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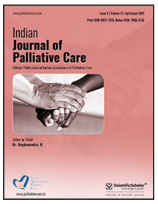

Original Article

The Relationship between Spiritual Care Needs, Psychological Distress and Quality of Life in Women with Gynaecological Cancer: A Cross-Sectional Study

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ABSTRACT

Objectives: This study aimed to examine the relationship between spiritual care needs, psychological distress (depression, anxiety and stress) and quality of life in Turkish women diagnosed with gynaecological cancer.

Materials and Methods: A descriptive cross-sectional study was conducted with 111 women receiving treatment at a university hospital in Ankara, Turkey, between April and October 2023. Data were collected using the Personal Information Form, spiritual needs assessment scale of patients with cancer (SNASPC), depression anxiety stress scales-21 (DASS-21) and functional assessment of cancer therapy-general (FACT-G). Statistical analyses were performed using IBM Statistical Package for the Social Sciences Statistics version 20.0 (Chicago, IL, USA). Frequencies, percentages, mean values, standard deviations (SDs) and Pearson Correlation Analysis were used to evaluate the data. $P < 0.05$ was considered statistically significant.

Results: The mean SNASPC score was 233.70 (SD = 30.02). The DASS-21 scores were 8.28 (SD = 5.02) for depression, 8.50 (SD = 5.91) for anxiety and 8.62 (SD = 5.04) for stress. The mean total FACT-G score was 65.67 (SD = 20.18). Significant positive correlations were found between unmet spiritual needs and depression (r = 0.283, $P = 0.004$), anxiety (r = 0.271, $P = 0.006$) and stress (r = 0.280, $P = 0.005$). In addition, spiritual needs were negatively correlated with quality of life (r = −0.584, $P = 0.001$).

Conclusion: The study revealed that higher unmet spiritual needs are associated with increased psychological distress and decreased quality of life in women with gynaecological cancer. Integrating spiritual care into treatment plans could improve both mental health outcomes and overall quality of life for this population.

Keywords: Depression, Gynaecological cancer, Psychological distress, Quality of life, Spiritual care needs

INTRODUCTION

Gynaecological cancers, encompassing a range of malignancies affecting the female reproductive system, represent a significant global health issue.[1,2] The incidence and mortality rates of these cancers are notably high, affecting a substantial number of women worldwide each year.[3] Globally, the age-standardised incidence rate per 100.000 is 14.1 for cervical cancer, 8.4 for endometrial cancer and 6.7 for ovarian cancer. In Turkey, the incidence rates are 4.8, 14.3 and 6.9 for cervical, endometrial and ovarian cancers, respectively.[4] The diagnosis and treatment of gynaecological cancer can lead to profound physical, emotional and psychological challenges. These challenges often extend beyond the clinical dimensions of the disease, impacting various aspects of the patient's life, including psychological health and overall quality of life.[5-7]

In Turkey, the cultural context adds another layer of complexity to the experiences of women with gynaecological cancer. Traditional views on womanhood and reproductive health are deeply rooted in Turkish society, where fertility and the ability to bear children are often closely linked to a woman's identity and social status.[8,9] Consequently, a diagnosis of gynaecological cancer is perceived not only as a health crisis but also as a threat to a woman's femininity

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and social role.[10,11] The potential loss of reproductive organs can exacerbate feelings of inadequacy, loss of femininity and social isolation, thereby intensifying psychological distress.[7,11] Therefore, comprehensive care that addresses both medical and psychosocial aspects is essential.

Beyond physical and emotional challenges, spiritual care needs to play a significant role in the well-being of women with gynaecological cancer.[1,6,10] Spirituality and religious beliefs provide comfort and strength for many individuals facing serious illnesses in Turkish culture.[12] For women with gynaecological cancer, spiritual care can be a means of coping with the existential fear and uncertainty associated with their diagnosis and treatment. Spiritual care involves addressing the spiritual and existential needs that arise from the cancer experience, such as the search for meaning, coping with existential fears and finding peace and solace.[5,13,14]

Addressing spiritual needs is crucial for reducing psychological distress, including anxiety, depression and stress.[5,11] Anxiety in patients with cancer often stems from fears about the future, disease progression and potential losses. Depression can arise from feelings of hopelessness, worthlessness and helplessness that accompany a cancer diagnosis. Stress can result from the numerous disruptions and demands brought on by the disease and its treatment.[7,15] When spiritual needs are unmet, these psychological distresses can intensify, further burdening the emotional load of the illness.[5]

Integrating spiritual care into the treatment of women with gynaecological cancer is vital for enhancing overall quality of life. Quality of life encompasses physical, emotional and social well-being, which can be significantly affected by a cancer diagnosis.[16] Spiritual care can improve quality of life by helping patients navigate their illness with a sense of purpose and resilience.[10,13,17-19] By addressing spiritual needs, healthcare professionals can support patients in finding inner peace, which contributes to better emotional stability and mental health.[20]

While the importance of spiritual care in cancer management is increasingly recognised[21,22] its specific relationship with psychological distress and quality of life in gynaecological cancer patients remains underexplored. Prior research has examined the general impact of spiritual care on cancer patients across various cancer types and stages.[10,13,14,23] However, to the best of our knowledge, this is the first study to comprehensively analyse the combined relationship between spiritual care needs, psychological distress (depression, anxiety and stress) and quality of life specifically in women with gynaecological cancer. Addressing this gap is essential, as gynaecological cancer patients face unique psychological and social challenges related to reproductive health, body image and disease stigma.[7,11] By focusing exclusively on women with gynaecological cancer, this study contributes novel insights into how spiritual care needs intersect with mental health and overall well-being.

MATERIALS AND METHODS

Design

This is a descriptive cross-sectional study. The 'Strengthening the Reporting of Observational Studies in Epidemiology Checklist' was used to design the study.[24]

Settings and participants

A convenience sample was obtained from the Gynaecological Oncology Clinic of a leading university hospital in Ankara, Turkey, between April and October 2023. Inclusion criteria were as follows: having been diagnosed with the disease at least 6 months prior, being hospitalised, undergoing curative treatment in the hospital, having the ability to provide written informed consent and being able to speak and write in Turkish. Exclusion criteria included being under 18 years old, having stage IV cancer, refusing to participate, having any known serious chronic illness (e.g., heart disease and kidney disease) and having a diagnosed psychiatric disorder or taking psychiatric medication. The minimum sample size was calculated using G Power 3.0, based on a medium effect size ($f^2 = 0.3$) with 0.95 power and 0.05 alpha level, resulting in a minimum sample size of 111 women with gynaecological cancer. A total of 170 women with gynaecological cancer were assessed for eligibility. However, 59 were excluded for not meeting the criteria: Less than 3 months since diagnosis (31), taking psychiatric medication (9), being under 18 (2), refusing to participate (5), having stage IV cancer (4) and having serious chronic illnesses (8). Thus, finally, we included 111 women with gynaecological cancer.

Measurements

Personal information form

Based on literature[1,5,10] this form includes the demographic and clinical characteristics of women with gynaecological cancer. Demographic characteristics were investigated using five items: Age, education level, employment status and perceived income. Clinical characteristics were investigated using four items: Cancer type, stage, diagnosis onset and type of treatment. In total, there are nine questions included in this section.

The spiritual needs assessment scale of patients with cancer (SNASPC)

Used to assess participants' spiritual needs. The scale was developed by Hatamipour *et al*.[25] and adapted into Turkish by Erci and Aslan.[26] It is a 38-item seven-point Likert-type scale consisting of five sub-dimensions: religious need (items 1–9), finding meaning and purpose (items 10–16), seeking peace (items 17–26), the need to communicate (items 27–32) and support and independence (items 33–38). The scale's score range is 38–266, with higher scores indicating higher spiritual needs.[26] The Cronbach's alpha value of this study was 0.81.

The depression anxiety stress scales – 21 (DASS-21)

Used to assess participants' levels of depression, anxiety and stress. The scale was developed by Brown *et al.*[27] and adapted into Turkish by Yılmaz *et al.*[28] It is a 21-item four-point Likert-type scale with seven items for each dimension. The score range for each dimension is 0–21. Scores of 5 or higher in the depression dimension, four or higher in the anxiety dimension and eight or higher in the stress dimension indicate the presence of the respective issues.[28] The Cronbach's alpha value of this study was 0.86 for anxiety, 0.82 for depression and 0.83 for stress in this study.

The functional assessment of cancer therapy-general (FACT-G)

Used to assess participants' quality of life. This instrument was developed by Cella *et al.*[29] and adapted into Turkish by Ay and Parvizi.[30] It is a 27-item five-point Likert-type instrument consisting of four sub-dimensions: Physical well-being, social/family well-being, emotional well-being and functional well-being. The score range is 0–108, with higher scores indicating better quality of life.[30] The Cronbach's alpha value of this study was 0.94.

Data collection procedure

Data were collected using structured questionnaires administered by the second and third authors, who had experience working with patients with cancer. When women with gynaecological cancer met the inclusion criteria, the study's purpose was explained to all. Each woman with gynaecological cancer was informed about the study, and those who decided to participate signed an informed consent form. Data were then collected through face-to-face interviews. Each interview lasted approximately 20 minutes and was conducted with a single patient in a specially designed room. Participants' medical records were checked to verify cancer type, diagnosis date, stage and treatments. Participants were assured that their data would be accessible only to the researchers and that their personal information would remain confidential. In addition, participants who experienced emotional distress during the interview were informed about available psychological support services. If necessary, they were referred to the hospital's psycho-oncology unit for further emotional support. Participants were also reassured that they could withdraw from the study at any point if they felt uncomfortable answering any of the questions.

Data analysis

Data were analysed using IBM Statistical Package for the Social Sciences Statistics version 20.0 (Chicago, IL, USA). The normal distribution of continuous variables was determined using the Kolmogorov-Smirnov test. Descriptive statistics such as percentages, frequencies, means and standard deviations (SD) were used to analyse the participants' characteristics. Pearson correlation coefficients were used to analyse the relationships between the SNASPC, the DASS-21 and FACT-G. $P < 0.05$ was considered statistically significant. All analyses were conducted at a 0.05 significance level.

RESULTS

Descriptive characteristics

Details of the participants' characteristics are presented in Table 1. The mean age of the participants was 56.09 (SD = 8.59) years, with the majority (59.5%) being over 55 years old. Among the participants, nearly half (48.6%) were primary school graduates, 76.6% were married, 71.2% were unemployed, and 70.3% had a moderate income. The average time since diagnosis was 14.23 (SD = 20.54) months; 58.6% were in stage III, and 61.3% received combined treatment (surgery + chemotherapy or surgery + radiotherapy).

Table 1: Characteristics of participants.

Characteristics	*n*	Percentage
Age (year) Mean (SD): 56.09 (SD=8.59) min-max: 26–65		
≤55	45	40.5
>55	66	59.5
Educational level		
Primary education	54	48.6
High school	20	18.0
University and above	37	33.4
Marital Status		
Married	85	76.6
Single	26	23.4
Working status		
Working	32	28.8
Nonworking	79	71.2
Perceived economic status		
High income	27	24.3
Average income	78	70.3
Low income	6	5.4
Time since diagnosis (month) Mean (SD): 14.23 (SD=20.54) min-max: 3–156		
≤12	82	73.9
>12	29	26.1
Stage of disease		
II	46	41.4
III	65	58.6
Type of treatment		
Single	43	38.7
Combined[a]	68	61.3

[a]Surgery+Chemotherapy/Surgery+Radiotherapy, SD: Standard deviation

Spiritual needs, depression, anxiety and stress and quality of life

The mean scores of the SNASPC subdimensions were as follows: religious needs 54.80 (SD = 9.67), finding meaning and purpose 43.78 (SD = 3.83), seeking peace 60.85 (SD = 8.43), need to communicate 37.35 (SD = 6.54) and support and independence 36.92 (SD = 6.04), with a total mean score of 233.70 (SD = 30.02). The DASS-21 results showed mean scores of 8.28 (SD = 5.02) for depression, 8.50 (SD = 5.91) for anxiety ($P = 0.018$) and 8.62 (SD = 5.04) for stress. The FACT-G subdimension scores were as follows: physical well-being 16.51 (SD = 6.15), social/family well-being 17.80 (SD = 6.33), emotional well-being 12.78 (SD = 5.72) and functional well-being 18.57 (SD = 4.61), with a total mean score of 65.67 (SD = 20.18) [Table 2].

Relationship between spiritual needs, depression, anxiety, stress and quality of life

Correlation analysis revealed significant positive relationships between depression and religious needs (r = 0.228, $P = 0.016$), seeking peace (r = 0.228, $P = 0.016$), need to communicate (r = 0.281, $P = 0.003$), support and independence (r = 0.307, $P = 0.001$) and the total SNASPC score (r = 0.283, $P = 0.003$). Similarly, anxiety was positively correlated with religious needs (r = 0.212, $P = 0.025$), seeking peace (r = 0.217, $P = 0.022$), need to communicate (r = 0.272, $P = 0.004$), support and independence (r = 0.294, $P = 0.002$) and the total SNASPC score (r = 0.271, $P = 0.004$). Stress showed significant positive correlations with religious needs (r = 0.215, $P = 0.023$), seeking peace (r = 0.242, $P = 0.010$), need to communicate (r = 0.265, $P = 0.005$), support and independence (r = 0.307, $P = 0.001$) and the total SNASPC score (r = 0.280, $P = 0.003$) [Table 3].

FACT-G results indicated significant negative correlations between physical well-being and religious needs (r = −0.592, $P = 0.001$), finding meaning and purpose (r = −0.346, $P = 0.001$), seeking peace (r = −0.601, $P = 0.001$), need to communicate (r = −0.514, $P = 0.001$), support and independence (r = −0.449, $P = 0.001$) and the total SNASPC score (r = −0.606, $P = 0.001$). Social/family well-being was negatively correlated with religious needs (r = −0.395, $P = 0.001$), finding meaning and purpose (r = −0.254, $P = 0.007$), seeking peace (r = −0.359, $P = 0.001$), need to communicate (r = −0.357, $P = 0.001$), support and independence (r = −0.302, $P = 0.001$) and the total SNASPC score (r = −0.399, $P = 0.001$). Emotional well-being showed negative correlations with religious needs (r = −0.325, $P = 0.001$), seeking peace (r = −0.298, $P = 0.001$), need to communicate (r = −0.307, $P = 0.001$), support and independence (r = −0.289, $P = 0.002$) and the total SNASPC score (r = −0.333, $P = 0.001$). Functional well-being was negatively correlated with religious needs (r = −0.556, $P = 0.001$), finding meaning and purpose (r = −0.319, $P = 0.001$), seeking peace (r = −0.601, $P = 0.001$), need to communicate (r = −0.542, $P = 0.001$), support and independence (r = −0.540, $P = 0.001$) and the total

Table 2: Descriptive Statistics Among SNASPC, DASS-21 and FACT-G.

Scales	Mean	SD	Min-Max	Low-High values	Skewness	Kurtosis
SNASPC						
Religious need	54.80	9.67	20–62	9–63	−1.307	2.897
Finding meaning and purpose	43.78	3.83	30–50	6–42	−1.428	2.407
Seeking peace	60.85	8.43	30–70	10–70	−1.941	2.258
Need to communicate	37.35	6.54	14–42	6–42	−1.854	2.514
Support and independence	36.92	6.04	20–42	6–42	−1.340	0.966
Total	233.70	30.02	145–261	38–266	−1.549	1.277
DASS-21						
Depression	8.28	5.02	0–20	0–21	1.226	0.349
Anxiety	8.50	5.91	2–20	0–21	1.246	−0.182
Stress	8.62	5.04	1–20	0–21	1.236	0.348
FACT-G						
Physical well-being	16.51	6.15	2–28	0–28	0.011	−0.012
Social/family well-being	17.80	6.33	2–28	0–28	1.826	2.428
Emotional well-being	12.78	5.72	0–24	0–24	−0.575	−0.369
Functional well-being	18.57	4.61	3–28	0–28	−0.528	1.519
Total	65.67	20.18	16–106	0–108	0.038	−0.268

SNASPC: Spiritual needs assessment scale of patients with cancer, DASS-21: Depression anxiety stress scales-21, FACT-G: Functional assessment of cancer therapy – general, SD: Standard deviation

Table 3: Correlation of SNASPC with DAS-21 and FACT-G.

Scales	SNASPC											
	Religious need		Finding meaning and purpose		Seeking peace		Need to communicate		Support and independence		Total	
	r	*P*	r	*P*	r	*P*	r	*P*	r	*P*	r	*P*
DASS-21												
Depression	0.228	0.016	0.174	0.067	0.228	0.016	0.281	0.003	0.307	0.001	0.283	0.003
Anxiety	0.212	0.025	0.185	0.051	0.215	0.022	0.272	0.004	0.294	0.002	0.271	0.004
Stress	0.215	0.023	0.186	0.051	0.242	0.010	0.265	0.005	0.307	0.001	0.280	0.003
FACT-G												
Physical well-being	−0.59	0.001	−0.346	0.001	−0.601	0.001	−0.514	0.001	−0.449	0.001	−0.606	0.001
Social/family well-being	−0.395	0.001	−0.254	0.007	−0.359	0.001	−0.357	0.001	−0.302	0.001	−0.399	0.001
Emotional well-being	−0.325	0.001	−0.149	0.118	−0.298	0.001	−0.307	0.001	−0.289	0.002	−0.333	0.001
Functional well-being	−0.556	0.001	−0.319	0.001	−0.601	0.001	−0.542	0.001	−0.540	0.001	−0.615	0.001
Total	−0.562	0.001	−0.325	0.001	−0.553	0.001	−0.515	0.001	−0.466	0.001	−0.584	0.001

SNASPC: Spiritual needs assessment scale of patients with cancer, DASS-21: Depression anxiety stress scales-21, FACT-G: Functional assessment of cancer therapy - general

SNASPC score (r = −0.615, *P* = 0.001). Overall well-being was negatively correlated with religious needs (r = −0.562, *P* = 0.001), finding meaning and purpose (r = −0.325, *P* = 0.001), seeking peace (r = −0.553, *P* = 0.001), need to communicate (r = −0.515, *P* = 0.001), support and independence (r = −0.466, *P* = 0.001) and the total SNASPC score (r = −0.584, *P* = 0.001) [Table 3].

DISCUSSION

This study is among the first to comprehensively examine the relationship between spiritual care needs, psychological distress (depression, anxiety and stress) and quality of life specifically in women with gynaecological cancer. While prior research has established links between spiritual well-being and mental health in general oncology populations,[10,22,31] to the best of our knowledge, no studies have specifically investigated this relationship in gynaecological cancer patients. Given the unique psychosocial challenges faced by women with gynaecological cancer – including concerns related to reproductive health, body image and femininity – our study provides new insights into the complex interplay between spirituality, mental health and quality of life in this specific patient population. Moreover, existing studies on spiritual care needs have primarily included advanced-stage cancer patients or mixed oncology groups, limiting their applicability to gynaecological cancer patients.[14,21] Our findings suggest that spiritual distress may play a particularly critical role in psychological well-being for gynaecological cancer patients, reinforcing the need for tailored interventions that integrate both psycho-oncology and spiritual care support. These findings contribute to a growing body of evidence that highlights the importance of individualised supportive care strategies for cancer patients, particularly for those with gynaecological malignancies.

The participants' spiritual needs were found to be high, which is consistent with previous studies that emphasise the significant role of spirituality in coping with cancer.[21-23] Several studies have reported that cancer patients often seek spiritual support as a means of managing distress, reducing anxiety and improving their overall well-being.[25,32] Our findings are consistent with the literature.[13,22,25] Contrary to our results, Fradelos *et al.*[31] reported that unmet spiritual needs were very low among Greek cancer patients. Regarding the subdimensions of spiritual needs, similar to the literature,[23,33] the participants' need to seek peace was the highest. Du *et al.*[10] reported meaning and purpose as the highest need. However, previous studies on spiritual needs have primarily focused on advanced-stage cancer patients or those with other cancer types, whereas our study specifically examines gynaecological cancer patients.[13,14,22] This distinction highlights the importance of investigating spiritual needs within different oncological contexts. Spiritual needs can vary based on many factors, such as culture, history, social background, values and religious beliefs.[21] The variation in findings across different studies may be due to differences in cancer types, disease stages, and cultural characteristics of the patient populations studied. Given the high levels of spiritual needs reported by gynaecological cancer patients, integrating spiritual care interventions such as mindfulness-based therapy and psycho-oncology support programs has been recommended in previous studies.[20,22]

Psychological distress is a complex and multifaceted experience that significantly impacts the well-being of cancer patients, affecting their ability to cope with diagnosis and treatment.[1,5,11] Women with gynaecological cancer often face additional emotional burdens beyond those

experienced by general oncology patients, particularly due to the implications of their diagnosis on reproductive health, body image and sexual well-being.[5,7] Research suggests that body image disturbances and concerns regarding femininity and fertility contribute to heightened levels of anxiety and depression in this population.[11] Given these challenges, addressing both psychological distress and spiritual needs is essential for providing holistic care to gynaecological cancer patients. In our study, participants reported high levels of depression, anxiety and stress, which aligns with previous research indicating that women with gynaecological cancer experience significant psychological distress due to cancer-related physical and emotional changes. This finding is consistent with studies reporting that cancer patients with unmet emotional and spiritual needs tend to exhibit higher levels of psychological distress.[10,13] Moreover, our results suggest that psychological distress in gynaecological cancer patients may be exacerbated by spiritual concerns and the perceived loss of control over one's health and future, further reinforcing the importance of integrating psychological and spiritual interventions into cancer care.[22,31] Addressing these issues through psycho-oncology support programs and spiritual care interventions could help reduce distress and improve the overall well-being of women facing gynaecological cancer.

In the present study, the participants' quality of life was moderate. Among the subdimensions of quality of life, the participants' mean scores for functional well-being were the highest, while emotional well-being scores were the lowest. Our findings are consistent with the literature.[2,6] Şenışık *et al*.[2] reported that the quality of life of women with gynaecological cancer was moderate. Similarly, Edianto *et al*.[6] reported that emotional well-being scores were the lowest, while physical well-being scores were the highest among women with gynaecological cancer. This emphasises the need for interventions tailored to the emotional well-being of patients, as gynaecological cancers are often associated with significant psychological and social burdens. These findings emphasise the importance of emotional support and physical health in treating gynaecological cancer. This study found that higher levels of spiritual needs were significantly associated with increased psychological distress among women with gynaecological cancer. While previous research has established a link between spiritual needs and psychological distress in cancer patients generally,[31,32] studies specifically examining this relationship in gynaecological cancer patients are scarce.[10,13] Fradelos *et al*.[31] reported that increased spiritual needs negatively affected the mental health component of quality of life, though their sample primarily consisted of non-gynaecological cancer patients. Similarly, another study indicated that anxiety was the strongest determinant in the relationship between spiritual needs and psychological distress, yet it was conducted in a mixed cancer population.[32] The inclusion of gynaecological cancer patients in this study provides a more specific perspective on the connection between spiritual needs and distress, further reinforcing the need for individualised care.

Surgeries and treatment methods associated with cancer can significantly affect patients' mental and physical states, leading to a decrease in quality of life.[1,5] Physical pain, fatigue, emotional stress and social isolation during this process can make it difficult for patients to perform daily activities and negatively impact their overall health.[6,22] The study found significant negative correlations between spiritual needs and various dimensions of quality of life, including physical, social/family, emotional and functional well-being. This result indicates that increased spiritual needs negatively affect the quality of life and that spiritual needs are not only related to mental health but also impact patients' physical, social, emotional and functional well-being. Similarly, a study conducted with cancer patients in Iran reported a significant relationship between spiritual needs and quality of life, indicating that increased spiritual needs negatively affect the quality of life.[22] The literature also reports a relationship between spiritual needs and quality of life.[18,34] The relationship between spirituality and quality of life can be explained by promoting social relationships, finding meaning in life and helping to face the reality of life's end.[34] By emphasising the unique challenges faced by gynaecological cancer patients, our study highlights the necessity of integrating spiritual care into cancer treatment plans. Our findings emphasise the importance of spiritual needs during cancer treatment and the necessity of evaluating patients holistically.

Limitations of the study

This study also has several limitations. First, participants who met the criteria were included in the study, which may have led to selection bias. However, a large percentage of invited women with gynaecological cancer agreed to participate, and the study results were consistent with the literature. Second, since the study is cross-sectional and observational, it only shows the relationship between spiritual needs and anxiety, depression, stress and quality of life and does not demonstrate a causal relationship. Third, the study was conducted with women receiving treatment at a university hospital, and the results may not be generalizable to other parts of the country.

CONCLUSION

This study provides valuable insights into the relationship between spiritual needs, psychological distress (depression, anxiety and stress) and quality of life in Turkish women with gynaecological cancer. The findings indicate that participants had high spiritual needs, with seeking peace and religious needs being the most prominent, while support, independence and communication needs were the least expressed. In addition, participants exhibited

significant levels of psychological distress, as reflected in their depression, anxiety and stress scores. Their overall quality of life was moderate, with emotional well-being being the lowest and functional well-being the highest. A positive correlation was identified between spiritual needs and psychological distress (depression, anxiety and stress), while a negative correlation was found between spiritual needs and quality of life. These findings underscore the importance of addressing spiritual needs as part of holistic care for women with gynaecological cancer.

Given the observed impact of spiritual needs on psychological distress and quality of life, integrating spiritual care into routine oncology care and periodically assessing these needs is essential. Increased awareness among healthcare providers regarding the spiritual dimensions of patient care may help improve psychological outcomes and overall well-being. Furthermore, developing structured assessment tools and personalised interventions tailored to the unique spiritual needs of women with gynaecological cancer is recommended to enhance their quality of life and mental health.

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