COMMENTARY

The challenges of psycho-oncology research in developing countries: A non-equivalent process of growth

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Psycho-oncology emerged only four decades ago. This discipline, as a subspecialty into the disease-specific domain of oncology, is focused on the psychological aspects of the treatment and management of patients with cancer. Today, this field contributes to the clinical care of patients and their families, to the training of staff in psychological management, and to collaborative research that ranges from the behavioral issues in cancer prevention to the management of psychiatric disorders and the psychosocial problems during the continuum of cancer illness, including survivorship and end-of-life care[1]. Despite the relatively short lifespan of psycho-oncology specialty, the extent of its clinical influence and the amount of research produced is enormous.

The development of psycho-oncology has been closely related to the development of the medical practice of oncology. During the last decade, we have witnessed an unprecedented outburst of new treatment approaches for cancer and new lines of research have arisen. These progresses and cancer control research have helped to reduce cancer incidence, morbidity and mortality[2]. As a consequence, survivorship as the ultimate goal of oncology is not an exception anymore. Now, this is a common expected outcome and cancer survivors are a growing population[3]. Besides, cancer is now considered as a chronic condition more than a death sentence. Therefore, the focused is placed not strictly on survival, but in improving adaptation to the disease and the global health status in the aftermath of cancer[4]. Precisely, psycho-oncology research is aimed at examining long-term psychosocial effects of treatment, survival, health-related quality of life, adaptation to cancer and to a life free of treatment and the disease, among other aspects[3]. All these aforementioned issues constitute the basis of a growing body of knowledge and the foundations of this field. However, there are still several challenges to overcome.

It is already known that, in psycho-oncology research, comparisons and generalizations are very difficult because of the variety of settings, sample populations, study designs, assessment tools, and operational definitions of constructs and variables studied. To these limitations, we must include resource availability differences depending on the country. In this sense, it is worthwhile to stress that approximately 70% of all cancer deaths occur in low- and middle-income countries[5]. That is to say, the ethnic minorities are overrepresented in cancer burden, yet underrepresented in research. Psycho-oncology (and oncology research, in general) has followed the guiding path of resources availability. That means that most scientific research in this area does not include unique aspects from developing countries. This represents a big limitation because practical models for designing multicultural responsive research studies in this field are lacking. This leads to what might be considered a paradox. Research in oncology may require many material means, but the findings are easily generalizable. On the other hand, research in psycho-
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Oncology requires less material means, but its results are less generalizable from one cultural context to another.

As mentioned, socio-cultural differences between developed and developing countries are many. Firstly, population access to care, priorities and type of treatments, as well as clinical outcomes are very different in developing countries. In low-income countries, hospitals must struggle with financial constraints and sometimes, expensive equipment or even the number of professionals is limited. For instance, multidisciplinary teams may lack of social workers or psychologists in some countries. This, obviously, will affect results obtained concerning patients’ experiences during and after cancer[6]. Secondly, social and cultural characteristics of developing countries are underrepresented in research. These features influence emotional and cognitive responses to cancer too. In this sense, the relationship between the medical team and the patient along with their family might be very different if we compare developed and developing countries[7]. The type and availability of social and community support is also very crucial when studying adaptation to cancer[8]. Similarly, patients’ participation throughout the process and decision-making might differ widely depending on several cultural aspects[9]. Thirdly, the awareness on how religion and spirituality influence cancer adaptation is scarce. In this sense, there are still very few studies examining how different concepts of death, disease and transcendence influence cancer-coping in both, family and the patients[10]. Although some research from developed countries includes religion and spirituality as a part of their targeted variables, most research has been carried out with Caucasian sample populations living in developed countries.

In summary, most psycho-oncology research comes from resource-rich settings and, therefore, some results might be very different in developing countries if we acknowledge that they have specific and unique features. Consequently, research from developing countries is highly necessary and needs to be supported to advance this knowledge and to favour a better understanding of the specific realities of cancer patients and their families in those countries.

Conflict of interest

The author declares no potential conflict of interest with respect to the research, authorship, and/or publication of this article.

References