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Research Article

Decreasing Financial Toxicity for Breast Cancer Patients: A Program Evaluation of a Financial Assistance Program to Improve Access Mental Health Support

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Abstract

Objective: This study examined patient experiences with a financial assistance program for psychotherapy among individuals with breast cancer. The purpose of this mixed methods study was to gather feedback from the initial cohort of program participants in pilot financial assistance program in which breast cancer patients received five sessions of free, brief, solution-focused supportive psychotherapy from licensed psychotherapists, explored the intersection of coping skills profiles may impact program participation and gathered feedback from program participants in order to refine the referral process.

Methods: A mixed method research design with purposive sampling included quantitative methods including a demographics survey and the Courtauld Emotional Control Scale and a brief open-ended qualitative questionnaire.

Results: Participants universally believed that the financial assistance program made it easier for them to obtain mental health support and that psychotherapy provided needed emotional support reduced barriers to care, and all participants described psychotherapy as helpful for symptom management. Most participants advocated for automatic referral upon diagnosis, with some emphasizing extended counseling specifically for metastatic breast cancer patients. Distinct trends emerged between two program groups in terms of their emotional suppression type: the suppressor group reported greater prior psychotherapy experience, stronger preference for automatic referral, higher session completion, and greater intention to continue therapy compared to the expressor group.

Conclusions: Financial support programs and systematic referrals to psychotherapy upon receiving a breast cancer diagnosis can enhance access and improve psychosocial outcomes for breast cancer patients.

Keywords

Breast cancer, Psychotherapy, Financial assistance, Mental health access, Psychosocial support, Referral practices.

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Introduction

Breast cancer is the most commonly occurring type of cancer, impacting women in over 157 countries, and with over 300,000 women being newly diagnosed every year [1,2]. A diagnosis of breast cancer is the beginning of an unpredictable and emotionally complex experience as the new breast cancer patient navigates doctors' appointments, treatment protocols, statistics about outcomes and negative psychological impacts during the diagnosis, treatment and post-treatment of breast cancer [3-6]. Mental health challenges often begin at diagnosis, as patients question their mortality, and continue through treatment in managing difficult side effects of treatment, painful surgeries, limited post-operative mobility and after treatment as they navigate changed interpersonal relationships, body image issues and sexual health challenges [7,8]. Diagnosed breast cancer patients have been found to have up to twice the rates of depression and anxiety than those who are never diagnosed with cancer, for which psychotherapy have been found to improve well-being, treat symptoms and alleviate symptoms of post-traumatic stress disorder [3,5,6].

Limited research has explored the efficacy of a variety of types of psychotherapy including group therapy, individual therapy and telehealth [4,9,10]. Evidence-based interventions that can be beneficial for breast cancer patients includes Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy (CBT), Mindfulness Based Stress Reduction (MBSR) and Meaning Centered Psychotherapy (MCP) in both individual or group therapy modalities. Psychosocial interventions can include peer support one-on-one, clinical group therapy, support group and one-on-one psychotherapy both in-person and via telehealth [11-13]. However, there are challenges to researching the intersection of breast cancer and psychotherapy which includes a long-standing tradition of excluding metastatic breast cancer patients from studies and significant heterogeneity in overall study design [14].

In addition to the emotional and physical toll of breast cancer, there is a significant financial cost related to breast cancer treatment as well. Women with a history of breast cancer incur higher health care expenses and out-of-pocket costs and experience higher rates of financial hardship compared to women with no cancer history. In general, cancer treatment incurs significant costs out-of-pocket for the patient, which continue after cancer treatment is completed [15,16]. Breast cancer has been identified as the most expensive of all cancer diagnoses in terms of financial challenges out-of-pocket for the patient [17,18] even for those who have access to health insurance and coverage. Financial hardship is now recognized as its own adverse impact of cancer treatment and has significant quality of life ramifications for the patient. The term *financial toxicity* is defined as the related stress and hardship caused by treatment-related costs which includes direct medical costs (surgery, chemotherapy), non-medical costs (transportation, childcare), and indirect costs (lost income) [15,17,19]. Studies have shown that financial toxicity reduces quality of life, increases nonadherence to treatment protocols and an increased risk of early mortality [6,20,21] and is found to be higher in patients diagnosed at a younger age [22], as well as in Black and African American women [17]. In general, historically marginalized groups, particularly African American women, LGBTQ individuals, and those with lower socioeconomic status [23-25] have both poorer outcomes related to a breast cancer diagnosis, as well as greater levels of financial toxicity related to their diagnosis.

While there is not much literature on the intersection of financial toxicity related to breast cancer care and accessing psychotherapy specifically, some limited research has found mixed results. Counselman-Carpenter and Williams [4] found in their mixed methods study that there was a universal belief among their participants that they should be referred to psychotherapy as part of a holistic treatment plan, whereas Boozaier et al. [26], in their research specific to metastatic breast cancer patients found barriers to recruitment related to psychotherapy may include insufficient time, negative clinician attitudes, socio-demographic factors, lack of interest and increased levels of patient illness. There are some programs within the United States that focus on managing financial toxicity for breast cancer patients, including those through TigerLily's R.A.I.S.E program [27] and Life Interrupted grants from the Allyson Whitney foundation [28] for younger breast cancer patients within the first year of cancer treatment. However, these financial programs can be used for all aspects of need such as rent, utilities, and travel expenses as well as all types of integrative therapies such as acupuncture, massage, and not just exclusively for psychotherapy. Many programs that provide complementary emotional support are peer-based support programs with trained volunteers, as opposed to licensed behavioral health professionals.

The aim of this study was to gather feedback from the initial cohort of program participants in a pilot psychotherapy program in which breast cancer patients (current and former) received 5 sessions of free, brief, solution-focused therapy from licensed psychotherapists, explore how the intersection of coping skills profiles may impact program participation and completion and gather feedback from program participants and those to whom referrals are made to refine the referral process and potentially replicate this program in the future with a focus on the role that financial assistance programs may have in improving access to therapy.

Materials and Methods

Program Referral Process

There were three sections to the program interest application: the patient portion, the counselor portion, and the administrative approval section. At the time the study was conducted, interested participants first filled out the patient portion of a paper application form either on their own or with the assistance from providers, hospital social workers, or nurse navigators. Applications could be found at partnering hospitals in coastal Georgia or by downloading them directly from [name redacted for anonymous review] website. The interest form included patient contact information, name, phone number, and email; eligibility requirements; and an informed consent form. It is important to note that there were two eligibility requirements for participation in the program: participants had to be a breast cancer patient in Georgia and require a need for financial assistance to therapy sessions. To demonstrate financial need for assistance, the application initially included a cap on income which was defined as below 400% of the current poverty rate. The application thus had questions about annual household income and total number of people in the household. However, no patient was denied treatment due to the initial financial cap.

In order to eliminate barriers within the referral process, health care providers had options. They could either direct patients to resources to find a counselor on their own through self-referral, or providers could refer using their usual process of referral. Patients were permitted to attend therapy sessions from a clinician of their choice under the program, so long as counselors agreed to two conditions: 1) the provider was able to see the patient in a timely manner and 2) the provider agreed to a cap of $100 billing amount per session. Once the referral was made, counseling partners would then complete their portion of the application, indicating that they were able to accommodate the number of sessions the client was requesting (with a session cap of 5 sessions in total), that the cost per session was no more than $100, and that [name redacted for blind review] Foundation was not subject to "no-show" payment policies. Counselors and patients were notified on the application of the invoice policy and that the client was subject to the counseling center's no-show policy and any relevant fees. Counselors would send completed applications (with both patient and counselor portions) to the Program Administrator for approval. Approval notifications were then emailed to both the participant and counselor indicating that they had been approved for the program, that the patient had three months to complete the five allotted sessions, and that patients would be welcome to reapply should they not complete the program.

It is important to note that although participant participation was tracked within the program in terms of completing the paperwork, scheduling appointments, attending appointments, paying invoices, notifying patients and counselors of concluding the five free sessions or allocations due to inactivity, and inviting them to reapply, attendance and participation was self-reported on the survey itself. At no time did clinicians share any clinical information with the sponsoring organization or clinical team.

Study design

A sequential mixed method research design consisting of quantitative methods followed by qualitative methods was employed in this study. This methodology was selected in order for the qualitative information to illustrate findings related to demographics, CECS scores and to add depth to the numbers by highlighting the participant's voices in a way specific to their experience in psychotherapy [29]. This mixed methods study gathered both qualitative and quantitative data. Participants received a multiple-choice and fill-in-the-blank survey questions about their experiences with the referral and psychotherapy process. Participants were also invited to complete the Courtauld Emotional Control Scale instrument (CECS), and all seven participants chose to complete the CECS. Participants who completed the questionnaire received a $20 Amazon gift card as compensation.

Ethics

All participants were informed of anonymity procedures, data protection, and study scope. Participants were provided with a written copy of informed consent and participation in this study was completely voluntary. This study was approved by [blinded for peer review] University Institutional Review Board [reference number #20240088]. All data was encoded in an electronic database which was password protected.

Sampling

This study used purposive sampling methods. Participants who participated in this study enrolled in the psychotherapy program between April and December 2024. Participants needed to be enrolled in the counseling program by completing the relevant consent forms and paperwork to participate in the research study but did not have to complete their complimentary sessions in order to be a participant in the study.

Inclusion and Exclusion criteria

Participants in the study had to be 21 years of age or older, have been diagnosed with breast cancer, and participated in [name redacted for blind review]. Therapy Assistance Program between April and December 2024. Nine women enrolled in the psychotherapy program but chose to not participate in the study. One of these nine participants did engage in some of the counseling sessions and agreed to participate in the research study, but she passed away shortly and suddenly after starting the therapy program, and had not yet had the opportunity to participate in the study. Seven women (44% of those eligible) participated in both the psychotherapy program and participated in the research study. Exclusion criteria included anyone who may have indicated participating in the study, but never enrolled in the counseling program (n=5). Of the seven participants, five (71%) had completed more than half of their complementary psychotherapy sessions and two had just begun psychotherapy. Of those who completed the survey, 4 had prior experience with therapy, while 3 participants had no experience with therapy. All participants had been referred by professionals related to their breast cancer treatment – either their oncologist or other physician (5) or another hospital professional, such as nurse navigator (2).

Data collection and instruments

The Courtald Emotional Control Scale

The Courtald Emotional Control Scale (CECS) (Appendix A) studies emotional suppression and expression in breast cancer patients. Watson and Greer [30] developed the scale based on research that showed people with cancer tend to suppress anger, and that women with breast cancer are more likely to suppress anger and anxiety than those with benign breast disease. It is the most frequently used tool to explore emotional regulation during breast cancer [31] by, measuring ability to control or suppress anger, depression, and anxiety. High scores indicate greater emotional control/suppression, whereas lower scores are indicative of emotional expression [30]. Emotional suppressors tend to have a more fatalistic attitude toward cancer while those who restrained their anger and anxiety specifically felt more hopeless [32,33]. Prior research [4] has shown that both emotional suppressors and emotional expressers believe that all breast cancer patients should receive a referral upon diagnosis. The CECS was chosen as an instrument to see if there was a correlation between emotional suppressors, emotional expressors, their experiences with the financial assistance program and their preferences for therapy.

The CECS (Appendix A) consists of 21 items that include Likert-type responses ranging from 1 (not at all) to 4 (very much so). Factor analysis through principal component analysis [PCA] verified sampling adequacy (Kaiser-Meyer-Olkin scores =.855), appropriate correlations between items (Bartlett's test, $p<.001$), and adequate correlations between items and three levels in rotated component matrix. The CECS showed high internal consistency in this study for all three emotions (Cronbach's $\alpha = 0.935$).

Findings

Although the sample size was too small for formal statistical analyses, the following conclusions were inferred by the data (Tables 1-3). CECS scores were almost identically divided among program participants with four expressors and three suppressors. From a demographics standpoint, the S (Suppressor) group appears to be more financially stable than the E (Expressor) group reporting higher income. From a program participation perspective, there were five noteworthy trends related to psychotherapy experience, preferences about referrals, number of completed sessions and intention to continue psychotherapy, and the stage of diagnosis during program participation. The S group was more likely to have prior experience with psychotherapy than the E group; had a stronger preference of being automatically referred to psychotherapy; completed more of the complementary psychotherapy sessions and reported a higher level of intention to continue participating in the program. The Expressors (E group) tended to join the program at an early stage of diagnosis, as in 'newly diagnosed' as compared to the S group.

Experiences with the referral and psychotherapy program

The qualitative data elaborated on the participant experience with program referral and participation. Four participants were referred to the financial support program by hospital employees, and the hospital also made their initial psychotherapy appointment. Two participants made their initial appointment themselves, and one participant worked with their provider they had been seeing for psychotherapy prior to receiving approval for the financial assistance program. Five participants reported there were no barriers to them receiving psychotherapy after their diagnosis, one participant stated that they struggled to make the call themselves, and one participant stated they preferred not to answer this question. However, all seven participants reported that the financial assistance program from [Name redacted for anonymous review] made it easier to receive mental health support, and all seven participants stated that psychotherapy helped them make it through their cancer treatment and post-treatment process. Five participants felt that breast cancer patients should be automatically referred for therapy upon diagnosis for at least one session as a basic standard of care; while two participants felt that patients should all be asked if they would like a referral, but not that a referral should be automatic.

Table 1: Number of expressors and suppressors.

Total Sample	Expressor	Suppressor
7	4	3

Table 2: Demographic characteristics of participants.

Variable		Frequency (n=7)
Gender	Male	0
	Female	7
Current Age	21-29	1
	30-39	0
	40-49	1
	50-59	2
	60-69	3
Ethnic Origin	White	4
	Black	3
Marital Status	Single/Never married	1
	Married/Partner	4
	Divorced	2
Total household income ($)	10K-19K	1
	20K-29K	1
	30K-39K	2
	40K-49K	0
	50K-59K	1
	60K-69K	0
	70K-79K	1
	No answer	1
Household dynamics at initial diagnosis (check all that apply)	No kids or elderly in the home to care for	1
	Young children ages (0-6) in home to care for	1
	Children (7-12) in home to care for	0
	Children (13-17) in home to care for	2
	Adult children	5
	Elderly in home to care for	0
Number of years since initial diagnosis	Still in treatment	2
	Less than 1year since diagnosis	0
	1-4 years since diagnosis	4
	5-9 years since diagnosis	1
Which of the following choices best describes you?	Currently in treatment	1
	NED	3
	Recurrence	1
	MBC	2
Attended psychotherapy prior to breast cancer diagnosis	yes	4
	no	3

Table 3: Findings.

			By CECS Type	
	Variable	**Entire Sample (n=7)**	**Expressor (n=4)**	**Suppressor (n=3)**
Age	21-29	1	1	0
	40-49	1	0	1
	50-59	1	2	0
	60-69	3	1	2
Ethnic group	White	4	2	2
	Black	3	2	1
Marital Status	Single/Never married	1	1	0
	Married/Partner	4	2	2
	Divorced	2	1	1
Household income ($)	10K-19K	1	1	0
	20K-29K	1	1	0
	30K-39K	2	1	1
	50K-59K	1	0	1
	70K-79K	1	0	1
	No answer	1	1	0
# of years since initial diagnosis	Still in treatment	2	1	1
	1-4 years since diagnosis	4	2	2
	5-9 years since diagnosis	1	1	0
Current Status	Currently in treatment	1	1	0
	NED	3	1	2
	Recurrence	1	1	0
	MBC	2	1	1
Attended psychotherapy prior to diag.	Yes	4	1	3
	No	3	3	0
Status when participated in the program	Newly diagnosed	2	2	0
	In the initial treatment	2	1	1
	In the long-term treatment	1	0	1
	Post treatment	1	1	0
	Living with stage 4	1	0	1
How first heard about the program	Provider	5	3	2
	Staff	2	1	1
How to get connected with clinician	Hospital referral made to	4	2	2
	I made the initial phone call	2	1	1
	I'm already established client	1	1	0
Barriers	Making the call myself	1	1	0
	No barriers	5	3	2
	No answer	1	0	1
Opinions related to access the therapy	Should automatically be referred to	5	2	3
	Should be asked	2	2	0
# of completed session after approval	3	1	1	0
	4	1	1	0
	5	4	2	2
	10	1	0	1
Plan to continue	Yes	3	1	2
	No	3	2	1
	No answer	1	1	0

How psychotherapy was helpful

All participants reported that the experience in psychotherapy was helpful in multiple ways including reducing symptoms of anxiety and depression and in providing strategies to cope with difficult conversations. One participant shared that in therapy, "I was able to discuss things that are uncomfortable with family. It helped me deal with anxiety. It helped knowing that I was speaking to someone who understood my situation and difficulties that I was having and it helped having someone to talk to who was not close to me for fear of someone feeling like I was a burden or just feeling sorry for me". One participant who lives with metastatic breast cancer noted that as part of treatment, "mental health therapy is imperative. Especially if you are living with a stage four diagnosis. It is also imperative that you have a therapist that is familiar with terminal diagnoses. I think it is necessary for someone to be diagnosed with stage four to receive counseling indefinitely. I understand funds are limited, but I think a stage four diagnosis should receive at least a year of counseling".

General feedback about the program

Responses were limited related to general feedback about the financial assistance program as a whole. Only two participants elaborated in their answers about the completion or lack of completion of their five free counseling sessions. One participant felt that five sessions was not enough due to her type of diagnosis and one participant stated they were unable to complete their five sessions due to moving related to needing post-surgical familial support.

Continuing with the program

Findings were mixed in terms of participant desire to continue complementary or financially supported psychotherapy. Three participants stated they would like to continue with the program and psychotherapy. One participant stated they were not sure they could continue psychotherapy, without elaborating on the reason why but followed up by stating that they found the experience "tremendously helpful" and would like to continue if they could. Another participant stated, "…my diagnosis has taken a mental toll on me. It is constant and ever present in my mind so professional help is absolutely needed", and one participant did not elaborate on the reasons why she would like to continue. Conversely, three participants stated that they did not want to continue therapy. One participant elaborated by saying that they simply did not feel they needed to continue, and one said that they had learned the coping skills that they had needed within the five complementary sessions. The third participant stated that they were unsure that they were not sure they could reapply for the program, and without financial assistance, could not afford to continue therapy. One participant chose not to answer any of these questions.

All seven participants chose to elaborate on how their participation in the psychotherapy program was helpful. One participant stated, "I have such a sense of gratefulness", while two other participants shared that it alleviated specific symptoms related to anxiety and depression. One participant demonstrated future-oriented thinking in her response stating that "it was helpful connecting to someone who may be helpful in the future".

Discussion

Although the response rate was small, it is similar to the response rate in other program evaluations for breast cancer support such as Mirrielees et al. [34] and Pruthi et al. [35] The study demonstrates the continued need for breast cancer patients to have access to different options of psychotherapy with trained providers, along with peer-based mentorship and support group options. This study supports prior findings such as Ashton and Oney [7], Counselman and Williams [4] and Jamshidifar et al. [5], that psychotherapy can improve the overall well-being and lived experience of those who are undergoing or have undergone treatment for breast cancer and, from self-report, that patients who participate in psychotherapy report lower levels of depression and anxiety. This study also supports prior findings [17] related to the need for continued research related to the intersection of financial toxicity related to breast cancer and its' relationship to overall well-being. This study also challenges the work of Akram et al. [1], who in their study discuss the 'stages' of being diagnosed with and treated for breast cancer, including the stage of 'returning to normal life'. This study's participants all demonstrate the need for continued emotional support after treatment and indicate that the emotional impact and fear of disease recurrence remains a constant source of stress.

Program refinement

During the development and implementation of this financial assistance program, important lessons were learned which could strengthen the development of similar programs. Although clinicians were contacted and encouraged to provide feedback on their experience with the referral process, all declined to do so and it was unclear to the research team as to the reason. There are many possible reasons which may include a lack of time, lack of interest or concerns about violating HIPAA policies. Future studies should continue to try to engage clinicians providing psychotherapy within a financial assistance program to better understand their perspective in the process. Finally, at the conclusion of this pilot program, the organizing organization decided to refine the referral process by removing the income cap to provide support to anyone who needed it to be more inclusive in terms of program access. Another refinement included moving from a paper referral system to a digital referral system to improve the speed and accessibility of the referral process for the next iteration of the program.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the small sample size (n = 7) significantly limits the generalizability of the results. Second, with a mixed methods design, the qualitative insights provide depth but may not fully represent the experiences of all breast cancer patients who participated in this financial assistance program. Third, participants were recruited from a single program, which may introduce selection bias and limits applicability to other settings or populations. As the data is self-reported, there may be social desirability bias, which can influence the accuracy of responses. Finally, the short duration of data collection and lack of longitudinal follow-up does not allow for a long-term assessment of outcomes of financial assistance on mental health support for breast cancer patients.

Implications

This study demonstrates the continuing need for financial support for breast cancer patients wishing to participate in psychotherapy as part of the current or post-treatment journey as well as continued program development to address financial toxicity in breast cancer patients. This program is unique in involving breast cancer patients in the design and refinement of the referral process and implementation of the financial assistance program as well as gathering feedback related to future iterations of the program. Future research should include the gathering of longitudinal data related to well-being and other benefits that may come from participating in psychotherapy, as well as psychotherapy programs that specifically include financial support and focus on decreasing barriers to access and managing the impact financial toxicity may have on quality of life. Other implications include the finding that proactive mental health engagement, and automatic referral to at least one session of psychotherapy should be considered for newly diagnosed patients, which aligns with growing evidence that early psychological intervention mitigates anxiety and depression and enhances coping during treatment. All participants reported that financial support facilitated access to psychotherapy, reducing barriers and improving continuity of care. This finding reinforces the importance of addressing economic determinants of health in oncology settings. Programs that subsidize mental health services can significantly enhance patient well-being, reduce the impact of financial toxicity and improve access to services.

The mixed responses regarding continuation of psychotherapy highlight the importance of designing programs that accommodate diverse patient preferences and financial challenges that accompany a breast cancer diagnosis and linger for many years post-treatment. Policies should include mechanisms with clear instructions for reapplication and a fixed-session model may not meet the needs of all patients, especially those with metastatic or advanced disease. Decreasing financial burden for all breast cancer patients, but particularly those with marginalized identities remains critically important. Participants also emphasized the necessity of therapists familiar with terminal diagnoses, particularly for stage IV patients. This points to a gap in mental health provider training and the need for oncology-specific mental health knowledge when providing treatment to breast cancer patients.

Conclusion

This study is the first of its kind to look at financial assistance programs for psychotherapy related to being diagnosed with and living with breast cancer. This study highlights the significant impact of integrated psychotherapy and financial assistance programs on the psychosocial well-being of breast cancer patients in addressing financial toxicity. Findings demonstrate that automatic referral to mental health services, particularly at the time of diagnosis, may reduce barriers to care and improve patient outcomes. Financial assistance programs can be a critical enabler of access, reinforcing the need for policies that address economic barriers to mental health care in oncology settings post-diagnosis. Participants consistently reported that psychotherapy alleviated symptoms of anxiety and depression, improved coping strategies, and provided emotional relief during treatment and survivorship. However, variability in session completion and desire for continuation suggests that flexible, patient-centered models are essential. These findings underscore the importance of embedding mental health services into cancer care pathways and tailoring interventions to disease stage and individual needs. Future research should explore scalable approaches to automatic referral, optimal session frequency, and long-term support for high-risk populations to ensure equitable and comprehensive cancer care.

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Appendix A.

Courtauld Emotional Control Scale

The following questions have listed some of the reactions people have to certain feelings or emotions. Read each one and indicate how far it describes the way you generally react. Indicate your answer by indicating the appropriate number on the scale. Please work quickly

1. When experiencing anger, I keep quiet
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anger, I refuse to argue or say anything.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anger, I bottle it up.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anger, I say what I feel*
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anger, I avoid making a scene.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anger, I smother my feelings.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)
0. When experiencing anger, I hide my annoyance.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing a depressed mood, I refuse to say anything about it.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing a depressed mood, I hide my unhappiness.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing a depressed mood, I put on a bold face.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing a depressed mood, I keep quiet.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing a depressed mood, I let others see how I feel.*
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing a depressed mood, I smother my feelings.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing a depressed mood, I bottle it up.
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anxiety, I let others see how I feel.*
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anxiety, I keep quiet
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anxiety, I refuse to say anything about it
Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anxiety, I tell others all about it.*
   Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anxiety, I say what I feel*
   Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anxiety, I bottle it up
   Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

0. When experiencing anxiety, I smother my feelings.
   Scale of: 1 2 3 4 (one is not at all and 4 is very much so)

Appendix B: Open-ended response questions

1) Do you believe that psychotherapy helped you or is helping you make it through your medical treatments? Please elaborate.
2) How many sessions have you completed after being approved for the program. Please elaborate on any reason that contributed to why you may have/have not completed all 5 sessions.
3) Do you plan to continue with psychotherapy after participating in this program? Why or why not?
4) In your own words, tell us what access to psychotherapy has meant to you. Has the opportunity of attending mental health support services helped you emotionally? If so, tell us how.
5) Anything else you'd like to tell us about how this experience/program impacted you?