Vita Medica Scientica Journal

**VMS J Vol.2, No.1, 27-37 (2026)**
doi: 10.64514/vmsjournal.2026.18
**ORIGINAL RESEARCH**

# Holistic Assessment of Unmet Supportive Care Needs and Psychological Distress in Newly Diagnosed Cancer Patients: A Cross-Sectional Study Across Cancer Types and Stages

Ferda Uçkun Ceylan[1], Feride Gülcüler[2], Umut Gök[3]

[1]Manisa Provincial Health Directorate, Manisa, Türkiye (0000-0002-0692-7734)
[2] Izmir City Hospital, Department of Family Medicine, Izmir, Türkiye (0009-0008-3644-8989)
[3] University of Health Sciences ,Izmir Faculty of Medicine, Izmir City Hospital, Department of Family Medicine, Izmir, Türkiye (0000-0002-5048-204X)

Accepted 24 February 2026.

## Abstract

### Objective and Aim

Physical, emotional, social, and mental stressors and anxieties that can cause a person to feel sad, depres-sed, scared, lonely, or worried are defined as “distress.” This study aimed to assess the needs of newly di-agnosed cancer patients of different types and stages using a holistic approach.

### Material and Methods

This descriptive cross-sectional study included 173 adults diagnosed with cancer. Data were collected through face-to-face interviews using a 77-item questionnaire containing 63 items from the James Supportive Care Screening Questionnaire (SCS). Data were analyzed using SPSS 25.0 with nonparametric tests (Mann-Whitney U, Kruskal-Wallis) and chi-square tests; $p<0.05$ was considered signi-ficant.

### Results

The highest unmet needs were observed in the areas of emotional concerns (15.67±10.09) and physical symptoms (15.64±10.45), with an average total score of 36.13±25.19. Women reported signifi-cantly higher needs than men in all subscales except health and cognitive concerns (all $p<0.05$). Scores related to emotional and religious/spiritual concerns decreased with age ($p=0.001$ for both). The 18-45 age group scored higher for health concerns and social/practical problems compared to other groups ($p=0.027$ and $p=0.045$, respectively). Scores related to health concerns increased with the education level of the pati-ents ($p=0.027$).

### Conclusion

Our study observed that cancer patients have unmet care needs in various areas and that their physical, emotional, social/practical, religious/spiritual, and sexual problems are neglected. A holistic and multidisciplinary

**Corresponding Author:**
Umut Gök
University of Health Sciences ,Izmir Faculty of Medicine, Izmir City Hospital, Department of Family Medicine, Izmir, Türkiye
Email: dr_ugb@yahoo.com

**To cite:**
Ceylan FU, Gülcüler F, Gök U. Holistic Assessment of Unmet Supportive Care Needs and Psychological Distress in Newly Diagnosed Cancer Patients: A Cross-Sectional Study Across Cancer Types and Stages. VMS Journal 2026;2(1):27-37.
doi: 10.64514/vmsjournal.2026.18

approach will be more effective in reducing unmet healthcare needs.

**Keywords:** Palliative care, Physiological Stress, Psychological Distress, Emotional Stress, Social Support

## 1. Introduction

Cancer is one of the chronic diseases with high mortality and morbidity, which is frequently seen all over the world and in our country. Cancer, which is the second leading cause of death in the world, is expected to rank first in 2030 (1). The increase in the number of patients diagnosed with cancer and the increase in expected lifespan in recent years have led to an increase in the patients admitted to the hospital. We observed that the reasons for admission are sometimes the side effects of chemotherapy and radiotherapy, and sometimes the symptoms directly related to cancer. Many of the studies investigating symptom management have dealt with individual symptoms. However, in cancer patients, several symptoms are usually seen together, depending on the disease or treatment (1,2). Various classifications and screenings have been de-veloped to address all the symptoms seen in these patients and to understand effects thereof. Many of these are studies to determine the level of distress in patients. Physical, emotional, social and mental tensions and concerns that can cause a person to feel sad, depressed, scared, alone or anxious are defined as “distress” (2). Feeling distressed is generally expected for patients diagnosed with “distress” cancer or in the process of treatment (3). In the literature, it has been determined that the distress level of women is higher than that of men, and younger participants than the elderly (4,5). It has been observed that the factors affecting the distress level the most are anxiety, fears, burnout, irritability, sleep problems, and sadness rather than phy-sical pain. The distress experienced by patients affects their life quality (5,6). Cancer disease usually makes people think about death. In many studies conducted in our country, it has been observed that patients who relax by praying are more determined during the treatment process. The moral support given by his family, relatives and Islamic religious official also increased the strength of the patients. It was observed that the depression rates of the patients with a higher relationship with religion were also lower.

## 2. Materials and Method

Our study is a descriptive/cross-sectional survey study. 173 patients who met the criteria were reached. The sociodemographic data questionnaire and the James Supportive Care Screening Questionnaire (SCS) were filled by the patient and/or the researcher by making necessary explanations in the face-to-face interviews. SCS is a screening that can be used in every stage and treatment of cancer, developed by Wells-Di Grego-rio et al. in order to determine the distress in last week experienced by individuals diagnosed with cancer and in which area they need support, with a total of 6 sub-dimensions [7]. The sub-dimensions of the scree-ning are Emotional Concerns, Spiritual/Religious Concerns, Health Care Concerns, Social Problems, Cognitive Concerns, and Physical Symptoms. Sub-dimension responses are: None (0), Mild (1), Moderate (2), and Severe (3). Screening questions may either be evaluated by scoring separately or over the total score. In addition, it consists of 7 questions answered as Yes/No and 1 open-ended question in which the most distressing situation is questioned, were prepared to provide additional information in the clinical setting, which is not included in the scoring of the screening. The validity and reliability study of the questionnaire for the Turkish population was conducted by Turkish researchers. In this study, it was aimed to evaluate the needs of newly diagnosed patients with different cancer types and stages with a holistic approach. The main goal of the researchers of the study is to shed light on new approaches that may reduce the distress level of the patients. Criteria For Including The Research Persons who admitted to Medical Oncology outpatient clinics, who

a. are aged 18 and over
b. are volunteered to participate in the study
c. having a newly diagnosed cancer patient
d. signed the informed volunteering consent form,
e. are capable of understanding and answering the questions asked

*Criteria for Exclusion from the Research*

Persons, who are in pregnancy status.

*Ethical Approval*

In this study, international ethical standards were followed, and ethical approval was obtained from the Local Ethics Committee of SBÜ İzmir Tepecik Training and Research Hospital. Ethics Committee Deci-sion No: 2019/18-33. Permission to use the James Supportive Care Needs Screening Scale was obtained via e-mail from Hacer Demirkol, who conducted the Turkish validity and reliability study of the scale.

*Statistical Analysis*

The data of the patients were evaluated with SPSS 25.0 for Windows (SPSS, Inc., Chicago, IL). For desc-riptive statistics in the study, date are provided as numbers (n), percentage (%), mean, standard deviation, minimum, maximum. Differences between groups were analysed with Mann Whitney u test and Kruskall Walllis tests for nume-rical variables and with chi-square test for categorical variables. As statistical significance, p=0.05 signifi-cance level was used at 95% confidence level.

## 3. Results

When the age distribution of the patients participating in our study was reviewed, it was determined that 26 (15.03%) of them were between the ages of 18-45, 63 (36.42%) of them 46-60 years old, 60 (34.68%) of them 61-75 years old, and 24 (%13,87) of them 76-90 years old. 121 (69.94%) of them were married and 52 (30.06%) of them were single or widowed. It was determined that 158 (91.33%) of them had children, 22 (12.72%) of them lived alone, 119 (68.78%) of them lived with family members, 32 (18.50%) of them lived with other people. 157 (90.75%) of the patients had supporters. When the supporters of the patients were reviewed, it was determined that 88 (50.87%) of them were sup-ported by their spouses, 49 (28.32%) of them were supported by their children, 15 (8.67%) of them were supported by their other people, and 5 (2.89%) of them were supported by their parents. Cancer diagnosis, stages and diagnosis durations of the participants are given in Table1.

Table 1: Cancer Diagnosis, Stages, and Duration Since Diagnosis of Participants

| Variable | Category | n | % |
|---|---|---|---|
| Cancer Type | Head-Neck | 6 | 3.47 |
| | Gynecological | 22 | 12.72 |
| | Lung | 3 | 1.73 |
| | Breast | 58 | 33.53 |
| | Brain | 4 | 2.31 |
| | Skin | 2 | 1.16 |
| | Gastrointestinal | 53 | 30.64 |
| | Other | 25 | 14.45 |
| Cancer Stage | Stage 1 | 16 | 9.25 |
| | Stage 2 | 16 | 9.25 |
| | Stage 3 | 21 | 12.14 |
| | Stage 4 | 25 | 14.45 |
| | Unknown Stage | 95 | 54.91 |
| Time Since Diagnosis | 0–3 months | 28 | 16.18 |
| | 3–6 months | 20 | 11.56 |
| | 6 months–1 year | 40 | 23.12 |
| | 1–5 years | 53 | 30.64 |
| | 5–10 years | 18 | 10.40 |
| | >10 years | 14 | 8.09 |

The mean scores of the SCS screening sub-dimensions are given in Table 2.

A statistically significant difference was found between the ages of the patients and the emotional concerns sub-dimension of the SCS screening (p=0.001). It was determined that the emotional concerns score decre-ased as the age group increased. A statistically significant difference was found between the gender of the patients and the emotional concerns sub-dimension of the SCS screening (p<0.001). Women had higher

emotional concerns scores than men.

Table 2. Mean Scores of SCS Subscales

| Subscale | Mean ± SD | Median | Minimum | Maximum |
|---|---|---|---|---|
| **Emotional Concerns** | 15.676 ± 10.09 | 10 | 0 | 39 |
| **Religious/Spiritual Concerns** | 0.92 ± 2.21 | 0 | 0 | 12 |
| **Health Care Concerns** | 4.3831 ± 2.42 | 0 | 0 | 12 |
| **Social/Practical Problems** | 4.6082 ± 3.88 | 2 | 0 | 16 |
| **Cognitive Concerns** | 2.5235 ± 2.88 | 2 | 0 | 9 |
| **Physical Symptoms** | 15.64 ± 10.45 | 14 | 0 | 45 |
| **Total** | 36.13 ± 25.19 | 31 | 0 | 125 |

It was determined that as the age group increased, the score for religious/spiritual concerns decreased (p=0.001). A statistically significant difference was found between the gender of the patients and the religious/spiritual concerns sub-dimension of the SCS screening (p=0.001). Women's scores on religi-ous/spiritual concerns are higher than men's (p=0.003); it was seen that the scores of the employees on religious/spiritual concerns were higher than those who did not work (p=0.027) (Table 3).

A statistically significant difference was found between the ages of the patients and the healthcare subscale of the SCS (p=0.023). Post hoc analysis revealed that the 18–45 age group had higher healthcare scores than the other groups. A statistically significant difference was also found between the patients' educatio-nal status and the healthcare subscale of the SCS (p=0.027). It was determined that healthcare scores increased as the educational level of the patients increased. A statistically significant difference was found between the ages of the patients and the social/practical problems subscale of the SCS (p=0.045). Post hoc analysis revealed that the 18–45 age group had higher social/practical problems scores than the other age groups. A statistically significant difference was found between the patients' gender and the social/practical problems subscale of the SCS (p=0.025). It was obser-ved that women's social/practical problems scores were higher than men's. A statistically significant difference was found between the patients' gender and the physical symptoms subscale of the SCS (p=0.010). It was determined that women had higher physical symptoms scores than men. In the answers given by the patients to the seven questions (not included in the screening score) answered as Yes/No in the SCS 76.88% did not experience any problems related to sexuality, 83.24% did not want to receive information about it, 73.99% did not experience speech/swallowing difficulties, 79.19% did not want to receive information about it, % 72.25% do not have any concerns about nutrition/diet, 72.25% do not want to receive information about it, 74.57% do not have concerns about how their family and friends will cope, 80.35% do not have any concerns about this issue. they did not want to receive information, 83.82% of them did not have a problem with the use of cigarettes or tobacco products, 89.60% of them did not want to receive information about it, and 96.53% of them stated that they did not have any problems. Regarding the misuse of alcohol, recreational substances, or therapeutic drugs, 97.69% of the patients sta-ted that they did not want to receive information on this issue, 91.91% reported that they did not experience any problems related to documenting their retirement procedures, and 90.17% stated that they did not want to receive information about this matter. "What is the most emotional distress for you right now?" to the question, 3.5% of the patients stated that they had financial problems, 4% stated that they had a lack of support, 6.9% stated that it was a difficult treatment process, 18.5% stated that the

disease itself 39.3% of those who thought about the situation of their children stated that they did not experience any problems, while 23.7% stated that the factor that caused the most emotional problems for them was other factors. The total score of the James Supportive Care Needs Screening Scale was found to be higher among individuals who reported concerns related to sexuality (p=0.042). The total scores were also significantly higher in those who experienced speech-related difficulties or concerns and in those who expressed a desire to receive information on this issue (both p<0.001). Similarly, participants who reported nutrition/diet-related concerns or problems, as well as those who wished to obtain information in this area, had significantly hig-her total scores (all p<0.001). Individuals who expressed concerns about how their family and friends would cope with the illness, and those who wanted information on this topic, also had significantly higher scores (p<0.001 and p=0.005, respectively). The total score was significantly higher among participants who reported concerns or problems related to smoking (p=0.022). Additionally, individuals who had con-cerns or problems about documenting retirement procedures and those who wished to obtain information about this process had significantly higher total scores (p=0.014 and p=0.007, respectively). A statistically significant correlation was found between the answers given to the question "What is the most emotional distress for you right now" and the total score (p=0.002). In the post hoc test, it was deter-mined that those who gave the answer "Lack of Support" scored higher than those who gave the other answers (Table 4).

## Discussion

When the cancer diagnoses of the patients were examined, it was found that 33.53% were diagnosed with breast cancer and 30.64% with gastrointestinal cancer, 14.45% with other cancers, 12.72% with gynaecological cancers, 3.47% with head and neck cancers, 2.31% with brain cancer, 1.73 with lung cancer, 1.16% with skin cancer, respectively. This is compatible with the literature (1,2). When their stages were questio-ned, it was determined that 54.91% of them did not know the stage. 9.25% are at stage 1, 9.25% are at stage 2, 12.14% are at stage 3, 14.45% are at stage 4. 58% of the group who knew their stage were stage 3 and 4. In the study conducted by Wells Di George et al. for the development of the James supportive care scree-ning, it was determined that 53% of the patients who knew their stage were in Stages 3 and 4 (7). There are various views about whether or not to tell patients about their cancer diagnosis. This view varies by culture. Some cultures have a patient-centred approach, while some have a family-centred approach. In the family-centred approach, the relatives of the patients want to get the correct information, but they want to hide it from the patient (8,9). The reason why our patients have low level of knowledge about their stages is that they could not get detailed information from the healthcare team, as the families wanted all information about the disease not to be shared with the patient.

It was determined that the most unmet care needs of our patients were in the emotional field. It was deter-mined that as the age group increased, the emotional concerns score decreased, and the emotional concerns score of women was higher than that of men. Again, in the screening study, it was revealed that the emoti-onal concerns sub-dimension was strongly associated with the CES-Depression Screening (7). Long and intense treatments such as surgical interventions, chemotherapy, radiotherapy, and uncertainties in the co-urse of the disease trigger fear, anxiety and depression in patients.

As the age increases, the average score obtained from the religious issues sub-dimension decreases. It is a common behaviour for people to seek support from religious rituals and prayers in coping with the disease (8,10). Therefore, the reason for the decrease in the frequency of depression in the older age group may be increased religious belief and being closer to rituals (11). It was determined that religious issues scores of women were higher than those of

men; and religious issues scores of those who are employed were higher than those who are unemployed. The scores of our patients in the religious issues sub-dimension are consis-tent with the SCS screening sub-

Table 3: Scores of the Emotional Concerns and Religious/Spiritual Concerns Subscales of the James Supportive Care Screening according to Sociodemographic Variables

| Variables | | Emotional Concerns | | | Religious/Spiritual Concerns | | |
|---|---|---|---|---|---|---|---|
| | | mean | median | p | mean | median | p |
| Age | 18-45 | 20.23±12.35 | 21.00 | 0.001 | 2.42±3.18 | 0.50 | 0.001 |
| | 46-60 | 12.75±9.25 | 12.00 | | 0.89±2.31 | 0.00 | |
| | 61-75 | 9.93±7.93 | 8.00 | | 0.48±1.35 | 0.00 | |
| | 76-90 | 9.29±10.39 | 5.00 | | 0.5±1.79 | 0.00 | |
| Gender | Female | 14.8±10.32 | 14.00 | <0.001 | 1.22±2.49 | 0.00 | 0.003 |
| | male | 8.36±8.29 | 6.00 | | 0.42±1.52 | 0.00 | |
| Marital Status | Married | 13.09±9.94 | 13.00 | 0.292 | 1.05±2.32 | 0.00 | 0.580 |
| | Single | 12±13.09 | 8.50 | | 1.33±3.55 | 0.00 | |
| | Widow | 10.5±9.56 | 6.50 | | 0.43±1.06 | 0.00 | |
| Education | Illiterate | 11.9±8.46 | 9.00 | 0.266 | 0.38±0.97 | 0.00 | 0.421 |
| | Literate | 7.83±6.2 | 6.00 | | 0.28±0.83 | 0.00 | |
| | Primary School | 13.75±10.26 | 13.00 | | 1.1±2.27 | 0.00 | |
| | Secondary School / High School | 11.51±10.08 | 9.00 | | 0.97±2.5 | 0.00 | |
| | University | 13.54±14.26 | 8.00 | | 1.46±3.38 | 0.00 | |
| Occupation | Employed | 12.38±10.91 | 10.50 | 0.472 | 0.94±1.69 | 0.00 | 0.027 |
| | Unemployed | 12.42±10.04 | 10.00 | | 0.92±2.26 | 0.00 | |
| Income Level | 0-499 | 13±10.92 | 12.00 | 0.874 | 1.13±1.64 | 0.00 | 0.836 |
| | 500-999 | 11.4±9.36 | 10.00 | | 1.13±2.39 | 0.00 | |
| | 1000-1999 | 10.88±10.14 | 6.00 | | 0.71±1.58 | 0.00 | |
| | 2000-2999 | 9.72±9.1 | 7.50 | | 0.67±1.74 | 0.00 | |
| | ≥ 3000 | 10±10.31 | 7.00 | | 1.2±2.9 | 0.00 | |
| Children | Yes | 12.25±9.89 | 9.50 | 0.705 | 0.89±2.09 | 0.00 | 0.919 |
| | No | 14.13±12.24 | 11.00 | | 1.33±3.27 | 0.00 | |
| Living Situation | Alone | 9.32±7.25 | 7.50 | 0.569 | 0.23±0.69 | 0.00 | 0.514 |
| | With spouse | 12.27±9.39 | 11.00 | | 0.79±1.68 | 0.00 | |
| | With spouse and children | 13.08±10.16 | 13.00 | | 1.24±2.66 | 0.00 | |
| | Other | 18.5±15.15 | 19.50 | | 2±4 | 0.00 | |
| Comorbidities | No | 12.72±11.95 | 9.50 | 0.168 | 0.88±2.38 | 0.00 | 0.778 |
| | Yes | 11.85±10.5 | 8.00 | | 0.99±2.35 | 0.00 | |
| Disease Type | Hypertension (HT) | 13.44±9.31 | 12.50 | 0.277 | 0.81±1.96 | 0.00 | <0.001 |
| | Diabetes Mellitus (DM) | 11.36±9.14 | 10.00 | | 0.23±0.75 | 0.00 | |
| | Coronary Artery | 12.2±5.55 | 11.00 | | 0.2±0.63 | 0.00 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Disease (CAD) | | | | | | |
| | Psychiat-ric disease | 15.17±7.17 | 13.50 | | 0±0 | 0.00 | |
| | other | 20.38±9.93 | 23.50 | | 3.38±3.34 | 3.00 | |
| | none | 14.86±11.11 | 15.00 | | 2±3.06 | 0.00 | |
| | HT,DM | 11.71±10.52 | 8.50 | | 1.04±2.39 | 0.00 | |
| Time Since Diagnosis | 0–3 months | 12.64±10.75 | 9.50 | | 0.14±0.53 | 0.00 | |
| | 3-6 months | 15.18±10.4 | 15.00 | 0.593 | 1.25±3.03 | 0.00 | 0.907 |
| | 6 months -1 year | 11.75±10.07 | 8.00 | | 1.1±2.99 | 0.00 | |
| | 1-5 years | 12.78±9.89 | 11.50 | | 0.67±1.67 | 0.00 | |
| | 5-10 years | 11.81±10.17 | 9.00 | | 0.87±1.79 | 0.00 | |
| | ≥ 10 years | 9.78±8.78 | 8.50 | | 0.5±0.79 | 0.00 | |
| Cancer Type | Gynecological | 12.5±11.72 | 9,00 | | 1.5±3.08 | 0.00 | |
| | Lung | 12.69±8.9 | 12.00 | 0.716 | 0.97±2.05 | 0.00 | 0.352 |
| | Gastroin-testinal | 11±10.91 | 9.00 | | 0.91±2.48 | 0.00 | |
| | Other | 14.5±10.02 | 18.50 | | 1±2.22 | 0.00 | |
| Stage | Stage 1 | 14.56±11.2 | 11.50 | | 1.19±2.26 | 0.00 | |
| | Stage 2 | 11.71±9.39 | 9.00 | 0.60 | 1.43±2.73 | 0.00 | 0.599 |
| | Stage 3 | 16.84±10.88 | 14.00 | | 1.04±2.44 | 0.00 | |
| | Stage 4 | 10.69±9.56 | 8.00 | | 0.73±2.03 | 0.00 | |
| | unknown | 12.64±10.25 | 11.00 | | 0.96±2.29 | 0.00 | |
| Supporter | yes | 10.25±8.26 | 7.00 | | 0.56±1.21 | 0.00 | |
| | no | 12.47±9.77 | 10.50 | 0.050 | 0.92±2.23 | 0.00 | 0.961 |
| Support Provider | Spouse | 26.6±15.66 | 37.00 | | 3.2±5.22 | 0.00 | |
| | Parents | 11.33±9.32 | 9.00 | 0.042 | 0.51±1.14 | 0.00 | 0.580 |
| | Child | 13.27±11.57 | 12.00 | | 1.93±3.39 | 0.00 | |
| | Other | 10.25±8.26 | 7.00 | | 0.56±1.21 | 0.00 | |
| | None | 20.23±12.35 | 21.00 | | 2.42±3.18 | 0.50 | |

Between-group comparisons were conducted using the Mann–Whitney U test for variables with two categories and the Kruskal–Wallis test for variables with three or more categories. A p value <0.05 was considered statistically significant.

scores. It can be said that there is a correlation between the total distress level and the religious issues sub-dimension. Religious issues affecting quality of life and distress level should be evaluated. It is very important for patients that religious officials, doctors and nurses provide moral support (11-13).

In the health care concerns sub-dimension, statistical significance was found between the age of the pati-ents, their educational status and the care provider. It was determined that as the education level of the pa-tients increased, the score of health care concerns increased. It was determined that those for whom care is provided by the parents were higher score than those for whom care is provided by the other care providing groups. Especially, cancer patients in the terminal period may have many symptoms such as pain, insom-nia, and loss of appetite (14). Families generally have concerns about long-term health care at

home (15). Palliative care centers are an important care solution option in the symptom management of such patients. One of the problems in social/practical problems sub-dimension is "lack of support". In a study conducted by Novotny et al., it was found that cancer patients under the age of 50 had lower social support from their surroundings (16). There is another study in which elderly patients had better

Table 4: The relationship between the total score of the James Supportive Care Screening Scale and the responses given to the questions

| Questions | Responses | Total score | | |
|---|---|---|---|---|
| | | mean | median | P |
| Experiencing concerns or problems related to sexuality | yes | 43.32±28.77 | 36.50 | **0.042** |
| | no | 33.47±23.39 | 29.00 | |
| Desire to receive information about sexuality | yes | 43.9±29.17 | 37.00 | 0.114 |
| | no | 34.49±24.18 | 29.00 | |
| Experiencing concerns or problems related to speech/swallowing difficulties | yes | 51.27±22.57 | 48.00 | **<0.001** |
| | no | 30.69±23.99 | 24.00 | |
| Desire to receive information on speech/swallowing difficulties | yes | 54.11±21.94 | 48.00 | **<0.001** |
| | no | 31.45±23.96 | 24.00 | |
| Nutrition/Diet Concerns | yes | 48.48±26.36 | 47.50 | **<0.001** |
| | no | 31.27±23.18 | 24.50 | |
| Desire to receive information about nutrition/diet-related concerns | yes | 47.72±25.47 | 48.00 | **<0.001** |
| | no | 31.7±23.83 | 25.00 | |
| Concerns About How Family and Friends Will Cope | yes | 48.91±25.9 | 47.00 | **<0.001** |
| | no | 31.8±23.62 | 26.00 | |
| Desire to receive information about how family and friends will cope | yes | 45.52±24.62 | 44.00 | **0.005** |
| | no | 33.83±24.96 | 28.00 | |
| Concerns or problems related to smoking | yes | 44.85±22.59 | 45.00 | **0.022** |
| | no | 34.44±25.45 | 28.00 | |
| Desire to receive information about smoking or tobacco use | yes | 38.65±19.09 | 40.00 | 0.363 |
| | no | 35.79±25.87 | 30.00 | |
| Concerns related to alcohol, recreational drug use, or misuse of prescribed medications" | yes | 38±22.03 | 34.00 | 0.744 |
| | no | 36.02±25.39 | 30.00 | |
| Concerns or problems related to alcohol use, recreational drug use, or misuse of prescribed medications | yes | 38±24.58 | 48.00 | 0.780 |
| | no | 36.04±25.33 | 30.00 | |
| Concerns or problems related to documenting retirement | yes | 53.62±26.68 | 53.00 | **0.014** |
| | no | 34.64±24.67 | 29.00 | |
| Desire to receive information about documenting retirement | yes | 52.19±25.34 | 54.50 | **0.007** |
| | no | 34.42±24.73 | 29.00 | |
| What is the most emotional distress for you right now? | Financial Situation | 39.83±21.68 | 39.50 | **0.002** |
| | Lack of Support | 54.71±20.51 | 57.00 | |
| | Treatment Process | 44±23.55 | 39.50 | |
| | Disease | 45.88±27.95 | 40.00 | |
| | My children | 36±16.37 | 37.00 | |
| | None | 27.96±23.81 | 22.50 | |

Between-group comparisons were conducted using the Mann–Whitney U test for variables with two categories and the Kruskal–Wallis test for variables with three or more categories. A p value <0.05 was considered statistically significant.

communication and social interactions with their relatives and friends (17). The total distress level was found to be higher in those who answered the question “What is the most emo-tional distress for you at the moment?” as “lack of support”. Spouse, family and social support may some-times be more effective than treatment for patients (16,17). The sub-dimension with the highest score along with emotional concerns is physical symptoms. It was determined that women's physical symptoms scores were higher than those of men. It was determined that those for whom care is provided by the parents had a higher physical symptom score than the other care providing groups. According to the results obtained by Harrison et al. upon evaluation of various studies conducted with cancer patients, the rate of unmet physi-cal needs of patients is between 7-89% (18). 27.75% of our participants stated that they had concerns about nutrition/diet and that they wish to obtain information about this issue. The vast majority were able to rece-ive nutritional information support from researchers during the study. 76.88% of the patients participating in the study stated that they did not have problems with sexuality, and 83.24% stated that they did not wish to obtain information on this issue. The total score average of those who had problems with sexuality was found to be higher.The rate of those who stated that they had prob-lems in the studies conducted in our country is less than in the studies conducted abroad (19). The reason for this may be that sexuality cannot be openly discussed in our country. Also there may be some deficien-cies in the questioning of the sexual needs of the patients by the healthcare team due to cultural reasons (19,20). Although the type of cancer is not directly related to the organs that affect sexuality, sexuality can be greatly affected due to the disease and treatment burden, and the emotional and physical distress expe-rienced by individuals (21). However, it is emphasized in the literature that this is ignored by the healthcare team, and patients are often not asked about the difficulties they experience in this regard (22). There seem to be multiple barriers preventing professionals from addressing sick sexuality; lack of knowledge and low levels of confidence are among the most common. Appropriate training is required to equip the staff and short-term training programs appear to be effective. Use of sexuality assessment tools and flashcards and access to information from cancer society websites can improve clinical practices. It is the responsibility of each person in the multidisciplinary team to address sexuality concerns. Patients require open discussion and professionals must handle sexuality issue deftly. Trainings in this regard should be accessible, affor-dable and sustainable. Patients in palliative care and their spouses may experience dramatic changes in their sexuality and may want nurses the opportunity to address them. It is also claimed that the holistic philosophy of palliative care encourages nurses working in this field to include sexual issues in their daily care. However, it is not known how palliative care nurses handle sexuality problems (23). Cancer can threaten patients' sexual identity in various ways. Physical changes, infertility, decreased self-esteem and psychological burdens are some of them (24). Early menopause, dyspareunia, obesity and va-ginal narrowing are common in women, and erectile dysfunction is common in men (25). Both genders may experience orgasm problems, loss of desire and libido, and fatigue (23,24). The necessity of focusing on psychological support as well as organic solutions in therapeutic studies is a common result both in our study and in other studies in the literature. Palliative care may be a promising solution that should start early for patients with multiple such problems.

**Limitations**

It was planned in 2020 and coincided with the period of the COVID -19 pandemic. Due to the decrease in hospital admissions of cancer patients for protection from infection, our sample number could be collected in a long time and was limited.

## Conclusion

In our study, although the total scores of unmet care needs of cancer patients were not very high, it was observed that they had neglected physical, emotional, social/practical, religious/spiritual and sexual problems. The positive effect of spiritual beliefs and social support in coping with the disease has come to the fore. Because of the multiplicity of problems, a holistic and multidisciplinary approach will be more effective in reducing unmet care needs.

## Conflict of Interest

There is no conflict of interest among the authors.

## Financial Support

The study has not received any financial support.

## References

1. Özmen V. A Patient Advocacy Group Summit, Cancer Care in Turkey and The Society of Breast Health. Eur J Breast Health. 2018;14:1–4.

2. Definition of distress - NCI Dictionary of Cancer Terms - National Cancer Institute [Internet]. [Access date:January 10, 2022]. Available from: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/distress

3. Zainal N, Hui K, Hang T, Bustam A. Prevalence of distress in cancer patients undergoing chemotherapy. Asia-Pacific Journal of Clinical Oncology. 2007;3(4):219–23.

4. Ayhan D, Mercan N, Dogan R, Yuksel C. Investigeting of distress and alexithymia in patients with hematological cancer. J Ist Faculty Med 2021;84(2):237-44.

5. Herschbach P, et al. Distress in cancer patients: Who are the main groups at risk? Psychooncology: 2020;29(4):703-710.

6. Dekker J, Graves KD, Badger TA, Diefenbach MA ;Management of Distress in Patients with Cancer-Are We Doing the Right Thing? Ann Behav Med. 2020;54(12):978-984.

7. Wells-Di Gregorio S, Porensky EK, Minotti M, Brown S, Snapp J, Taylor RM, et al. The James Supportive Care Screening: integrating science and practice to meet the NCCN guidelines for distress management at a Comprehensive Cancer Center. Psycho-Oncology [Internet]. 2013;22(9):2001–8.

8. Aydın HT, Günay D. The determination of the supportive care needs of patients diagnosed with cancer. Cumhuriyet Medical Journal. 2020;42(2):152–62.

9. Mosher CE, Adams RN, Helft PR, O'Neil BH, Shahda S, Rattray NA, et al. Family caregiving challenges in advanced colorectal cancer: patient and caregiver perspectives. Support Care Cancer. 2016 May;24(5):2017-2024.

10. Varol M. Kanser Hastalarının Alternatif Bir Tedavi Yöntemi Olarak Dua Tercihi. Türkiye Bilimsel Araştırmalar Dergisi. 2018;3(1):43–53.

11. Ripamonti CI, Giuntoli F, Gonella S, Miccinesi G. Spiritual care in cancer patients: a need or an option? Curr Opin Oncol. 2018;30(4):212-218.

12. Ellington L, Billitteri J, Reblin M, Clayton MF. Spiritual Care Communication in Cancer Patients. Semin Oncol Nurs. 2017 Dec;33(5):517-525.

13. Sprik PJ, Tata B, Kelly B, Fitchett G. Religious/spiritual concerns of patients with brain cancer and their caregivers. Ann Palliat Med. 2021;10(1):964-969.

14. Chopra D, De La Garza R. Depressive, anxiety, and distress symptoms among cancer patients who endorse appearance problems. Palliat Support Care. 2019;17(3):328-332

15. Tanco K, Park JC, Cerana A, Sisson A, Sobti N, Bruera E. A systematic review of instruments assessing dimensions of distress among caregivers of adult and pediatric cancer

patients. Palliat Support Care. 2017;15(1):110-124.

16. Novotny PJ, Smith DJ, Guse L, Rummans TA, Hartmann L, Alberts S, et al. Cancer Management and Research A pilot study assessing social support among cancer patients enrolled on clinical trials: a comparison of younger versus older adults. Cancer Management and Research. 2010;2:133–42.

17. Liang SY, Chang TT, Wu WW, Wang TJ. Caring for patients with oral cancer in Taiwan: The challenges faced by family caregivers. Eur J Cancer Care (Engl). 2019 Jan;28(1):e12891

18. Harrison JD, Young JM, Price MA, Butow PN, Solomon MJ. What are the unmet supportive care needs of people with cancer? A systematic review. Supportive Care in Cancer. 2009 Aug 25;17(8):1117–28.

19. Rochmawati E, Minanton M. Embedded spiritual conversation in cancer communication: lived experiences of nurses and patients/relatives. Int Nurs Rev. 2021;68(3):289-298

20. Green A, Jerzmanowska N, Thristiawati S, Green M, Lobb EA. Culturally and linguistically diverse palliative care patients' journeys at the end-of-life. Palliat Support Care. 2019;17(2):227-233

21. Ziran Bi et al. Negative correlations of psychological distress with quality of life and immunotherapy efficacy in patients with advanced NSCLC. Am J Cancer Res. 2022; 12(2): 805–815.

22. Williams M, Addis G. Addressing patient sexuality issues in cancer and palliative care Br J Nurs 2021 May 27;30(10):S24-S28

23. Benoot C, Enzlin P, Peremans L, Bilsen J. Addressing sexual issues in palliative care: A qualitative study on nurses' attitudes, roles and experiences. J Adv Nurs. 2018;74(7):1583-1594.

24. Julian Mütsch et al. Sexuality and cancer in adolescents and young adults - a comparison between reproductive cancer patients and patients with non-reproductive cancer. BMC Cancer. 2019;19: 828.

25. Smith AW, Seibel NL, Lewis DR, Albritton KH, Blair DF, Blanke CD, et al. Next steps for adolescent and young adult oncology workshop: an update on progress and recommendations for the future. Cancer. 2016;122:988–999.