

Psychosocial Needs and Improved Quality of Life among Cancer Patients Receiving Palliative Care

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Abstract

Cancer disease is a threat to individual life. Patients with cancer experience varied degrees of physical and emotional distress from various issues and drought of desirable psychosocial needs. The study investigates the relationship between psychosocial needs and improved quality of life (QOL) of cancer patients receiving chemotherapy in Oncology and Palliative Care Clinic Federal Medical Centre, Makurdi. The study was a correlational design. A total of 55 cancer patients were sampled for the study. Participants comprised of 39.3% males and 60.7% females. A typical case sampling type of purposive sampling technique was used for sample selection. Results shows that health professional needs have no significant relationship with (QOL) ($\beta = -.026$, $t = -0.165$; $P < 0.05$). Support network needs have no statistically significant relationship with QOL of the patients ($\beta = .057$, $t = 0.358$; $P > 0.05$). Emotional and spiritual needs did not have a statistically significant relationship with QOL ($\beta = -.061$, $t = -0.036$; $P < 0.05$). Likewise, Practical needs and Childcare needs have no significant relationship with QOL. There is a significant positive relationship between Information needs and QOL as ($\beta = .336$, $t = 2.096$; $P > 0.05$). There is a relationship between identity needs and QOL ($\beta = -.175$, $t = -1.109$; $P < 0.05$). Regardless of the

outcome of these results, psychosocial needs are vital therapeutic ingredients that minimize patients' physical and emotional distress to enhance well-being and improve QOL. Therefore, health care managers of cancer patients should always endeavor to identify patients' needs and collaborate with the family caregivers to address them.

Introduction

Cancer is an outrageous disease that is a potential threat to the individual wellbeing, which might reduce either his or her lifespan and life expectancy. Receiving a cancer diagnosis is associated with a peak of negative mood and distress for many people [1]. Moreover, its treatment procedures are deleterious and appalling to experience in the struggle for survival. Unfortunately, the incidence of cancer is progressively rising in the population of Nigeria. This is visible in the growing number of patients referred for chemotherapy to Oncology and Palliative Care Clinic, Federal Medical Centre Makurdi and from available statistics on cancer in Nigeria. Patients with cancer experience various degrees of physical and emotional distress most times due to drought of psychosocial needs. Unfortunately for some, this often leads to an experience of poor quality of life (QOL), which may accelerate a patient's health deterioration and progression to early death [2] when these needs are not provided. Invariably people with cancer are prone to experience a complete disruption of the perceived cohesion in the ambience of his or their physical, emotional, and psychosocial security.

Writers have recognized that the concept of QOL is broad and it cannot be defined from one perspective as it is affected by health. The definitions range from those with a holistic emphasis on the social, emotional and physical well-being of patients after treatment (Greer 1984) to those that describe the impact of a person's health on his or her ability to lead a fulfilling life (Bullinger, Anderson, Cella, & Aaronson, 1993) cited in (Carr, Gibson & Robinson, n.d.) [3]. De Walden-Gałuszko also agreed that QOL is a broad concept and that it can be modified by many factors relating to physical health, psychological state, level of independence, and social relations, as well as personal beliefs and their relations with significant aspects of the external environment. In sum, World Health Organization (WHO) conceptualized that quality of life is an individual's perception of their position in life in the context of the cultural and values systems in which they live and in relation to their goals, expectations, standards, and concerns. In other words, it is the appraisal of a fragment of one's life which takes place between the human subject on the one hand and the factors which have an impact on him/her from the external environment and the internal environment (his/her own body) on the other hand [4]. De Walden-Gałuszko further emphasizes that QOL is a broad concept and that it can be modified by many factors relating to physical health, psychological state, level of independence, and social relations, as well as personal beliefs and their relations with significant aspects of the external environment. Standard indicators of QOL include wealth, employment, the environment physical and mental health, education, recreation, and leisure time, social belonging, religious beliefs, safety, security and freedom (Nussbaun & Sen, 1993 Barcaccia, 2013) [5]. Knowledge about what influences QOL and how it changes over time during treatment is important for the Psychological-oncological treatment team could help to identify areas where interventions for patients can be useful to improve patients' QOL [6]. Therefore, there is a need to satisfy cancer patients' requirements which would enable them to live a healthy and satisfactory life [7]. Aiming to satisfy the cancer patients' needs and expectations in the course

of their treatment means that a comprehensive assessment of their psychosocial needs is essentially required. This often helps the patients' managers to identify the required needs and adequately help them to meet those needs with the assistance of family members.

Basically, it is recognized that psychosocial issues affect patients at all stages of cancer [7]. Obviously, the positive impact of psychosocial needs for improved quality of life cannot be overemphasized. It is an essential recipe for the effective management of cancer patients in a multidisciplinary intervention framework in oncology and palliative care. According to Morris *et al* (2001) [7] psychosocial needs are rooted in features and qualities of life and social relationships that, from the viewpoint of patients and informal carers are necessary, important, or critical to their psycho-emotional ability to live with the knowledge and social consequences of cancer, and thus to their ability to hold themselves and their social worlds together. Psychosocial needs are categorized into seven aspects and these include health professional needs, information needs, support network needs, identity needs, emotional and spiritual needs, practical needs and child care needs [8]. Invariably, cancer patients are people from the different socio-economic, religious, occupational, marital or parental background. As a result, they will definitely have varied needs at different times on their cancer journey beginning from the stage of diagnosis through to treatment, recovery or even at the dying stage. Scholars have even clarified that cancer patients have their specific needs and prioritized in order of their importance, which they desire should be met at different points and times.

Many studies have provided evidence of the relationship between psychosocial needs and improved quality of life of cancer patients of different backgrounds, different cancer type, different ages and sex worldwide. But basically, the primary needs include health professional needs, information needs, support network needs, identity needs, emotional and spiritual needs, practical needs and childcare needs that significantly lubricate the ability of the individual to adjust and cope with his or her illness cum improve QOL. Empirical evidence on psychosocial needs and QOL specifies that health professional need plays a very significant influence on cancer patients to improve QOL [9]. Healthcare professional supports have a significant association between received support (as well as the need for and satisfaction with received support) and all aspects of quality of life, compared with support from families and friends [10,11].

On information needs and QOL, healthcare professionals have recognized it as one of the indicators of adjustment and improve QOL of patients with cancer. According to the stress and coping theory, information is a resource that aids adjustment [12]. Exposure to correct and adequate information is helpful for cancer survivors to cope with their physical and psychological problems (Husson, Mols, & van de Poll-Franse, 2010). Information on QOL is important at every stage of the cancer trajectory, including the therapeutic phase, long-term survivorship, palliative care, and end-of-life care [13]. Providing information that matches patients' needs is an important determinant for patient satisfaction and it might also affect health-related quality of life (HRQoL) including anxiety and depression levels of cancer survivors [14].

Regarding identity needs and quality of life; it represents the physical effects of experience from treatment procedures such as surgery; radiation therapy and chemotherapy. This is usually experienced in form of disfigurement or disability created when the affected part of the person's body is mutilated or removed. Psychologically, perceived negative body image leads to a variety of relationship issues that provoke distress for the patient. Baucom, Porter, Kirby, Gremore, & Keefe (2006) [15] found that breast cancer, in particular,

affects women and their male partners. Both partners could experience psychological distress including depression and anxiety. These people need support from their spouses or family members to help them adjust, and revive their self-esteem for optimum social functioning without feeling self-stigmatized because of the disability.

At the level of spirituality and religiosity, Skevington and O'Connell (2010) state that spiritual, religious, and personal beliefs (SRPB) are important and distinctive to assessing the quality of life in health. However, in assessing Quality of life relating to spiritual, religious, and personal beliefs (SRPB), there was no evidence found to support the model of the spiritual quality of life as a concept that overarches every other quality of life domain. However, Skevington and O'Connell reported that spiritual quality of life is most closely associated with the psychological domain, particularly hope, optimism and inner peace. Emotional support is therapeutic for adjustment and coping with illness as well as alleviates emotional stress like fear, anxiety and depression experienced as an emotional reaction to having cancer they perceived to be a death sentence. Unmitigated emotional stress from lack of psychosocial needs frequently leads to patients defaulting treatment, which leads to poor response to treatment, slow prognosis due to weak health. The diagnosis of cancer causes a disruption in the emotional stability and the threat to life itself triggers a complex set of issues that the individual must confront with resilience in attaining inner peace and struggle for survival. Extrapolating from this reality regarding the necessity of providing desired matching psychosocial needs of patients to augment medical treatment to improve QOL; the study examines the relationship between psychosocial needs and quality of life among cancer patients receiving chemotherapy.

Research Hypotheses

1. There will be a significant relationship between health professional needs and improved quality of life among cancer patients receiving chemotherapy.
2. There will be a significant relationship between information needs and improved quality of life among cancer patients receiving chemotherapy.
3. There will be a significant relationship between support network needs and improved quality of life among cancer patients receiving chemotherapy.
4. There will be a significant positive relationship between identity needs and improved quality of life among cancer patients receiving chemotherapy.
5. There will be a significant relationship between emotional and spiritual needs and improved quality of life among cancer patients receiving chemotherapy.
6. There will be a significant positive relationship between practical needs and improved quality of life among cancer patients receiving chemotherapy.
7. There will be a significant positive relationship between childcare needs and improved quality of life among cancer patients receiving chemotherapy.

Methodology

Research Design

The study adopted a correlational design to achieve the objectives. Correlation research helps in the predictability of the existing relationship between two or more variables measured.

Participants

A total number of (n=58) cancer patients receiving chemotherapy in the Palliative Care Unit, Federal Medical Centre, Makurdi was involved in the study. However, two patients declined their participation. While analyzing the data, only 55 questionnaires were found to be valid to determine the outcome of the study. The participants involved in the study include those diagnosed with hepatobiliary carcinoma (1.8%), alveolar rhyabdocarcinoma (7.1%), Kaposi sarcoma (14.3%), invasive ductal carcinoma or breast cancer (17.9%), cervical cancer (15.7%), papillary carcinoma (9.1%), adenocarcinoma mucinous (4.7%), squamous carcinoma (3.6%), ovarian cancer (7.1%), prostate cancer (12.3%), neurofibroma sarcoma (1.8%), nasopharyngeal carcinoma (3.6%), liver cancer (1.8%). Most of the patients had surgery as their first treatment procedure before they were referred for chemotherapy. Others were receiving chemotherapy as a neo-adjuvant treatment to shrink and weaken the tumour progression before undergoing surgery. Actually, the hospital intervention in the management of patients' cancer for now is surgery and administration of chemotherapy after which they are referred for radiotherapy to any of the eight centres the patients would prefer to go. Counselling and psychotherapy were provided to help the patients overcome the waves of emotional reactions or psychopathologies emanating from the diagnosis, treatment side effects, and emerging psychosocial concerns.

Table 1: Analysis of demographic characteristics of the Participants (N=55).

Variables	N	Percentage
Sex:		
Males	22	39.3
Females	33	60.7
Marital status		
Single	7	14.13
Married	37	67.09
Separated	1	1.09
Widowed	8	16.01
Educational status		
No education	12	21.04
Primary	8	14.13
Secondary	10	17.09
Tertiary	25	46.04

Religion		
Christianity	49	89.09
Islam	5	8.09
Traditionalist	1	1.08

Sampling Technique

A typical case sampling type of purposive sampling technique was used for sample selection. Typical case sampling was used because the participants involved were patients diagnosed with cancer irrespective of the type but are all receiving chemotherapy in the same hospital. This means cancer has exposed the patients to the experience of similar challenges of the disease and its treatment. Actually, the word typical in this context is not implying that the sample was representative as it is applied in the pure principle of probability sampling technique, but because the participant's share similar characteristics caused by cancer, and receiving the same treatment in the same hospital. Participants responded to two standardized instruments for data collection and these were; 1) Psychosocial Needs Inventory (PNI) and Integrative Global Quality of Life (IGQOL) scales were used. PNI has an internal reliability Chronbach alpha coefficient of 0.76 (24). Integrated global quality of life survey questionnaire (IQOL) re-evaluated by Ventegodt *et al* (2003) [16] has internal reliability Chronbach alpha coefficients of 0.67. Its internal reliability as estimated by Chronbach alpha 0.67 was obtained through a pilot study of (N=22) cancer patients receiving palliative care services at Federal Medical Centre, Makurdi. As Nunnally (1978-1988) [17] stated a newly developed measures can be accepted with an alpha value of 0.60, otherwise, 0.70 should be the threshold, however, considering the use of these scales for the first time in a different culture and environment, the cut-off value for the alpha coefficient was set up at 0.60 for all the scales.

Data Analysis

The linear regressions analysis was used for the data analysis and the statistical significance level of the hypotheses was determined at $P < 0.05$. The data was computed in the statistical package for social science (SPSS), Version 20.0.

Results

The purpose of the study was to investigate the relationship between psychosocial needs and improved quality of life among cancer patients in palliative care. Below from the output of the data analysis is the result of the linear regression analysis for the hypothesis.

Table 2: Linear regression analysis of the hypothesis tested

Variables	R	R ²	F value	df	β	T	p-value
Model	.43	.182	1.47	7,46			0.204
Health professional needs					-.026	-0.165	0.870
Information needs					.336	2.096	0.042

Support network needs					057	0.358	0.722
Identity needs					-.175	-1.109	0.277
Emotional and spiritual needs					-.061	-0.369	0.714
Practical needs					-.190	-1.168	0.249
Childcare need					-.054	-0.369	0.714

Correlation is significant at $P < 0.05$

The results in table 2 show that there is no significant relationship between health professional needs and the improved quality of life of patients receiving chemotherapy ($\beta = -.026$, $t = -0.165$; $P < 0.05$). There is a significant relationship between information needs and improved QOL receiving chemotherapy ($\beta = .336$, $t = 2.096$; $P > 0.05$). Support network needs also have no statistically significant relationship with improved QOL of the patients receiving chemotherapy ($\beta = .057$, $t = 0.358$; $P < 0.05$) and it was rejected. Similarly, emotional and spiritual needs have no statistically significant positive relationship with improved quality of life of the patients receiving chemotherapy ($\beta = -.061$, $t = -0.036$; $P < 0.05$).

There is also no significant relationship between Identity needs and improved quality of life of the patients receiving chemotherapy ($\beta = -.175$, $t = -1.109$; $P < 0.05$). But, there is a negative significant relationship between practical needs and improved quality of life of the patients receiving chemotherapy ($\beta = -.190$, $t = -1.168$; $P < 0.05$) which shows that the hypothesis was accepted. Lastly, there is no significant relationship between childcare needs and improved quality of life of patients receiving chemotherapy ($\beta = -.054$, $t = -0.369$; $P < 0.05$).

Discussion

The study aimed to investigate the relationship between psychosocial needs and the quality of life of cancer patients that were receiving chemotherapy in the Oncology and Palliative Care Clinic in Federal Medical Centre, Makurdi. Cancer is a life-threatening illness, and its treatment is equally challenging. But, unfortunately, cancer is growing increasingly in the population of Benue State and Nigeria at large. The development of cancer eventually is not limited to age; sex and ethnicity, the poor and the rich are equally sufferers. Of course, cancer is a disease like any other illness, though its characteristics and the experience of its signs and symptoms vary with other diseases. Invariably, it is right to admit that a person diagnosed with cancer did not however imply that he or she has obtained a death warrant and that dying would be immediate or possible. But according to Luszczyńska *et al* (2013) [8], the waves of intense emotions similar to grief reactions with periods of calmness are common.

The knowledge about having cancer usually sends in cold shivers of fear and anxiety associated with death and dying in the person. Besides, the trauma in most cases is heightened by a plethora of psychosocial issues that disrupt his or her emotional stability. Cancer patients often experience varying degrees of physical and emotional distress from various issues and a drought of desirable psychosocial needs and the needs are variable to each patient. All things being equal, many cases of early cancer detection are treated with a positive curative outcome. In some cases, because of late reporting of the disease commonly at advanced stages are treated with a focus primarily on improving the QOL of the patients which invariably helps to prolong life. Thus, from the findings, the hypotheses are discussed.

Hypothesis one; there will be a significant relationship between health professional needs and improved QOL of patients receiving chemotherapy. The hypothesis was rejected, this shows there is no significant relationship between health professional needs and improved QOL of patients receiving chemotherapy at ($\beta = -0.26$, $t = -0.165$; $P > 0.05$). The outcome of the result corresponded with the findings that medical intervention does not necessarily reduce the risk of cancer recurrence and death. Nevertheless, it is not reasonable to conclude that cancer patients may not crave health professional needs. Lipsey (1990) [18] argued that such a conclusion may be premature when a study does not have adequate statistical power. All the same, Zhen *et al* (2013) [19] reported that cancer patients' health needs which encompass psychosocial as well as disease treatment needs have been officially acknowledged. Zhen and colleagues in a study found that 41% of tumour patients need professional psycho-oncological support. Evidence on healthcare professional needs association with QOL indicates that those who received support (as well as the need for and satisfaction with received support) have significant experience of improving health and well-being (Wenzel *et al.*, 2005). Psychological burden associated with cancer is common, but psychosocial interventions including health professional needs have been shown to effectively reduce distress in cancer patients as found in [12] studies.

Hypothesis two; there will be a significant relationship between information needs and improved QOL of patients receiving chemotherapy. The findings show that there is a significant positive relationship between information needs and improved QOL at ($\beta = .336$, $t = 2.096$; $P < 0.05$). The result supports many studies on the psychosocial needs of cancer patients. Hoff, Tidefelt, Thaning and Hermerén (2007) [20] found that most patients, regardless of the type of cancer they have, expressed a wish to be well informed all through the course of the disease even when the messages are bad. Patients need information about the onset, progression, treatment and management of their disease [21]. Educating patients about their illness enhances greater outcomes that empower both patients and their caregivers; optimizing treatment outcomes; limiting treatment-related adverse events and hospitalizations [22]. Patients with fulfilled information needs and fewer information barriers, in general, experience better HRQoL and less anxiety and depression [23]. Cancer patients need to know about the normal course of their condition, the treatments available and the side effects and expected treatment outcomes so that they can make decisions that are consistent with their preferences, adjustment and coping as well as care for themselves on their journey.

The goal of providing information to patients is to prepare them for their treatment, increase adherence to therapy, increase their abilities to cope with the illness and promote recovery [23]. Information from health managers of cancer patients helps to prevent patients from the gullibility of receiving and accepting inaccurate information and advise from non-health professionals which are misleading to promote mismanagement of the disease through the use of unorthodox treatment alternatives. Essentially, information is a useful tool that enables patients to develop ways of adjusting and coping with their illness despite the intermittent stress experienced on the journey as they live and feel fulfilled with their life.

The third hypothesis states that; there will be a significant relationship between support network needs and improved QOL of patients receiving chemotherapy. The result shows there is no statistically significant relationship between support network and improved QOL of patients receiving chemotherapy at ($\beta = .057$, $t = 0.358$; $P < 0.05$). This means the hypothesis is rejected and this is in opposite of the evidence in the available previous studies. Notwithstanding, the positive influence of support networks for patients' with life-threatening illnesses such as cancer illness cannot be overemphasized. Social support is an instrumental

mechanism that enhances cancer patients' well-being. It is evident that early multidisciplinary for palliative care with caregivers' support can help patients to achieve effective symptom control and better quality of life. According to King *et al* (2006) [14], there are three categories of psychological support that are linked to self-perception and enabling beliefs. These include (a) emotional support (valuing and acceptance leading to the perception of "being believed in" and a sense of self-esteem), (b) instrumental support (guidance and provision of strategies leading to self-efficacy), and (c) cognitive support (affirmation, confirmation, and new perspective leading to coherence in self-concept and worldview). Indeed, social support network has been found to have a significant relationship with QOL for patients with a terminal illness [24], it is associated with less distress due to pain [25,26]. Decrease the risk of mortality [27]. It is a key element in how people manage and cope with illness [28,29].

The fourth hypothesis states that there will be a significant relationship between identity needs and improved QOL of cancer patients receiving chemotherapy. This result shows that there is a significant negative relationship between Identity needs and improved Quality of Life, ($\beta = -.175$, $t = -1.109$; $P > 0.05$). The finding supports evidence-based studies on psychosocial issues in cancer patients. For example, Baucom, Porter, Kirby, Gremore and Keefe (2006) [15] found that younger women with breast cancer experience a lower quality of life after cancer compared to older women. In part, this lower quality of life results from the effects of medical treatment procedures related to surgery which often involves the removal of the breast. The result to breast deformity is always perceived with negative feelings about disfigured body image and low self-esteem for such young women. Disfigurement associated with cancer treatment effects experienced from surgery and radioactive therapies reduce self-worth and dampen the interpersonal relationship of patients (Onyeka, 2010) for both the woman and the partner.

The fifth hypothesis states that there will be a significant relationship between practical needs and improved QOL of cancer patients receiving chemotherapy. The results indicate that there is a negative significant relationship between Practical needs and improved Quality of life ($\beta = -.190$, $t = -1.168$; $P < 0.05$). The finding corresponded with evidence from Ness *et al* (2005) study that 3, 7, and 8 percent reported limitations from the activities of daily living such as the ability to eat, bathe, dress, or get around their home by themselves; perform everyday household chores, hold a job or attend school. Others include bathing, using the toilet, dressing, preparing meals, feeding oneself; using a telephone, shopping, paying bills, and using transportation [26]. Apparently, for most cancer patients seen in the clinic; in-so-much-as they are diagnosed with cancer irrespective of the stage it is, and so long as he or she is not physically incapacitated they are always asking if he or she can continue to perform their daily activities like going to school, work and business. In fact, an unperceived limitation by the patient to perform his or her daily tasks at home, office or market gives her/him a sense of wellness, and strength to function well rather than seeing his/herself as incompetence and stigmatization in their community.

The sixth hypothesis states that there will be a significant relationship between emotional and spiritual needs and improved QOL among patients receiving chemotherapy. The findings indicate there is no statistically significant relationship between emotional and spiritual needs and improved QOL among the patients receiving chemotherapy at ($\beta = -.061$, $t = -0.036$; $P < 0.05$). Emotionality and spirituality are absolutely two separate parts of human life that can seamlessly fuse together to promote the individual subjective wellbeing. Statistically, this hypothesis was not supported, but this is not to conclude that emotional and spiritual needs

are less important or ineffective in helping to improve patients' QOL. It is necessary to recognize that spiritual quality of life, but not most other aspects of quality of life, is higher for religious people (Skevington, & O'Connell, 2010) and perhaps the elderly. On the ground of this observation, both emotional and spiritual variables may not jointly correlate with QOL but independently each could do. This is confirmed by the studies that spirituality and social support are important predictors of quality of life in patients with a terminal illness (Ganzini *et al.*, 1999; Houck, Avis, Gallant, Fuller, & Goodman, 1999) [21,31].

Contrary, Riddick, Sawyer and Brackett (2011) [27] from cross-sectional survey research with 64 at 105 years old males and females found no statistically significant relationship between spirituality and physical well-being among the elderly rural African-Americans nearing the end of life. On emotional support; it is found that emotional support helps to placate as well as helps patients to cope effectively with their emotional response to the challenges of cancer [28,32]. Cancer is an appalling life-threatening illness that when a person is diagnosed with it, anxiety, mood disorder, fear of dying, concerns about negative body image, and the family disrupt the individual state of emotional equilibrium. The lack of providing emotional support to patients induces great psychological distress that relates to fear for the future; inability to make plans; uncertainty and worries, about death and dying.

Hypothesis seven, states that there will be a significant relationship between childcare needs and improved QOL among cancer patients receiving chemotherapy. The result shows that there is no significant relationship between childcare needs and the patients' improved QOL at ($\beta = -.054$, $t = -0.369$; $P < 0.05$). This finding corresponded with results from a Danish Population Sample study and the Copenhagen Perinatal Cohort and a Quality of Life Research Center, the University Hospital Copenhagen in Denmark. Both studies showed that having children and catering for them did not show any strong relationships to quality of life and neither did relations with one's parents. Our results indicate that what is really important is not what one has, but how he sees, evaluates and experiences what he has [33-43].

Conclusion

Cancer is a major health challenge to everyone with its diagnosis. Generally, following the initial days after receiving the diagnosis, most individuals are able to develop a constructive plan of action for their cancer journey. But for many, and in most cases, the primary treatment objective is palliative care to improve the QOL of patients faced with this life-threatening illness through a multidisciplinary approach. Quality of life may be achieved when the patients receive adequate matching social support needs that address their psychosocial concerns. This is evident in many studies including ours which was focused on the relationship between psychosocial needs and QOL among patients receiving chemotherapy. In view of this, healthcare professionals are to recognize that people who are diagnosed with cancer transit on the continuum of the disease with a dislocated emotional state. Usually, this will be often heightened by the patient's experience of the wave of intense emotional reactions associated with a drought of desirable psychosocial needs. Consequently, it is to be realized that human needs are an expression of our nature, and these needs are traditionally related to the quality of life such that when one's needs are fulfilled, his or her QOL increases high. Hence, it is pertinent that patients' psychosocial needs should be always identified and prioritized in psycho-oncological treatment decisions and plan in order for it to be adequately provided by all caregivers involved (health professionals and family members) to reinforce and sustain patients' QOL.

Recommendations

1. Healthcare professionals in charge of managing cancer patients should always carry out an in-depth assessment for people diagnosed with cancer in order to identify each patient's needs and factor these in their formulation of a treatment plan tailored toward improving his or her QOL.
2. Healthcare professionals in charge of managing the cancer patients should always provide required comprehensive information to educate patients and through which they will be able to develop adaptive strategies for adjustment and coping with the illness to improve their QOL.
3. Psychosocial issues are common parameters that cause waves of intense emotional reactions in cancer patients. Thus, clinical psychologists should be always involved in patient management at every stage of the disease to help them overcome their emotional distress for enhanced QOL.
4. Psychologists on multidisciplinary team for patients' management should frequently employ faultless approach to identify the patient's psychosocial needs as well as use diligent professional skills in collaboration with other MDT members and family caregivers to address those desirable needs which can help to improve their QOL.
5. Almost all cancer patients experience the trauma of diagnosis with emotional disorders such as anxiety, fear and depression etc. Thus, psychologists on multidisciplinary team could use group therapies for the camaraderie of patients with similar psychosocial needs issues to benefit from the goals of therapy.

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Conflict of Interest

The manuscript has been prepared in accordance with the recommended style of the journal, and the authors have approved its contents with satisfaction and unanimity in agreement on the outcome of the article for publication.

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