up procedures or safety netting mechanisms. This lack of diagnostic inquiry contributed to feelings of neglect, being unheard, and missed opportunities for early cancer detection. Diagnostic overshadowing, as experienced by participants with coexisting cancer and SMI, was perceived to have serious repercussions on both physical and mental health, extending beyond active treatment.

> *"I think for me, trying to get diagnosed was bad, I think. It took over two years and long before then I had symptoms and other things going on with my body that if they had just investigated, they would have found my tumour…" Maggie*

Participants described prolonged efforts to understand persistent physical symptoms, often over several months, with repeated unsuccessful attempts to access diagnostic investigations contributing to significant delays in cancer diagnosis. Reflecting on her cancer experience, one participant reported repeated dismissal of her symptoms, culminating in her being detained under the Mental Health Act (1983/2007) without medical investigation; the symptoms were later confirmed as cancer-related.

> *"I had a lot of pain in my gut, I was very constipated which was unusual, I've never felt that type of pain before. So, I went to see my GP and he said eat more and do more exercise, I knew there was something wrong, I couldn't even walk and I was telling them that I'm in a lot of pain, I need help…..I was referred to the community --- team and I told them what I've told you and they said --- … I asked him if I could be referred to a*

> *gastroenterologist… the gastroenterologist then looked at me and discharged me back to the GP… So, in November --- I hadn't been eating, I had lost a lot of weight, I'd been sectioned until the Mental Health Act… so I was telling the staff look I'm in a lot of discomfort, a lot of pain but they just kept putting it down to my lack of nutrients." Lisa*

This participant continued to advocate for further investigations, ultimately seeking emergency support that led to her cancer diagnosis. Another participant described her symptoms being disregarded, triggering post-traumatic stress and exacerbating her mental health condition, with dismissal occurring both during the diagnostic phase and later stages of care.

> *"… nobody was listening, I asked for a scan, I asked for an x-ray, I got no investigations whatsoever. So, then I was discharged, and nothing was resolved really…" Lisa*

In some instances, delays persisted even after initial investigations were initiated, leading to prolonged gaps between symptom recognition and definitive diagnostic testing. This indicates that diagnostic overshadowing continues to shape clinical decision making across the diagnostic pathway. For some participants, the severity of these experiences prompted consideration of legal action for medical negligence.

> *"I feel they neglected their duty of care, the gastroenterology team weren't listening to me, they were just told…they did absolutely no tests whatsoever and I think it's criminal…I mean, because my life has been cut short basically". Lisa*

Participants' accounts illustrated that diagnostic overshadowing occurred across multiple encounters with different healthcare professionals, with symptoms either dismissed or attributed to unrelated causes.

> *"Especially the whole like being believed you know, a part of like PTSD as well is that not being believed and especially with a cancer that you know they can't cure you of, so when they did start believing that was real and not all in my head and that's kind of how they've made me feel at times that some of this I've imagined some of this, I definitely haven't you know." Maggie*

These experiences left participants feeling excluded from meaningful participation in their care and reinforced the perception that they were not regarded as equal partners in healthcare decision making.

Discussion

People with SMI and cancer experience perceived health-related stigma, which in turn affects the quality of care they receive, their symptom management, outcomes, and overall wellbeing. This study examined health-related stigma, operating through potential structural mechanisms within healthcare systems and shaped by broader social inequalities, given the widespread negative beliefs about SMI [9]. Healthcare professionals are part of wider society, therefore they may also hold such biases, reinforcing inequities in care and highlighting the ongoing need for research aimed at reducing public stigma. An intersectional lens is also important for the interpretation of these findings. As previously outlined, stigma associated with SMI does not operate in isolation. It is also shaped by broader social and structural inequalities, including those relating to socioeconomic status, gender and other marginalised positions, many of which can be experienced by people with SMI [27]. Evidence suggests that individuals who encounter multiple marginalised positions may experience compounded forms of stigma within healthcare settings. The current study identified stigma operating through mechanisms of diagnostic overshadowing, power imbalance and limited information sharing, yet it is possible that these processes may be experienced differently, and potentially more acutely in people from intersecting underserved groups, that were not represented by the study population. The findings should be interpreted with this consideration.

Stigma in healthcare settings created significant perceived challenges for participants entering cancer care, operating through interrelated mechanisms of withholding of information,, limited shared decision making and diagnostic overshadowing. It is recognised that people with SMI experience poorer cancer care and physical healthcare outcomes, including lower screening uptake, delays in diagnosis, and suboptimal experience of living with long term conditions and survivorship compared to the general population [28, 29, 30, 31, 32]. Previous evidence surrounding healthcare-based stigma often involves negative attitudes, assumptions about recovery, lack of awareness, and avoidance by staff, resulting in less effective treatment and poorer outcomes, which can further compromise survivorship, recovery, and wellbeing [33, 19].

Consistent with previous research [30, 34, 35] stigmatising behaviours and beliefs within the healthcare system may have compromised patient and provider relationships through issues of trust and experiences where symptoms were not taken seriously. The most significant mechanism of health-related stigma described in this study was diagnostic overshadowing, where physical symptoms were misattributed to mental illness [15]. Some participants received late cancer diagnoses, and symptom dismissal continued even post-diagnosis, negatively affecting their ability to manage symptoms and maintain quality of life. Evidence indicates that individuals with

SMI are more likely to be diagnosed with cancer via emergency admissions [36], reinforcing the importance of taking physical symptoms seriously and ensuring safety netting processes are in place [37].

Molloy et al. [38] provide a multidimensional explanation of diagnostic overshadowing, identifying healthcare system limitations, incomplete diagnostic assessment, and misunderstanding of lived experience as contributing factors, alongside service users' uncertainty about whether symptoms are physical or psychological. In contrast, participants in this study were often confident in the physical origin of their symptoms, possibly due to higher health literacy or more advanced disease. However, given reduced cancer screening uptake and help seeking behaviours that are reported among some people with SMI [39], the importance of ensuring physical symptoms are taken seriously, is further reinforced. The findings in this study highlight how clinical interpretations of physical symptoms may be shaped by broader assumptions associated with SMI, reinforcing stigma within healthcare experiences.

Participants also described perceived power imbalances in care. Despite the emphasis on patient autonomy in modern healthcare, paternalistic models of care persist [40]. Limited opportunities for shared decision making and having physical symptoms attributed to mental illness imply patterns of health-related stigma [41 - 42]. These imbalances can affect the quality of cancer care, adherence to treatment, and long-term survivorship experiences that could be improved through increased shared decision making and asset-based approaches to care [42].Withholding of information was another probable manifestation of stigma. Participants highlighted the importance of receiving information tailored to their needs, and in some cases described how comprehensive information sharing was influential on coping, engagement, and management of symptoms. Strong therapeutic relationships and collaborative, asset-based approaches can empower individuals with SMI and improve outcomes, including quality of life and wellbeing [43].

Overall, this study highlights how health-related stigma, may create barriers at multiple points in cancer care for people with SMI. Diagnostic overshadowing, perceived power imbalances, and withholding of information function as interrelated mechanisms through which stigma reinforces inequities, undermines autonomy, and adversely affects both mental and physical health outcomes. Interventions that address stigmatising behaviours and beliefs, and promote collaborative, person-centred care are essential to improving cancer experiences from pre-diagnosis to survivorship, ensuring equitable, high-quality care.

Limitations should be considered when interpreting these findings. Firstly, although efforts were made to recruit a diverse sample through engagement with health services and voluntary sector organisations, all participants in this study identified as White British. This may reflect limitations in the approach taken to recruitment as well as broader structural barriers to research participation among minoritised and underserved groups. The absence of greater diversity may limit the transferability of the research findings, particularly considering the intersecting forms of stigma that may be encountered by people with multiple marginalised positions. Future research should prioritise inclusive and targeted recruitment strategies to better understand how intersecting inequalities influence stigma and healthcare experiences in this population. Secondly, the restrictions imposed by the COVID-19 pandemic meant that all interviews were conducted remotely. While this approach ensured participant safety and accessibility, it reduced opportunities to observe nonverbal communication that might have added further depth to the findings. Thirdly, ethical requirements aimed at safeguarding participant anonymity meant that detailed demographic information, as well as specific cancer and SMI diagnoses, could not be collected. As a result, it was not possible to explore differences across subgroups by cancer or SMI diagnoses, which may have limited the nuance of the analysis. Although the study was not designed to examine subgroup variation, it is recognised that this population is diverse, and future work would benefit from investigating these potential differences more closely. In addition, ethical approval restrictions also prevented the interviewing of individuals who were inpatients or detained under the Mental health Act. This decision was made as a result of practical and ethical considerations including the feasibility of practically undertaking the interviews and complexity surrounding consent. This approach means that people with inpatient experiences of cancer and SMI are not represented within the study. Future research specifically targeting this population would further develop understanding of experiences of stigma in people with cancer and SMI. In addition, the study reflects the perspectives of individuals with lived experience of both SMI and cancer. While these insights offer rich and meaningful understanding of the challenges faced, they represent only one side of the care experience. Future research that incorporates the views of healthcare professionals would help to contextualise and extend these findings, offering a more comprehensive understanding of how best to support this population.

Conclusion

Findings from this study illustrate how health-related stigma, operating within broader systems of structural inequality is perceived to create significant barriers in cancer care for people with SMI, including diagnostic overshadowing, power imbalances in decision making, and the withholding of information. Addressing these challenges requires interventions that redistribute power within clinical settings, promoting shared decision making, and ensuring that patients are fully informed and actively involved in their care. Health professionals should prioritise clear, tailored communication about diagnosis, treatment options, and potential side effects, while healthcare education more broadly must focus on reducing stigmatising behaviours and beliefs by improving understanding of SMI. At a policy level, embedding mechanisms for early recognition of physical symptoms, preventing diagnostic overshadowing, and promoting continuity of care is essential to enable timely intervention and optimal survivorship outcomes. By integrating the perspectives of people with lived experience of SMI and cancer into service design and delivery, healthcare systems can foster trust, enhance engagement, and improve equity, safety, and overall quality of care for this population.

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Author contributions

Laura Charlesworth was involved in the study's conception, design and analysis and writing and critical revision of the article.

Russell Ashmore supervised the design, implementation and analysis of the research and was involved in writing, and critical revision of the article.

All authors read and approved the final manuscript.

Ethical approval

Approval was obtained from Sheffield Hallam University (ER5430039), NHS Health Research Authority London-Surrey Research Ethics Committee (20/HRA/3177) and local research and development teams across four NHS Trusts in England. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

Consent to participate

Informed consent was obtained from all individual participants included in the study, including consent to publish.