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Breast Cancer, Disability, and Caregiving: An Evidence Mapping Review of Psychosocial Needs, Barriers to Care, and Support Interventions

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Abstract

Background: *Women with pre-existing disabilities may experience substantial inequalities across the breast cancer care continuum, including barriers to screening, communication, diagnosis, treatment, and psychosocial support. Although disability-related disparities in breast cancer screening are increasingly recognized, evidence concerning psychosocial needs, caregiver involvement, and supportive adaptations remain fragmented.*

Objective: *This evidence mapping review aimed to identify and conceptually organize research published between 2016 and 2026 addressing breast cancer among women with pre-existing disabilities, with particular attention to psychosocial needs, barriers to care, caregiving, and supportive interventions.*

Methods: *A Focused evidence mapping approach was used to synthesize primary empirical studies relevant to four predefined domains: psychosocial and emotional needs; barriers across screening, diagnosis, treatment, and survivorship; caregiving, advocacy, and supported decision-making; and supportive interventions and person-centred adaptations. Studies were mapped according to disability population, stage of the breast cancer continuum, methodological characteristics, caregiver involvement, and principal findings.*

Results: *The evidence was unevenly distributed across the breast cancer continuum, with research concentrated predominantly on breast awareness and screening and substantially less evidence addressing diagnosis, active treatment, and survivorship. Psychosocial concerns included fear, anxiety, uncertainty, inadequate preparation, communication difficulties, and threats to autonomy. Family members, caregivers, and support workers frequently facilitated access, communication, advocacy, and decision-making, yet their own psychosocial needs were rarely examined. Accessible information, individualized preparation, supported decision-making, navigation, and disability-responsive communication emerged as promising adaptations, although evaluated interventions remained limited.*

Conclusions: *Disability-inclusive breast cancer care requires a shift from a predominantly screening-focused perspective toward accessible, psychologically informed, autonomy-supportive, and caregiver-aware care across the entire cancer trajectory. Future research should prioritize co-designed interventions, post-diagnosis experiences, psychosocial outcomes, and caregiver well-being.*

Keywords: breast cancer; disability; psychosocial needs; caregiving; healthcare accessibility; supported decision-making

Introduction

Breast cancer remains a major public health concern and a leading cause of cancer-related morbidity among women worldwide. Although advances in screening, diagnosis, treatment, and survivorship care have substantially improved outcomes, these benefits are not experienced equally across population groups. Women living with disabilities constitute a particularly important yet frequently underrepresented population within breast cancer research and care. Disability may intersect with cancer across multiple levels, influencing access to preventive services, communication with healthcare professionals, diagnostic pathways, treatment decision-making, psychosocial adjustment, and the capacity to navigate complex healthcare systems (Keegan et al., 2023; Iezzoni, 2022). Recent evidence indicates that disability-related disparities extend beyond screening: women with disabilities may experience later-stage diagnosis, reduced receipt of standard cancer treatments, and poorer outcomes compared with women without disabilities (Keegan et al., 2023; Choi et al., 2025).

Much of the existing literature has focused on breast cancer screening, particularly mammography. Women with disabilities have consistently been shown to experience lower participation in breast cancer screening, although the magnitude and nature of these disparities vary according to disability type and severity (Andiwijaya et al., 2022; Shin et al., 2020). A systematic review and meta-analysis found that women with disabilities had significantly lower odds of participating in breast cancer screening than women without disabilities (Andiwijaya et al., 2022). More recent evidence has similarly identified demographic, clinical, financial, service-related, structural, and accessibility barriers contributing to lower screening participation (Almohammed, 2024). These barriers may include inaccessible mammography equipment, difficulties with positioning or transferring, inadequate appointment time, transportation limitations, communication barriers, and insufficient disability-related knowledge among healthcare professionals (Keegan et al., 2023; Iezzoni, 2022; Almohammed, 2024). Importantly, such barriers should not be understood solely as consequences of individual impairment; they also reflect the extent to which healthcare environments and procedures are designed—or fail to be designed—to accommodate diverse functional, sensory, cognitive, and communication needs.

The challenges encountered by women with disabilities are also psychosocial. Breast cancer screening, diagnostic procedures, and treatment can generate fear, uncertainty, embarrassment, loss of control, and concerns regarding autonomy. These experiences may be intensified when information is inaccessible, procedures are unfamiliar, or healthcare encounters fail to accommodate individual communication and support needs. Research involving women with intellectual disabilities, for example, has identified inadequate preparation and fear of mammography as important barriers, while positive attitudes and support from extended family can facilitate participation (Arana-Chicas et al., 2020). Arana-Chicas et al.'s qualitative study involving 30 women with intellectual disabilities and their caregivers illustrates how screening behaviour is embedded within a wider interpersonal and support context rather than determined by physical accessibility alone (Arana-Chicas et al., 2020).

These findings highlight the importance of moving beyond a narrow understanding of access as physical entry into a healthcare facility. Psychosocial accessibility is also important: women need understandable information, adequate preparation, respectful communication, emotional safety, meaningful involvement in decisions, and recognition of their preferences and autonomy (Iezzoni, 2022; Arana-Chicas et al., 2020). Depending on the nature of disability, standard breast cancer pathways may require adaptations in communication, environmental conditions, procedural preparation, decision support, or continuity of care. Such needs may become even more complex following a cancer diagnosis, when women must navigate surgery, systemic therapy, radiotherapy, follow-up, and survivorship while simultaneously managing a pre-existing disability. Contemporary population-based evidence indicates that disparities persist after diagnosis. In a large Korean cohort of 150,412 women diagnosed with breast cancer, women with disabilities—particularly those with severe disabilities—were more likely to present with distant or unknown-stage disease and were less likely to undergo surgery or receive chemotherapy or radiotherapy; mortality was also significantly higher (Choi et al., 2025).

Within this context, family members and other caregivers may occupy a critical but insufficiently examined position. They may provide emotional reassurance, facilitate communication, arrange appointments and transportation, assist with preparation for procedures, advocate for reasonable accommodations, interpret information, and support treatment decisions. For women with intellectual or developmental disabilities in particular, the involvement of family members, paid carers, or other trusted supporters may influence whether and how breast cancer screening and care are accessed (Arana-Chicas et al., 2020; Swaine et al., 2013). However, caregiver involvement also raises important questions concerning autonomy, supported decision-making, responsibility, and the distinction between facilitating a woman's choices and inadvertently substituting another person's preferences for her own. Consequently, caregiving within disability-inclusive cancer care should be conceptualized not merely as practical assistance but as a relational process situated at the intersection of support, advocacy, communication, autonomy, and healthcare accessibility.

The importance of the family context is well established in the broader breast cancer literature. A recent scoping review by Sørensen et al. examined psychosocial experiences and family support interventions among families living with metastatic breast cancer (Sørensen et al., 2026). The review included 56 studies, of which 46 addressed psychosocial experiences and 10 evaluated family support interventions. Four major thematic areas were identified: emotional and psychosocial challenges; family relationships and communication; role changes and practical burden; and support needs and end-of-life coping. Despite these extensive needs, intervention evidence remained limited and heterogeneous, with most studies reporting feasibility or short-term outcomes rather than sustained effectiveness (Sørensen et al., 2026).

This evidence is highly relevant, yet an important conceptual gap remains. The broader breast cancer caregiving literature primarily examines the consequences of cancer for patients and families, whereas the disability literature has more often concentrated on screening inequalities, healthcare accessibility, and disparities in receipt of care (Keegan et al., 2023; Andiwijaya et al., 2022; Almohammed, 2024). Far less attention has been directed toward the intersection of breast cancer, pre-existing disability, psychosocial needs, and caregiving. As a result, evidence concerning emotional experiences, communication and informational needs, caregiver and support-network roles, advocacy, supported decision-making, and person-centred adaptations remains distributed across different disability populations, stages of

the cancer pathway, and methodological traditions. Moreover, the concentration of research on mammography may obscure what happens after screening: during diagnosis, treatment, follow-up, and survivorship. Recent evidence demonstrating disparities in breast cancer treatment and survival among people with disabilities reinforces the need to extend attention beyond preventive screening alone (Choi et al., 2025; Hansford et al., 2024).

Bringing these strands of evidence together is important for both clinical practice and research. Disability-inclusive breast cancer care requires more than increasing screening uptake. It requires an understanding of how psychological, relational, environmental, organizational, and communication factors interact across the care continuum, and of how formal and informal supporters can facilitate equitable care without compromising autonomy. Mapping the available evidence can therefore clarify where knowledge is concentrated, where supportive approaches have been developed, and where substantial gaps remain.

Accordingly, the present evidence mapping review aims to identify and conceptually organize research published between 2016 and 2026 concerning breast cancer among women with pre-existing disabilities. Specifically, it maps four interconnected domains:

1. psychosocial and emotional needs;
2. barriers encountered across breast cancer screening, diagnosis, treatment, and survivorship;
3. the roles of family members, caregivers, support networks, and advocates, including supported decision-making; and
4. supportive interventions and person-centred adaptations designed to improve accessibility, participation, and psychosocial care. A further objective is to identify areas of evidence concentration and critical research gaps across disability groups and stages of the breast cancer care continuum.

Methods

Review Design

This study employed evidence mapping review approach to identify, organize, and descriptively synthesize the literature at the intersection of breast cancer, pre-existing disability, psychosocial needs, caregiving, and supportive care. Evidence mapping was selected because the available literature is heterogeneous in terms of disability populations, methodological designs, stages of the breast cancer care continuum, and outcomes of interest. Rather than estimating pooled effects or addressing a narrowly defined intervention-effectiveness question, the purpose of the review was to characterize the distribution and nature of the available evidence, identify recurrent conceptual domains, and highlight areas in which empirical research remains limited. The mapping framework was structured around four prespecified and interconnected domains:

1. psychosocial and emotional needs;
2. barriers to breast cancer care;
3. caregiving, advocacy, and supported decision-making;
4. supportive interventions and person-centred adaptations. Evidence was additionally mapped according to the stage of the breast cancer care continuum—screening and prevention, diagnosis, active treatment, and survivorship/follow-up—to determine where evidence was concentrated and where substantive gaps remained.

Review Question and Scope

The review was guided by the following overarching question: What evidence has been published during 2016–2026 concerning the psychosocial needs of women with pre-existing disabilities in the context of breast cancer, the barriers they encounter across the breast cancer care continuum, the roles of family and other caregivers, and interventions or adaptations intended to support accessible and person-centred care? Three complementary questions informed the evidence mapping:

1. What psychosocial and emotional needs and experiences have been reported among women with pre-existing disabilities in relation to breast cancer and breast cancer care?
2. What individual, interpersonal, environmental, organizational, and healthcare-system barriers and facilitators have been identified across screening, diagnosis, treatment, and survivorship?
3. What roles are performed by family members, informal or paid caregivers, support workers, and advocates, and what supportive interventions or person-centred adaptations have been described or evaluated?

The review focused on literature published from January 2016 to August 2026, providing a contemporary 10-year mapping of developments in disability-inclusive breast cancer research.

Information Sources and Search Approach

A structured literature search was undertaken using four major bibliographic sources relevant to medicine, psychology, oncology, disability, and health services research: PubMed/MEDLINE, Scopus, Web of Science Core Collection, and APA PsycINFO. Searches were supplemented by backward reference checking of particularly relevant studies and evidence syntheses and by targeted citation searching to identify additional publications related to the predefined conceptual domains. The search strategy combined three principal concept blocks. The first captured breast cancer and breast health, including terms such as *breast cancer, breast neoplasm, breast carcinoma, mammography, breast screening, and breast health. The second captured pre-existing disability, including disability, intellectual disability, developmental disability, learning disability, physical disability, mobility impairment, sensory disability, visual impairment, and hearing impairment.* The third encompassed the psychosocial and caregiving dimensions of interest and included combinations of terms related to *psychological, psychosocial, fear, anxiety, distress, stigma, embarrassment, autonomy, communication, decision-making, barriers, accessibility, caregiver, carer, family, support worker, advocacy, social support, supportive care, intervention, education, patient navigation*, and *supported decision-making*. The general conceptual structure was: *Breast*

cancer/breast health AND disability AND (psychosocial needs/ barriers OR caregiving/support/intervention).

Search terminology was adapted to the indexing conventions and search functionality of each information source. The purpose of the search was to construct a focused evidence map, rather than to claim exhaustive identification of every publication addressing breast cancer screening or disability more generally.

Eligibility Criteria

Studies were considered eligible when they addressed women with a pre-existing disability in the context of breast cancer or breast health and contributed evidence to at least one of the four domains of the review. Eligible disability populations included women with intellectual or developmental disabilities, learning disabilities, physical or mobility disabilities, cerebral palsy, visual impairment, hearing impairment or deafness, and other clearly defined pre-existing disabilities. Disability arising exclusively because of breast cancer or its treatment was not considered sufficient for inclusion. Studies could address any stage of the breast cancer care continuum, including breast awareness and screening, diagnostic assessment, active treatment, follow-up, rehabilitation, and survivorship. Screening studies were retained only when they provided evidence relevant to psychosocial experiences, barriers or facilitators to care, caregiver involvement, communication, decision-making, or supportive interventions. Studies reporting screening prevalence or utilization alone, without one of these dimensions, were excluded from the core evidence map.

Primary empirical studies employing qualitative, quantitative, mixed-methods, intervention, participatory, observational, or case-study designs were eligible. Studies incorporating the perspectives of family caregivers, informal carers, paid caregivers, support workers, advocates, or healthcare professionals were included when these perspectives directly concerned breast cancer care for women with disabilities. Reviews, systematic reviews, scoping reviews, meta-analyses, meta-syntheses, editorials, commentaries, and other non-primary publications were not incorporated into the primary evidence map. Relevant reviews were, however, used as contextual sources and for citation checking, without being counted as primary evidence. Studies were restricted to those published in English between 2016 and August 2026.

Study Selection and Evidence Verification

Potentially relevant publications were assessed against the predefined eligibility criteria. Attention was given to confirming three elements before inclusion:

- the presence of a pre-existing disability;
- an explicit breast cancer or breast-health context; and
- substantive relevance to at least one psychosocial, access/ barrier, caregiving, or supportive-intervention domain.

Studies were excluded when they addressed cancer populations without separable breast cancer evidence; involved women without a pre-existing disability; conceptualized disability solely as a consequence of cancer or cancer treatment; reported only screening rates or epidemiological associations without relevant psychosocial, caregiving, accessibility, or support findings; or represented secondary evidence rather than primary empirical research. Bibliographic details and study characteristics were checked against the available source records before inclusion in the evidence map. Where multiple publications addressed overlapping populations or research programmes, they were treated as separate sources only when they reported distinct empirical analyses or outcomes relevant to the review questions.

Data Extraction and Evidence Charting

A structured evidence-charting framework was developed to ensure consistent characterization of the included studies. For each study, information was extracted, where available, on the author(s) and year of publication, country and healthcare context, study design and methodological approach, sample size and participant characteristics, type of disability, and stage of the breast cancer care continuum. Data were also extracted regarding the involvement of family members, informal caregivers, paid carers, support workers, or healthcare professionals; psychosocial and emotional needs or experiences; barriers and facilitators to care; caregiver roles and support needs; intervention or supportive-care components; and principal findings relevant to the review questions. The resulting evidence matrix formed the basis of the descriptive and conceptual mapping presented in the Results.

Evidence Mapping and Synthesis

Because of substantial heterogeneity in study populations, disability types, designs, outcomes, and breast cancer contexts, meta-analysis was neither planned nor considered appropriate. Instead, findings were synthesized through structured descriptive mapping. Each study was mapped against the four prespecified domains: psychosocial and emotional needs; multidimensional barriers to care; caregiving, advocacy and supported decision-making; and supportive interventions/ person-centred adaptations. Individual studies could contribute to more than one domain when their findings crossed conceptual boundaries. A second mapping dimension classified evidence according to the breast cancer care continuum: screening/ prevention, diagnosis, active treatment, and survivorship/ follow-up. This matrix-based approach enabled simultaneous examination of both the thematic content and distribution of evidence across stages of care. Attention was paid to recurring concepts such as fear and anxiety, embarrassment and dignity, accessible communication, autonomy, physical and procedural accessibility, healthcare-provider attitudes, caregiver involvement, advocacy, supported decision-making, accessible education, patient navigation, and individualized adaptations. Areas with few or no identified primary studies were retained as evidence gaps rather than interpreted as evidence of absence of need. The mapping process informed the development of Figure 1, which visually summarizes the relationship between the four principal evidence domains and their distribution across the breast cancer care continuum.

Figure 1: Evidence map of research on breast cancer, disability, psychosocial needs, caregiving, and supportive care across the breast cancer continuum (2016–2026)

Evidence domain	Screening / Prevention	Diagnosis	Active Treatment	Survivorship / Follow-up
Psychosocial & Emotional Needs	●●●	●●	●	●
Barriers to Care	●●●	●●	●●	●
Caregiving, Advocacy & Support Networks	●●●	●	●●	●
Supportive Interventions & Person-Centred Adaptations	●●●	●	●	○

Legend:
●●● = high concentration of evidence
●● = moderate concentration of evidence
● = limited evidence
○ = little or no direct evidence

Figure note: Evidence is predominantly concentrated in the screening/prevention stage, particularly regarding barriers to care and psychosocial experiences. Evidence becomes progressively more limited across diagnosis and active treatment, while survivorship/follow-up represents the most substantial research gap. Caregiving, advocacy, supported decision-making, and person-centred adaptations are represented primarily in screening-related studies, with comparatively limited empirical investigation across later stages of the breast cancer care continuum.

Methodological Quality and Interpretation

The principal objective of an evidence map is to characterize the distribution, nature, and gaps of an evidence base, rather than to generate pooled estimates of effectiveness. Accordingly, findings were interpreted descriptively and in relation to the methodological characteristics and scope of individual studies. Greater interpretive weight was not automatically assigned because of study frequency alone, as clusters of publications may reflect research concentration rather than greater clinical importance. Similarly, areas in which relatively few studies were identified, particularly active treatment, survivorship, caregiver psychological outcomes, and disability-specific psychosocial interventions—were interpreted as under-researched areas requiring further investigation, rather than as evidence that these needs or challenges are uncommon.

Study	Country	Population / disability	Sample	Design / method	Breast cancer context	Caregiver / support involvement	Main mapped findings	Domain*
(Saleeby & Hunter-Jones, 2016)	USA	Women with physical, mobility, sensory, and developmental disabilities	Women with disabilities†	Participatory qualitative research	Breast health services / screening	Support systems considered within service access	Attitudinal, environmental, financial, and structural barriers were identified; facilitators included accessible facilities and equipment, improved information, and professional education.	B, D
(Peters & Cotton, 2016)	Australia	Women with physical disabilities	12	Qualitative interviews	Mammography / screening	Healthcare professionals	Inaccessible or inflexible equipment, positioning difficulties, and service-process barriers were prominent; individualized care and reduction of physical and emotional discomfort were important.	A, B, D
(Berman et al., 2017)	USA	D/deaf breast cancer survivors	29	Mixed/qualitative survivor study	Diagnosis, treatment, and survivorship	Advocacy and support networks	Communication and information-access difficulties extended across diagnosis, treatment, and recovery, highlighting the need for culturally and linguistically accessible cancer support.	A, B, D
(Nandam et al., 2018)	USA	Women with cerebral palsy	118	Prospective cross-sectional survey	Breast cancer screening	Providers / care delivery	Disability-specific barriers affected access to breast cancer screening and highlighted opportunities to improve service delivery for women with cerebral palsy.	B, D
(Reidy et al., 2018)	Ireland	Women with intellectual disabilities	45	Descriptive study	Breast awareness / screening	Not specifically examined	Limited knowledge of breast cancer and screening, together with worry and low confidence, supported the need for accessible education and preparation.	A, B, D
(Kilic et al., 2019)	Türkiye	Women with physical disabilities / wheelchair users	16	Qualitative descriptive study	Breast and cervical cancer screening	Healthcare providers	Physical, service-related, interpersonal, and attitudinal barriers interacted to restrict participation in cancer screening.	A, B
(Bates & Triantafyllopoulou, 2019)	UK	Women with intellectual disabilities	131	Cross-sectional survey	Breast screening	Carers/professionals and decision-support processes	Mental capacity emerged as an important determinant of access, particularly regarding consent, decision-making, and participation in screening.	B, C

(Magasi et al., 2019)	USA	Women with physical disabilities	40 women in formative qualitative phase	Community-based participatory research / programme development	Mammography	Community partners and healthcare providers	Previous stigma and mistreatment, accessibility problems, and limited provider knowledge informed development of the ScreenABLE accessible mammography programme and provider education.	A, B, D
(Arana-Chicas et al., 2020)	USA	Women with intellectual disabilities	30 women with ID and caregivers	In-depth qualitative interviews; thematic analysis	Mammography	Caregivers and extended family	Fear, inadequate preparation, insufficient education, and difficulties obtaining accommodations were barriers, while family support and positive attitudes facilitated screening.	A, B, C, D
(Walsh et al., 2022)	Ireland	Women with mild/moderate intellectual disabilities	25: 14 women with ID, 2 caregivers, 9 HCPs	Qualitative descriptive study; interviews/focus groups	Breast awareness / intervention development	Caregivers and HCPs	Fear of cancer and informational and support needs were identified; a multimodal, practical, person-centred intervention involving caregivers and professionals was recommended.	A, C, D
(Sykes et al., 2022)	UK	Women with learning disabilities	21: 13 women, 3 family carers, 5 paid carers	Q methodology with post-Q-sort interviews	Breast/cervical cancer screening	Family and paid carers	Two perspectives—"Personal choice and ownership" and "Protecting vs. enablement"—highlighted tensions between autonomy, protection, and supported decision-making.	A, B, C, D
(Cooper, 2022)	UK	Woman with learning disability and primary breast cancer	1 case	Case-study evaluation	Screening → diagnosis → surgery → systemic therapy → radiotherapy → endocrine therapy	Family, breast-care nurse, and MDT	Demonstrated the importance of coordinated multidisciplinary care and the breast-care nurse in supporting the patient and family throughout screening and treatment.	B, C, D
(Weise et al., 2024)	Australia	People with intellectual disability / accessible breast screening	14 experts	Three-round modified online Delphi	Screening / service design	Support networks, peer mentors, navigators	Consensus was reached on 52 strategies, including accessible information, support for consent and decision-making, peer mentors, service navigation, and stakeholder capacity-building.	B, C, D

(Adolfsson et al., 2026)	Sweden	Women with intellectual disabilities	11	Qualitative interviews / group interviews	Preventive breast healthcare / mammography	Trusted personal networks	Breast healthcare could evoke embarrassment and fear; familiarity with procedures and supportive personal networks facilitated participation, whereas inadequate support impeded care.	A, B, C
(Aksoy Can et al., 2026)	Türkiye	Women with visual impairment	15	Qualitative descriptive study	Breast self-examination / awareness	Healthcare and educational support	Knowledge limitations and disability-specific barriers influenced breast self-examination; accessible and disability-adapted breast-health education was emphasized.	A, B, D
(Hansford et al., 2026) – case study	Canada	Woman with mild IDD and stage II breast cancer	1 woman + support worker + sister + surgeon; 4 interviews	Critical realist case study	Diagnosis and active treatment	Support worker, sister, and surgeon	Attitudes, relationships, shared decision-making and accessible accommodations, and advocacy influenced receipt of guideline-concordant treatment; specialized patient navigation was proposed.	A, B, C, D
(Hansford et al., 2026) – cohort study	Canada	Women with IDD diagnosed with stage I–III breast cancer	365	Population-based retrospective cohort	Active breast cancer treatment	Family interview examined as a health-system factor	Sociodemographic, clinical, cancer-related, and health-system factors were associated with treatment receipt; family involvement was relevant to surgical treatment decision-making.	B, C
(Wagner et al., 2026)	Austria	Women with mild/moderate intellectual disabilities	17 women + 10 caregivers	Dual-perspective qualitative study	Breast cancer screening	Caregivers	Psychological, social, and structural barriers interacted with self-determination and caregiver support; accessible information, individualized support, and person-centred communication facilitated inclusion.	A, B, C, D

Abbreviations: CP, cerebral palsy; HCP, healthcare professional; ID, intellectual disability; IDD, intellectual or developmental disability; MDT, multidisciplinary team.
Domains: A = Psychosocial and emotional needs; B = Barriers to care; C = Caregiving, advocacy, and supported decision-making; D = Support interventions and person-centred adaptations.

Results

Characteristics and Distribution of Mapped Evidence

The mapped evidence comprised 18 primary publications meeting the predefined conceptual eligibility criteria. The evidence map identified a heterogeneous but coherent body of primary research examining the intersection of breast cancer, pre-existing disability, psychosocial experiences, barriers to care, caregiving, and supportive adaptations. The characteristics of mapped primary studies are summarized in Table 1. The evidence encompassed women with intellectual and developmental disabilities, physical and mobility disabilities, cerebral palsy, visual impairment, and D/deaf women, while several studies additionally incorporated family caregivers, paid carers, support workers, healthcare professionals, or other members of the women's support networks.

The methodological profile of the evidence was diverse but predominantly qualitative. Individual and group interviews, qualitative descriptive approaches, participatory research, Q methodology, case studies, mixed-methods research, intervention studies, Delphi consensus methods, and population-based observational designs were represented. This methodological diversity reflected the breadth of the review question but also limited direct comparison across studies. Rather than examining a common set of outcomes, studies addressed different components of accessibility, psychological experience, caregiver involvement, decision-making, and support.

As shown in Table 1, the distribution of evidence was notably uneven across the breast cancer care continuum. Most studies addressed breast awareness, mammography, or screening, whereas relatively few extended into diagnosis and active oncological treatment. Cooper's case-based analysis and the recent studies by Hansford and colleagues were among the comparatively small number of publications examining experiences and determinants of care following an actual breast cancer diagnosis. Cooper followed the care pathway of a woman with a learning disability across screening, diagnosis, surgery, systemic therapy, radiotherapy, and endocrine therapy, highlighting the coordinating and supportive role of the breast-care nurse. Hansford et al., in turn, examined active breast cancer treatment among people with intellectual or developmental disabilities and demonstrated the importance of relationships, accessible accommodations, advocacy, and shared decision-making.

The caregiver dimension was similarly concentrated within a subset of the mapped evidence. It was particularly prominent in the studies by Arana-Chicas et al., Walsh et al., Sykes et al., Cooper, Weise et al., Hansford et al., and Wagner et al. Across these studies, caregivers and other supporters were not peripheral participants; they frequently constituted an integral component of access to breast cancer care. Their roles included preparing women for procedures, explaining information, facilitating communication, arranging healthcare encounters, providing emotional reassurance, advocating for accommodations, and supporting decision-making.

Four interconnected domains emerged from the mapping process:

1. psychosocial and emotional needs;
2. multidimensional barriers to breast cancer care;
3. caregiving, advocacy, and supported decision-making; and
4. supportive interventions and person-centred adaptations. Importantly, these domains frequently overlapped within individual studies, indicating that psychosocial experience, accessibility, and caregiving should not be understood as independent components of breast cancer care.

Psychosocial and Emotional Needs

Psychosocial and emotional needs were consistently visible across disability groups, although they were more frequently explored through qualitative accounts than measured using standardized psychological instruments. Recurrent experiences included fear, anxiety, embarrassment, uncertainty, insufficient confidence, vulnerability, and concerns regarding autonomy and control. Among women with intellectual disabilities, lack of familiarity with breast healthcare procedures appeared particularly important. Arana-Chicas et al. identified inadequate preparation and fear of mammography as barriers to participation, while family support and positive attitudes toward screening could facilitate attendance. The findings suggested that emotional responses to screening were closely connected to women's understanding of what would occur and to the availability of trusted support.

Reidy et al. similarly demonstrated that breast cancer knowledge and emotional responses were interrelated. Women with intellectual disabilities showed substantial gaps in awareness of breast cancer risk factors and screening, alongside worry and limited confidence in recognizing breast changes. Such findings suggest that accessible information is not simply an educational requirement but may also have a psychological function by reducing uncertainty and improving preparedness. Fear and emotional discomfort were not limited to intellectual disability. Studies involving women with physical disabilities described the emotional consequences of inaccessible or poorly adapted screening encounters, including discomfort associated with positioning, dependence on professionals, and previous negative healthcare experiences. For women with visual impairment, difficulties recognizing breast changes and accessing appropriate information similarly interacted with fear and uncertainty.

Evidence from D/deaf women further demonstrated that psychosocial needs cannot be separated from communication accessibility. Difficulties accessing understandable and culturally appropriate cancer information may affect women's sense of control and their ability to participate meaningfully in healthcare encounters. This was particularly apparent in research extending beyond screening into diagnosis, treatment, and survivorship, where communication needs become increasingly complex.

Overall, the mapped literature demonstrates the presence of significant psychosocial concerns but also reveals a major measurement gap. Fear and anxiety were repeatedly described, yet formal assessments of cancer-related distress, depression, resilience, body image, sexuality, quality of life, or psychological adjustment were uncommon. The psychosocial evidence base is therefore richer descriptively than psychometrically.

Multidimensional Barriers to Breast Cancer Care

Barriers identified across the mapped studies operated simultaneously at physical, informational, interpersonal, organizational, and healthcare-system levels. Table 1 demonstrates that accessibility difficulties were reported across multiple disability groups rather than being restricted to a single diagnostic population.

For women with physical or mobility disabilities, environmental and procedural barriers included inaccessible mammography equipment, difficulties standing or maintaining positioning, transferring difficulties, pain, fatigue, and insufficient procedural flexibility. However, the findings indicate that physical accessibility cannot be separated entirely from psychosocial experience. An inaccessible procedure may simultaneously produce physical difficulty, anxiety, dependence, loss of dignity, or reluctance to return for future care. For women with intellectual and developmental disabilities, barriers frequently concerned information, communication, preparation, consent, and inflexible service procedures. Standardized healthcare pathways were not always adapted to cognitive or communication needs. Accessible explanations, additional preparation time, familiar supporters, and individualized procedural adaptations were therefore repeatedly identified as important facilitators.

Healthcare-professional knowledge and attitudes represented another recurrent dimension. Studies involving women and healthcare providers indicated that professionals may have limited preparation for communicating with disabled patients or adapting routine breast healthcare procedures. Consequently, successful access sometimes depended on the flexibility and disability competence of individual professionals rather than on systematically embedded inclusive practices.

The small body of evidence concerning active breast cancer treatment suggests that these difficulties continue beyond screening. Hansford et al.'s critical realist case study is particularly informative because it examined the perspectives of a woman with intellectual/developmental disability, her support worker, her sister, and her surgeon. The study identified attitudes, relationships, shared decision-making and accessible accommodations, and advocacy as interrelated mechanisms influencing receipt of guideline-recommended breast cancer care. The population-based work by Hansford and colleagues further strengthens the argument that access after diagnosis deserves greater attention. Rather than viewing disability-related inequality solely as a screening problem, these findings demonstrate the need to examine actual treatment receipt and the health-system factors influencing treatment pathways.

Thus, a central finding of the evidence map is that accessibility is multidimensional. Physical entry into a screening or oncology service does not necessarily constitute meaningful access. Meaningful access also requires communication accessibility, psychological preparation, procedural flexibility, appropriate accommodation, continuity of support, and opportunities for meaningful participation in healthcare decisions.

Caregiving, Advocacy, and Supported Decision-Making

Caregiving emerged as one of the most conceptually important components of the evidence map, particularly in studies involving women with intellectual or developmental disabilities. Family caregivers, paid carers, support workers, and trusted supporters frequently acted as intermediaries between women and healthcare systems.

In Arana-Chicas et al., caregivers assisted women in navigating mammography and extended-family support emerged as an important facilitator. Walsh et al. similarly incorporated the perspectives of women with intellectual disabilities, caregivers, and healthcare professionals when exploring the development of an accessible breast-awareness intervention. The findings supported multimodal, practical, person-centred education involving not only women themselves but also those who support them.

The most explicit examination of the tension inherent in caregiver involvement was provided by Sykes et al. Their Q-methodology study identified two perspectives characterized as “Personal choice and ownership” and “Protecting vs. enablement.” The findings demonstrate that caregiving can operate in different directions. Supporters may enable access, comprehension, and participation, but a desire to protect women from discomfort or distress may also restrict opportunities for autonomous decision-making.

This distinction is important because caregiver involvement should not automatically be equated with person-centred support. The relevant question is whether caregiving supports the woman's own preferences and decision-making capacity or unintentionally substitutes another person's judgment for her. Supported decision-making therefore emerged as a more appropriate conceptual framework than either complete independence or caregiver-led decision-making.

The treatment-focused evidence reinforces this interpretation. In Cooper's report, family involvement and the breast-care nurse contributed to navigating a complex pathway involving surgery and multiple systemic and local treatments. In Hansford et al., the support worker and sister formed part of the relational network through which communication, accommodation, advocacy, and treatment decisions were facilitated. Recent work by Wagner et al. similar places caregiver support alongside self-determination rather than in opposition to it. The study included women with intellectual disabilities and caregivers and demonstrated the interaction between psychological, social, and structural barriers, individualized support, and women's participation in breast screening.

Across the mapped evidence, however, an important asymmetry was apparent: caregivers were primarily studied in terms of what they did for women with disabilities rather than in terms of their own psychosocial needs. Evidence concerning caregiver burden, anxiety, uncertainty, coping, resilience, quality of life, or formal psychological support was notably limited.

Support Interventions and Person-Centred Adaptations

The evidence map identified a range of supportive approaches, although relatively few had been evaluated through controlled intervention designs. The strongest recurring principle was adaptation of care to the woman rather than expecting the woman to adapt to standardized healthcare systems.

Accessible health information constituted one major intervention category. Approaches included simplified or visual information, multimodal educational materials, repeated explanation, practical preparation for procedures, and communication tailored to specific disability needs. Research involving D/deaf women provides an important example, demonstrating the feasibility of culturally and linguistically tailored breast cancer education rather than reliance on mainstream information designed primarily for hearing populations. For women with intellectual disabilities, Walsh et al. supported a multimodal, hands-on and person-centred educational approach integrating women, caregivers, and healthcare professionals. Such interventions potentially address both informational and psychosocial barriers because better preparation may simultaneously improve understanding and reduce fear or uncertainty.

Weise et al. extended this work from identification of barriers to development of practical strategies. Their Delphi study generated consensus around 52 strategies to improve accessible breast screening for people with intellectual disability. Particularly relevant strategies included accessible information, support for consent and decision-making, peer mentors, service navigators, and stakeholder education and capacity building. These findings provide an important bridge between evidence describing barriers and evidence proposing actionable service responses.

Navigation and advocacy also emerged as promising approaches beyond screening. Hansford et al. suggested that patient navigators with expertise in intellectual and developmental disability may facilitate cancer treatment by coordinating communication, accommodation, and relationships between patients, supporters, and oncology teams.

Nevertheless, a major finding of the map is that recommended adaptations substantially outnumber empirically evaluated interventions. Accessible communication, professional training, caregiver education, longer appointments, individualized preparation, supported decision-making, navigation, and advocacy are repeatedly proposed, but comparatively few studies have evaluated their effectiveness using prospective intervention designs.

Distribution of Evidence Across the Breast Cancer Continuum

When the studies summarized in Table 1 were mapped onto the breast cancer continuum, a pronounced imbalance became evident. Research was concentrated predominantly on awareness and screening, particularly mammography. Diagnosis and active treatment were represented by only a small number of studies, including Cooper and the recent work of Hansford et al., while dedicated research addressing survivorship and long-term psychosocial adjustment was particularly sparse. This imbalance represents an important result. Women with disabilities are predominantly represented in the literature as individuals who must overcome barriers to enter breast cancer care, rather than as women who subsequently experience diagnosis, treatment, recovery, recurrence concerns, survivorship, and the long-term psychological consequences of cancer.

A parallel imbalance was observed in caregiving research. Caregiver involvement was relatively visible in studies of screening access, communication, advocacy, and decision-making, but caregiver-specific psychosocial outcomes and structured caregiver-support interventions were largely absent.

Accordingly, the evidence map identifies two intersecting areas of scarcity: research after breast cancer diagnosis and research addressing caregivers as individuals with their own psychosocial and supportive-care needs.

Overall Evidence Map and Research Gaps

Taken together, the mapped studies indicate that psychosocial needs, barriers to care, caregiving, and supportive adaptations form an interconnected system. Lack of accessible information may increase uncertainty and fear; inaccessible procedures may undermine dignity and autonomy; inadequate professional communication may increase reliance on caregivers; and appropriately structured caregiver involvement may improve communication, advocacy, emotional security, and participation in decision-making.

At the same time, the map reveals several substantial evidence gaps. Psychological constructs are frequently described but rarely measured systematically. Research is heavily concentrated on intellectual disability and screening, with comparatively limited evidence concerning other disability populations and later stages of the cancer trajectory. Active treatment and survivorship remain under-researched, and rigorously evaluated disability-specific psychosocial interventions are scarce. Most notably, caregivers occupy a central practical and relational position in the literature, yet their own emotional burden, coping, resilience, and support requirements remain insufficiently investigated.

The evidence summarized in Table 1 therefore points to a broader conceptual shift. The challenge is not solely to improve mammography participation among women with disabilities, but to develop disability-inclusive, psychologically informed, and caregiver-aware breast cancer care across the entire continuum—from screening and diagnosis to treatment

and survivorship. Future research should move beyond documenting barriers toward evaluating person-centred, disability-responsive interventions that simultaneously promote accessibility, autonomy, psychosocial well-being, and appropriate support for both women and those involved in their care.

Discussion

The present evidence mapping review brings together a fragmented body of literature at the intersection of breast cancer, pre-existing disability, psychosocial experience, caregiving, and supportive care. Four interconnected domains emerged: psychosocial and emotional needs; multidimensional barriers to care; caregiving, advocacy, and supported decision-making; and supportive interventions and person-centred adaptations. Collectively, the findings indicate that inequalities affecting women with disabilities cannot be understood solely in terms of physical accessibility or screening participation. Rather, breast cancer care is shaped by interactions among disability-related needs, emotional responses, communication, healthcare environments, professional practices, autonomy, and formal and informal support (Keegan et al., 2023; Iezzoni, 2022).

A particularly important finding was the uneven distribution of evidence across the breast cancer continuum. Most mapped studies focused on breast awareness, mammography, and screening, whereas comparatively few examined diagnosis, active treatment, psychosocial adjustment, or survivorship. This pattern is consistent with the broader disability and cancer literature, which has historically emphasized inequalities in screening and access to preventive services (Keegan et al., 2023; Iezzoni, 2022; Almohammed, 2024). Consequently, women with disabilities remain better represented in research as individuals attempting to enter cancer services than as women subsequently navigating diagnosis, treatment, recovery, and survivorship. Recent evidence concerning treatment and survival disparities reinforces the need to extend disability-focused research beyond screening alone (Choi et al., 2025; Hansford et al., 2024).

From Physical to Psychosocial Accessibility

Physical and structural barriers remain prominent. Peters and Cotton found that women with physical disabilities encountered environmental, structural, and procedural difficulties during mammography, including problems related to equipment and positioning, and that negative screening experiences could influence willingness to return (Peters & Cotton, 2016). Such findings complement broader evidence showing that people with disabilities may encounter inaccessible diagnostic equipment, inadequate communication accommodation, and healthcare professionals insufficiently prepared to address disability-specific needs (Keegan et al., 2023; Iezzoni, 2022).

The present mapping suggests, however, that accessibility should be understood more broadly as psychosocial accessibility. Physical difficulty may simultaneously generate anxiety, embarrassment, dependency, loss of control, or reluctance to return for further care. Accessible breast cancer care therefore requires not only appropriate facilities and equipment but also understandable information, adequate preparation, respectful communication, emotional safety, and meaningful participation in healthcare decisions.

Arana-Chicas et al. demonstrate this interaction particularly clearly. Their qualitative study of women with intellectual disabilities and caregivers identified inadequate preparation, fear, insufficient education, and difficulties obtaining appropriate accommodations as barriers to mammography, whereas positive attitudes and family support facilitated participation (Arana-Chicas et al., 2020). Similarly, Berman et al. examined 29 D/deaf breast cancer survivors and identified substantial gaps in breast cancer knowledge, communication difficulties in clinical settings, and insufficient access to support and advocacy during diagnosis, treatment, and recovery (Bermanet al., 2017). These findings suggest that accessibility encompasses physical, informational, communicative, relational, and psychological dimensions. The psychosocial evidence remains limited, however, by the relatively infrequent use of standardized psychological measures. Fear, anxiety, uncertainty, embarrassment, and concerns about autonomy recur across qualitative studies, yet cancer-related distress, depression, quality of life, resilience, body image, sexuality, and psychological adjustment have received much less systematic attention. This represents an important gap, particularly after diagnosis, when pre-existing disability may interact with surgery, treatment toxicity, changes in functioning, body image, and uncertainty about recurrence.

Caregiving, Autonomy, and Supported Decision-Making

Caregivers emerged as a central component of disability-inclusive breast cancer care. Family members, paid carers, support workers, and other trusted individuals may facilitate appointments, explain information, prepare women for procedures, provide emotional reassurance, advocate for accommodations, and assist with decision-making. Walsh et al., for example, involved women with mild-to-moderate intellectual disabilities, caregivers, and healthcare professionals in identifying the need for an accessible breast cancer awareness intervention, highlighting the value of multimodal and person-centred educational support (Walsh et al., 2022). Nevertheless, caregiver involvement is not automatically equivalent to person-centred care. Sykes et al. identified two contrasting perspectives, “Personal choice and ownership” and “Protecting vs. enablement”, illustrating the tension caregivers may experience between protecting women from perceived harm and enabling autonomous participation in screening decisions (Sykes et al., 2022). These finding positions supported decision-making as a particularly important principle. The aim should neither be complete independence nor caregiver-controlled decision-making, but the provision of sufficient communication and relational support for women to understand information, express preferences, and participate meaningfully in decisions.

Recent evidence extending into active breast cancer treatment strengthens this interpretation. Hansford et al.'s critical realist case study examined a woman with intellectual/developmental disability with stage II breast cancer together with her support worker, sister, and surgeon. Four themes influenced the treatment experience: attitudes, relationships, shared decision-making and accessible accommodations, and advocacy (Hansford et al., 2026). The authors also identified specialist patient navigation as a potentially useful strategy for improving cancer care for people with intellectual or developmental disabilities.

Population-level evidence now provides further support for examining disability beyond screening. Hansford et al.'s 2026 retrospective cohort study investigated factors associated with breast cancer treatment receipt among women with intellectual or developmental disabilities and showed that sociodemographic, clinical, cancer-related, and health-system factors influenced treatment pathways (Hansford et al., 2026). Together, these findings suggest that caregiver and support-network involvement should be integrated into cancer care in ways that enhance rather than replace women's autonomy.

The Missing Caregiver: Who Supports the Supporter?

One of the clearest gaps identified in the present evidence map concerns caregivers' own psychosocial needs. Within disability-specific research, caregivers are highly visible through what they provide—communication assistance, advocacy, practical support, emotional reassurance, and decision support—but substantially less visible through what they themselves experience.

This contrasts with the broader breast cancer caregiving literature. Sørensen et al.'s 2026 scoping review of families living with metastatic breast cancer identified considerable emotional, relational, and practical challenges for both patients and family members. Of the 56 studies included in that review, 46 addressed psychosocial experiences whereas only ten reported family support interventions, which were heterogeneous and predominantly characterized by feasibility or short-term outcomes (Sørensen et al., 2026). The authors concluded that family support interventions remain limited relative to the complexity and changing nature of families' needs.

This comparison exposes an important intersectional gap. Caregiving may become particularly demanding when a woman receiving breast cancer treatment already requires ongoing disability-related support. Existing caregiving responsibilities may be compounded by oncology appointments, treatment decisions, symptom management, communication with multiple professionals, and increased emotional support. Yet disability-specific breast cancer research provides little evidence concerning caregiver burden, anxiety, depression, coping, resilience, quality of life, preparedness, or unmet psychosocial needs.

Future research should therefore move beyond asking how caregivers enable women with disabilities to access breast cancer care and examine how breast cancer affects caregivers themselves.

From Identifying Barriers to Testing Solutions

Another important finding is the discrepancy between the numerous adaptations recommended in literature and the relatively small number that have been formally evaluated. Accessible information, individualized preparation, flexible procedures, healthcare-professional education, caregiver involvement, advocacy, navigation, and supported decision-making are consistently proposed (Keegan et al., Iezzoni, 2022; Walsh et al., 2022).

Weise et al. provide an important example of translating documented barriers into actionable strategies. Their three-round modified Delphi study with 14 experts achieved consensus on 52 strategies for improving breast screening accessibility for people with intellectual disabilities. Key areas included decision-making and consent, accessible information, peer mentors, service navigators, and equipping relevant stakeholders (Weise et al., 2024).

However, agreement concerning what services should provide is not equivalent to evidence of intervention effectiveness. One important exception is Cumberland et al.'s randomized controlled trial involving 209 D/deaf women, which evaluated a culturally and linguistically tailored breast cancer education programme. The intervention improved breast cancer knowledge over follow-up and increased intention to obtain mammography, demonstrating the feasibility of designing support around the communication and cultural needs of a specific disability population (Cumberland et al., 2018).

The field should therefore progress from documenting barriers toward developing and testing solutions. Potential approaches include disability-adapted psychoeducation, preparation before screening or treatment procedures, specialist patient navigation, caregiver education and psychological support, supported decision-making protocols, and disability-responsive communication interventions. Wherever possible, these programmes should be co-designed with women with disabilities and their caregivers rather than developed solely on their behalf.

Clinical and Research Implications

Breast cancer services should assess accessibility requirements early and revisit them throughout the cancer trajectory. Relevant needs may include mobility and positioning support, preferred communication formats, additional preparation, decision-support requirements, caregiver involvement, and reasonable procedural accommodations. Disability competence among healthcare professionals should extend beyond physical accessibility to include communication, autonomy, supported decision-making, and recognition of caregivers as potential partners without displacing the woman's own voice. Importantly, disability-related inequalities do not end once

screening has been completed. Existing reviews describe disparities across cancer detection, diagnosis, and treatment (Keegan et al., 2023; Iezzoni, 2022), while recent treatment-focused studies demonstrate the importance of accessible accommodations, advocacy, relationships, and health-system characteristics following diagnosis (Hansford et al., 2026; Hansford et al., 2026). Research should consequently extend more decisively into surgery, chemotherapy, radiotherapy, rehabilitation, recurrence, and survivorship.

Psychosocial outcomes also require more systematic examination. Future research should combine qualitative approaches with validated measures of distress, anxiety, depression, adjustment, resilience, quality of life, and caregiver burden. Longitudinal designs would be especially useful for determining how needs evolve from screening through treatment and survivorship.

Strengths, Limitations, and Overall Interpretation

A major strength of this evidence mapping review is its integration of research across different disability populations and stages of breast cancer care while explicitly connecting psychosocial needs, accessibility, caregiving, and supportive interventions. This broader perspective helps expose areas that are obscured when disability-related breast cancer research is considered primarily through screening uptake. Several limitations should nevertheless be acknowledged. The evidence map provides a structured conceptual synthesis rather than an exhaustive systematic review. The available evidence is heterogeneous in population, design, terminology, and outcomes and remains disproportionately concentrated on intellectual/developmental disabilities and breast screening. The restriction to English-language literature published between 2016 and 2026 may also have excluded relevant research. Accordingly, sparsely populated areas of the map should be interpreted as gaps in the identified evidence rather than evidence that corresponding clinical needs are absent.

Overall, equitable breast cancer care for women with disabilities requires more than physical access. It requires psychologically safe, communicatively accessible, autonomy-supportive, and person-centred care, together with appropriate recognition of the role played by families and other caregivers. The evidence base remains heavily weighted toward documenting screening barriers, while considerably less is known about women's experiences following diagnosis, during treatment and survivorship, or about the psychosocial consequences for those supporting them.

The next stage of research should therefore move from documenting barriers to testing solutions and from viewing caregivers solely as facilitators to recognizing them as partners who may themselves require support. Disability-inclusive breast cancer care should integrate accessibility, psychosocial well-being, supported autonomy, caregiver involvement, and continuity across the entire cancer trajectory.

Conclusions

This evidence mapping review highlights the complex intersection of breast cancer, pre-existing disability, psychosocial needs, and caregiving across the cancer care continuum. The available evidence demonstrates that women with disabilities encounter barriers extending beyond physical accessibility to encompass informational, communicative, psychological, relational, and organizational dimensions (Keegan et al., 2023; Weise et al., 2024). Fear, uncertainty, inadequate preparation, communication difficulties, and concerns regarding autonomy may interact with structural barriers, influencing women's ability to participate meaningfully in breast cancer screening and subsequent care.

The mapping also reveals a pronounced imbalance in existing literature. Research remains concentrated on breast awareness and screening, while substantially less is known about the experiences of women with disabilities during diagnosis, active treatment, follow-up, and survivorship. Recent treatment-focused evidence nevertheless demonstrates the importance of accessible accommodation, supportive relationships, advocacy, and shared decision-making following a breast cancer diagnosis (Hansford et al., 2026). Caregivers, family members, and support workers may therefore play essential roles in facilitating communication, practical assistance, advocacy, and supported decision-making; however, their own psychological burden and support needs remain comparatively overlooked. This gap is particularly important given evidence from the broader breast cancer literature demonstrating substantial and evolving psychosocial needs among patients and their families (Sørensen et al., 2026).

Future research should move beyond documenting barriers toward developing and evaluating co-designed, disability-responsive interventions across the full breast cancer trajectory. Attention should be given to psychosocial outcomes, supported autonomy, caregiver well-being, accessible communication, patient navigation, and continuity of care (Hansford et al., 2026; Weise et al., 2024). Ultimately, equitable breast cancer care requires more than enabling access to services: it requires healthcare systems capable of providing accessible, psychologically informed, autonomy-supportive, and person-centred care while appropriately supporting the families and caregivers involved in women's care.

Declarations

Ethics Approval and Consent to Participate

Not applicable. This study is an evidence mapping review based exclusively on previously published literature and did not involve the recruitment of human participants, collection of primary data, or access to identifiable personal information. Therefore, ethics approval and informed consent were not required.

Consent for Publication

Not applicable. The manuscript does not contain identifiable individual-level data, images, or other personal information requiring consent for publication.

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Conflict of Interest
The authors declare that they have no competing interests or conflicts of interest relevant to this work.

Data Availability
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Author Contributions
Georgia Konstantopoulou: Conceptualization, methodology, evidence synthesis, interpretation of findings, writing – original draft, writing – review and editing, supervision.

Eirini Chytopoulou: Literature review, evidence extraction and organization, interpretation of findings, writing – review and editing.

Both authors contributed to the development of the manuscript, critically reviewed its intellectual content, and approved the final version for submission.

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