

UCSF

UC San Francisco Previously Published Works

Title

Experiences of Advanced Breast Cancer Among Latina Immigrants: A Qualitative Pilot Study

Permalink

<https://escholarship.org/uc/item/6kp6837g>

Journal

Journal of Immigrant and Minority Health, 22(6)

ISSN

1557-1912

Authors

Glaser, Johanna
Coulter, Yvette Z
Thompson-Lastad, Ariana
[et al.](#)

Publication Date

2020-12-01

DOI

10.1007/s10903-020-01069-4

Peer reviewed



Published in final edited form as:

J Immigr Minor Health. 2020 December ; 22(6): 1287–1294. doi:10.1007/s10903-020-01069-4.

Experiences of Advanced Breast Cancer Among Latina Immigrants: A Qualitative Pilot Study

Johanna Glaser, MD^{1,2}, Yvette Z. Coulter, BA¹, Ariana Thompson-Lastad, PhD¹, Lisabeth Castro-Smyth, MSW¹, Elina Serrano, MD², Shelley R. Adler, PhD^{1,2,3}

¹Osher Center for Integrative Medicine, University of California, San Francisco, CA

²School of Medicine, University of California, San Francisco, CA

³Department of Family and Community Medicine, University of California, San Francisco, CA

Keywords

Latina; immigrants; advanced cancer; end of life; breast cancer; qualitative research

Introduction

Although there is growing attention to end-of-life (EOL) care in the United States, EOL care for underserved populations has been less widely considered. Latinx Americans are the largest US ethnic minority group at 18% of the population [1], and approximately one-third are foreign-born [2]. Both US-born and immigrant Latinx Americans experience significant health and healthcare disparities [3–5], including disparities in EOL care [6]. Intersecting factors contributing to disparities include language barriers, poverty, and lack of access to health insurance [5, 7, 8]. Nationally, as many as one in five Spanish-speaking Latinx Americans reports avoiding medical care due to language barriers [4]. Furthermore, 20% of Latinx immigrants experience poverty [9] and 40% are uninsured [10] compared to 9% [11] and 7% [12] of white European Americans respectively.

Latina women experience disparities specifically in the context of breast cancer care. Breast cancer is the most commonly diagnosed cancer and the leading cause of cancer death among US Latinas [13]. They are, however, less likely to receive screening mammography [13], timely follow-up of abnormal screening results [14], and appropriate treatment than are white European American women [15], and are more likely to be diagnosed at an advanced stage of disease [16].

Terms of use and reuse: academic research for non-commercial purposes, see here for full terms. <https://www.springer.com/aam-terms-v1>

Corresponding author: Johanna Glaser, UCSF Osher Center for Integrative Medicine, 1545 Divisadero Street, Room 515, San Francisco, CA 94115, Phone: (510) 332-1444, Johanna.glaser@ucsf.edu.

Publisher's Disclaimer: This Author Accepted Manuscript is a PDF file of an unedited peer-reviewed manuscript that has been accepted for publication but has not been copyedited or corrected. The official version of record that is published in the journal is kept up to date and so may therefore differ from this version.

DECLARATIONS & COMPETING INTEREST:

The authors declare that they have no competing interests. The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Despite these disparities, few studies have examined the EOL experiences of underserved Latina women with breast cancer. Of those that have, relevant findings include difficulties navigating the healthcare system, in part due to language barriers and patient-provider mistrust [17]. Yet contrary to cultural stereotypes of fatalism as a deterrent to health-promoting behaviors among this population [18], Latina women have been shown to utilize positive reframing, spirituality and religion, and family support to cope with breast cancer and adhere to treatments [17, 19–22]. Latinas also express interest in complementary medicine (CM) for cancer treatment. CM use among Latinas with breast cancer varies in frequency and modality [23, 24], but appears to be common, with estimates ranging from 35% to 93% depending on how CM is defined [25, 26]. Given unique and intersecting challenges faced by low-income Latina immigrants with breast cancer, and lack of data elucidating their EOL experiences, we undertook a qualitative pilot study to explore how members of this population relate to their support networks and cope with advanced disease.

Methods

Participants

We included Latina immigrants who were 18 or older with limited English proficiency, an annual family income \leq 200% of the federal poverty level, and confirmed metastatic breast cancer. We excluded women unable to be interviewed due to illness severity or dementia. We recruited participants at two sites: Zuckerberg San Francisco General Hospital (ZSFG, the county safety-net hospital) and the Charlotte Maxwell Clinic (CMC, a free clinic that provides integrative cancer care to low-income women in Oakland, CA). Clinic staff at both sites identified potential participants. We sent recruitment letters to 28 patients, then screened respondents by phone. Ten did not meet eligibility criteria, three were unreachable, and two declined to participate. We enrolled 13 patients.

Although our primary focus was on patients' illness experiences, we were also interested in how patients related to their support networks, and how EOL conversations were perceived by all those involved. We asked each patient to identify an informal caregiver, physician, and, if applicable, CM practitioner to be interviewed as members of their support network. All patient participants named an informal caregiver, twelve named a physician, and six named a CM provider for support network interviews. We interviewed all CM practitioners. One informal caregiver was unreachable, and only four physicians agreed to be interviewed. The UCSF institutional review board approved this study (#10–00302).

Materials

We first created an English version of the semi-structured interview guide and tested it in a separate study. We utilized a professional service to translate and back-translate the final version of the interview guide between English and Spanish, then reviewed it via focus groups with a variety of Spanish-speaking health educators, ZSFG and CMC staff, and CMC patients not enrolled in the study.

Procedure

Patients met in person with a bilingual interviewer for four semi-structured interviews. All interviewers were trained by the study's principal investigator (SRA) in qualitative research methods and best practices for conducting semi-structured interviews. We conducted two interviews in person or by phone with each informal caregiver, and one with each physician and CM practitioner. We conducted all patient interviews and some informal caregiver interviews, depending on caregiver preference, in Spanish. Interviews were audio-recorded, transcribed verbatim, and, if conducted in Spanish, professionally translated. Patient interviews explored EOL concerns and the physical, psychological, social, and spiritual aspects of living with advanced breast cancer. Informal caregiver, physician, and CM practitioner interviews focused on the relationship of the interviewee with the patient and on communication about EOL issues. Two reviewers developed a comprehensive codebook (JG, AT-L). All authors independently coded transcripts and conducted thematic analysis using qualitative data management software (Dedoose), meeting to modify the codebook and reconcile differences in categories. Each interview transcript was coded by at least two authors. Two bilingual authors (LC-S, ES) compared selected portions of English and Spanish interview transcripts for accuracy. All authors discussed and agreed upon themes.

Results

Interviews were conducted between July 2008 and February 2011. Mean patient age was 56 (SD 8.4). All were born in Latin America, and mean number of years in the US was 24 (SD 9.4). Ten women (77%) had an annual household income of less than \$30,000 and 8 (62%) had a high school education or less (Table 1). Nine (69%) accessed CM therapies through a practitioner, specifically mentioning massage, acupuncture, and herbs. Informal caregivers included children, friends, siblings, spouses, extended family members, and employers (Table 2).

Our qualitative analysis revealed two predominant themes. First, staying positive was a primary patient coping mechanism (Table 3), and related to patients' and their networks' approaches to EOL conversations. Second, patients' socioeconomic status, immigration-related issues, and language barriers in medical settings posed specific challenges for study participants.

Staying Positive as a Primary Coping Mechanism among Patients

All patients described staying positive as a method of coping with illness. They perceived staying positive, fighting, and maintaining hope as interconnected. "You've got to fight... It's all about the effort you put into it so you can keep going. Be positive and leave the negative aside" (P2). "We have to be positive about things, not let yourself get down, and give yourself hope" (P13).

Spirituality was important to participants, and though many conceived of God as the ultimate decider of their fate, they also viewed doctors as instruments of God and considered staying positive and adhering to medical treatments as part of their role. "Always be optimistic and positive. Keep going and comply with whatever the doctor asks us to do... the

scripture says, ‘Help yourself and I will help you’... Sometimes we expect God to do everything, and no! God sent people like doctors. You have to seek and not give up” (P18). “I manage [my cancer] well. God gives us the disease and the remedy” (P4).

A positive mindset did not mean denying reality: “I do know that I’m ill, but I try to find a way to not have it... just in my mind” (P17). Rather, the importance of positivity was related to the belief that negative thinking worsens health. “Of course you don’t stop thinking about your illness, but at the same time you have to be brave... If we get too sad, thinking about the illness, we get even sicker” (P13). Negative thinking was sometimes equated with giving up, or seen as hastening death. “I knew a woman who was given three months to live and she arranged everything in two days and died exactly two weeks later... the mind is powerful, so I always remain positive.” (P14).

Patients also stayed positive to protect loved ones. “‘If I feel down, [my family] also feels down.... Everything positive... because if they see I have a happy face, then they’re also happy’” (P18). Some expressed appreciation when members of their support networks maintained positivity, stating that this helped keep them motivated. “The doctor says, every time I go there, ‘You look good.’ That lifts you up, and then you say, ‘I have to keep moving forward, I have to keep up the fight’” (P2).

Sometimes, however, staying positive resulted in isolation. Several women described downplaying physical or emotional struggles in ways that limited their ability to receive support. “Many times you want to share your sorrows, so that others can lift your spirits, but you don’t want to make them feel bad.... I say, ‘Everything is fine, I’m alright, nothing hurts.’ But the truth is that... you do have problems and you don’t want to say anything” (P9). The most extreme examples included one woman who hid her diagnosis from her extended family, and another who moved away from her family to spare them from seeing her suffer.

Staying Positive among Support Network Members

Staying positive functioned similarly for informal caregivers (Table 3). Many considered staying positive to be part of their caregiving role, and equated positivity with being strong. Many similarly felt that positivity reduced their stress, and believed that positive thinking promoted better outcomes for their loved ones. When asked what advice he had for other caregivers, one said, “Just stay positive.... I always put on a strong face for her and the family” (CG 16). Another responded, “Be supportive and see the best side of everything. If you keep on looking at the worst, you definitely won’t anywhere” (CG 10).

A number of CM practitioners discussed positivity and warmth at the CM clinic. During appointments, practitioners focused on immediate symptom relief and positive physical touch. “With chemo, there’s a lot of really aggressive, invasive stuff happening to them. My approach is just to give them that positive touch... to allow them to be present... By the end, a lot of them have smiles on their faces. They really thank you, and there’s almost always hugs” (CM 4). In contrast to specifically encouraging patients to focus on positive thoughts, CM practitioners commonly spoke of helping patients to “be present” (CM 2) or “come back into their bodies” (CM 9) through mindfulness techniques (Table 3).

Physicians also discussed staying positive, but less so than other study participants. Physicians tended to encourage optimism among patients while multiple treatment options remained, reserving prognostic conversations for when patients were found to have new metastases or a particular treatment stopped being effective (Table 3). “It’s been, when this drug stops working... We’re there for you if things develop. We’ll figure out what the options are and talk about it then” (MD 6). Some physicians associated patients’ positivity with resilience. “She’s really quite a strong person.... She’s always held onto a degree of optimism which is, ‘Maybe it will get better.... Maybe when I feel stronger I’ll go back to [chemo].’ A kind of a resilience and optimism” (MD 14).

Staying Positive and End-of-Life Conversations

Participants’ desire to stay positive resulted in complex approaches to EOL conversations. Many patients reported that they preferred not to discuss death because it made them feel sad or anxious: “The most difficult topic is almost always death. You don’t want to think about that, but unfortunately you have to.... I don’t like it” (P2). Others felt comfortable discussing it, either in general or with specific confidants. A number had discussed EOL care and after-death arrangements with family, while others chose not to in order to spare loved ones from distress. Some felt a desire to discuss these topics but met resistance. As one patient described, “Sometimes I bring up [dying] and my daughter tells me, ‘No, don’t talk about negative things, please. Think of positive things all the time’” (P18).

Patients and informal caregivers had mixed reactions to EOL conversations with physicians. Some described prognostic discussions as “cruel” or “negative,” especially when physicians seemed rushed or uncaring. Participants felt more trust for providers whom they perceived as having adequate time and a warm demeanor. “The primary thing for me in a doctor is that they give their patient a sense of trust.... [The specialist] is very unpleasant. He treats the patient as if they were a dollar bill.... I go to my general practitioner and he takes his time... He’s friendly, asks how you feel... it’s a big difference” (P10). Multiple women expressed desire and gratitude for the opportunity to talk about EOL issues in a supportive context. Those who attended cancer support groups for Spanish-speaking women described such spaces as safe environments to discuss difficult topics without burdening loved ones. Women also appreciated the opportunity to discuss EOL topics during the study, with feedback such as, “It’s very useful... I was able to get express everything I was holding inside and get it out” (P22).

Socioeconomic Status, Immigration, and Language Barriers

Despite strong family and social support networks, participants’ socioeconomic status, immigration-related issues, and language barriers in medical contexts exacerbated challenges facing patients and their informal caregivers. Financial constraints were a primary source of distress: “The biggest concern is always the economic situation” (P10). Several patients described themselves as “just getting by” and the majority reported not having enough money for rent, food, or utilities within the last year. Medical costs added to financial burden: “Doctors and part of the medications, which are very expensive.... It’s too much money. All the bills are already in collection. I don’t know what to do because I don’t have a penny to pay” (P14). Some patients had to continue working despite physical

symptoms. “There are times I get up... I say, ‘God, give me strength’... If I had money, I’d stay in bed...but I have to support my nine-year-old son.... This is an illness that, economically, if you’re not prepared, you don’t survive” (P17). Others were unable to continue working due to physical limitations or frequent medical appointments. “I used to work. I had two jobs.... Now I only live on the small amount I get from Social Security. That’s stressful, that you don’t have enough to pay the rent.... Working is better than being like this” (P16). Increased dependence troubled patients. “Without work it’s very difficult to support myself, and that’s why my quality of life is bad... my friends help me out a little bit and I’m able to get enough together for my rent, but I’m mortified over that... my main concern is to recover and start working” (P22).

Financial constraints were often connected to immigration issues. All participants had immediate or extended family in their countries of origin, and many sent remittances. “My wish for the future is that God keeps me positive and to be able to continue working.... I have a brother who is 85 years old. I send him a little money to help with food, a bit of medicine... in our homeland poverty is worse than ever.... if I don’t send them that money, how will they live?” (P6). Participants greatly missed distant family and expressed grief over their inability to travel to their home countries due to financial limitations or immigration status. Several discussed their desire to die in their home country, or to have their body sent home for burial.

Language barriers affected patients’ and caregivers’ medical interactions. Some participants described “getting by” with limited English or ad hoc interpreters including children and administrative staff. “The doctor makes an effort to understand me, but it’s not the same as me telling him in Spanish... I ask my son, because he sees that I’m struggling... Then he’s the one who tells [the doctor], even though he doesn’t want to” (P2). A few participants reported confusion after medical visits: “[The doctor] only speaks English, so it’s hard for her to understand what he’s saying. She’ll come back and show me letters, and we try to understand... The letters are in English. It’s all doctor terminology.... It’s just hard” (CG 10). Patients generally preferred bilingual providers, describing an increased sense of comfort and trust when communicating directly in Spanish.

In summary, for low-income Latina immigrants with advanced breast cancer, staying positive is a primary coping mechanism, but caregivers’ desire to stay positive can interfere with patients’ ability to openly discuss matters relating to EOL. Economic difficulties, immigration concerns, and language discordance negatively impact this population’s illness experience.

Discussion

In this qualitative pilot study of the lived experiences of Latina immigrants with advanced breast cancer and their support networks, we found that staying positive functioned as a primary coping mechanism for patients and their informal caregivers, and influenced interactions between patients and their physicians and CM practitioners. Socioeconomic status, immigration-related issues, and language barriers contributed substantially to patients’ and their informal caregivers’ challenges. Our findings reflect and expand upon

previous studies that (a) show positive reframing to be a key aspect of coping among Latina women with cancer [17, 19–20], and (b) challenge cultural stereotypes of so-called “fatalistic” beliefs in this population as barriers to health-promoting behaviors [20–22]. Our results also reinforce previous findings highlighting language and systemic barriers that contribute to health and healthcare disparities among Latinx patients with cancer [17, 19]. Though few studies exist that examine the cancer experience of members of other immigrant groups in the US, there is some evidence that socioeconomic distress, immigration-related issues, lack of cultural sensitivity of healthcare providers, and language barriers are similarly important barriers to care experienced by Asian immigrants with cancer [27,28]. Evidence also suggests that older immigrants, particularly those belonging to racial/ethnic minority groups, engage in less advanced care planning than the overall elderly population in the US [29], and that undocumented immigrants in particular face challenges accessing appropriate EOL care [30].

Maintaining a positive attitude was a complex matter for participants in our study. Since positive reframing has not been linked to enhanced cancer survival [31,32], the question of whether staying positive contributes to enhanced quality of life for cancer patients and their families appears salient. While a positive mindset aided patients in adhering to difficult cancer treatments and managing physical and emotional pain, it also caused stress and isolation for patients and members of their support networks who felt pressured to project false positivity and refrain from expressing their full range of emotions. Prognostic and EOL conversations were particularly fraught for study participants for these reasons, but despite some reservations, patients generally expressed a desire for supportive environments to engage with these topics. The enthusiasm among patients in interviews and retention rate of this pilot study suggest that larger studies involving this population are viable.

Navigating the pragmatic, emotional, and financial challenges of terminal illness is difficult for all patients. These difficulties were amplified for the women in our study, who experienced additional, intersecting challenges. Costs associated with treatments were compounded by pre-existing financial hardship, adding to the struggle of maintaining daily provisions as well as to participants’ distress. Pragmatic and emotional challenges were exacerbated by immigration issues, which limited women’s ability to fulfill EOL wishes such as visiting or being buried in their home countries, and language discordance, which limited women’s communication with providers and understanding of their care plans.

Strengths and Limitations

A major strength of our study is that we conducted four in-depth interviews with each patient and also interviewed informal caregivers, physicians, and CM practitioners within patients’ support networks. The depth (multiple interviews with patients and caregivers) and context (network member interviews) allowed us to gain a nuanced understanding of the experiences of our study population, which is inadequately represented in the medical literature. Limitations include our study’s small number of participants in a limited geographic region, which restricts the generalizability of our findings, and the delay since completing interviews, as intervening policy changes and increased living costs could affect the current EOL experiences of similar populations. Little has changed, however, in the way

of access to health and social services in the study setting during this time. Regardless, we caution against drawing broad conclusions from our study about the EOL experience of Latina immigrants.

Implications

Our findings have a number of practical implications for clinical care and health and social policy. Several changes could contribute to more supportive EOL conversations with Latina immigrants in a clinical context. Shared language is crucial; best practice includes access to bilingual clinicians or professional interpreters [33], and specific training in EOL discussions for professional interpreters may provide additional benefit [34]. Given the well-documented shortage of bilingual medical providers, however, it is also important to integrate bilingual staff members such as social workers, nurses, and CM providers into care teams providing oncological and EOL care [35]. Longer medical visits that provide adequate time for EOL conversations, a caring demeanor on the part of clinicians, and inquiry about transnational families and other social context may also build trust and enhance communication. It is interesting to note that participants in this study did not mention the possibility of hospice care during discussions about EOL; it is unclear whether this topic's absence was due to barriers to accessing desired hospice services, lack of interest in hospice services, or participants' lack of awareness of hospice care options. Since participants were generally enthusiastic about supportive environments in which to discuss EOL outside of family relationships, offering focused, context-sensitive information about hospice services might also be of benefit.

Severe financial distress, as experienced by many of our study participants, has been shown to decrease quality of life among cancer patients and limit access to medical care, contributing to worse health outcomes and higher risk of early mortality [36, 37]. Clinicians should proactively address patients' financial constraints when discussing healthcare access and devise realistic treatment plans, and medical staff should ensure that patients and their informal caregivers are aware of and receive support in applying for available public benefits (e.g., state disability insurance, paid family leave, and in-home support services for Medicaid recipients). Financial distress was exacerbated by participants' unemployment and underemployment, and it is known that low-income cancer patients are more likely to face unaccommodating employers and job loss than their more affluent counterparts [38]. Given some patients' desire to continue working and difficulty meeting basic needs despite receiving Social Security benefits, it is necessary to advocate for labor rights for underserved populations and to maintain and expand public assistance programs. Clinicians remain an important voice in advocating for the expansion of medical and social safety-net programs to better serve vulnerable patient populations [38, 40].

Disclosures and Acknowledgments:

The authors have no conflicts of interest to disclose.

We are deeply grateful to the study participants from Zuckerberg San Francisco General Hospital and the Charlotte Maxwell Clinic and their informal and professional caregivers for generously sharing their experiences with us. We also offer special thanks to the staff and volunteers of CMC, as well as Julissa Cabrera, BA, one of the UCSF interviewers.

This work was supported by a grant from Susan G. Komen for the Cure (DISP0707207; Adler, PI). The participation of Johanna Glaser, BA, and Ariana Thompson-Lastad, PhD, was supported by the UCSF Osher Center research training fellowship program (NCCIH T32 AT003997; Hecht and Adler, MPIs). Two concomitant studies that informed the conduct of this research were funded by the National Institutes of Health (R21 009363; Adler, PI) and the California Breast Cancer Research Program (13BB-1000; Adler and Stone, MPIs).

REFERENCES

1. United States Census Bureau. Hispanic heritage month 2018 <https://www.census.gov/newsroom/facts-for-features/2018/hispanic-heritage-month.html>. Accessed 14 June 2019.
2. Pew Research Center. Facts on US Latinos, 2015 <https://www.pewhispanic.org/2017/09/18/facts-on-u-s-latinos-current-data/>. Accessed 14 June 2019.
3. Lauderdale DS, Wen M, Jacobs EA, Kandula NR. Immigrant Perceptions of Discrimination in Health Care: the California Health Interview Survey 2003. *Med Care*. 2006;44(10):914–920. doi: 10.1097/01.mlr.0000220829.87073.f7. [PubMed: 17001262]
4. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: Institute of Medicine; 2003.
5. 2017 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; September 2018 AHRQ Pub. No. 18–0033-EF.
6. Johnson KS. Racial and Ethnic Disparities in Palliative Care. *Journal of Palliative Medicine*. 2013;16(11):1329–1334. doi: 10.1089/jpm.2013.9468. [PubMed: 24073685]
7. Vega WA, Rodriguez MA, Gruskin E. Health Disparities in the Latino Population. *Epidemiologic Reviews*. 2009;31(1):99–112. doi: 10.1093/epirev/mxp008. [PubMed: 19713270]
8. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O 2nd. Defining Cultural Competence: Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Rep*. 2003;118(4):293–302. doi: 10.1093/phr/118.4.293. [PubMed: 12815076]
9. Center for Immigration Studies. Immigrants in the United States: A Profile of America's Foreign-Born Population. <https://cis.org/Immigrants-United-States-Profile-Americas-ForeignBorn-Population>. Accessed 14 June 2019.
10. Pew Research Center. Hispanic Immigrants more likely to Lack Health Insurance than U.S.-Born. <https://www.pewresearch.org/fact-tank/2014/09/26/higher-share-of-hispanic-immigrants-than-u-s-born-lack-health-insurance/>. Accessed 14 June 2019.
11. United States Census Bureau. Income and Poverty in the United States: 2017 <https://www.census.gov/library/publications/2018/demo/p60-263.html>. Accessed 14 June 2019.
12. National Center for Health Statistics, Centers for Disease Control and Prevention. Health of White non-Hispanic population. <https://www.cdc.gov/nchs/fastats/white-health.htm>. Accessed 14 June 2019.
13. American Cancer Society. Cancer Facts & Figures for Hispanics/Latinos 2018–2020. Atlanta: American Cancer Society, Inc. 2018 <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-hispanics-and-latinos/cancer-facts-and-figures-for-hispanics-and-latinos-2018-2020.pdf>. Accessed 14 June 2019.
14. Press R, Carrasquillo O, Sciacca RR, Giardina EG. Racial/Ethnic Disparities in Time to Follow-up after an Abnormal Mammogram. *J Womens Health (Larchmt)*. 2008;17(6):923–930. doi: 10.1089/jwh.2007.0402. [PubMed: 18554094]
15. Chen L, Li CI. Racial Disparities in Breast Cancer Diagnosis and Treatment by Hormone Receptor and HER2 Status. *Cancer Epidemiol Biomarkers Prev*. 2015;24(11):1666–1672. doi: 10.1158/1055-9965.EPI-15-0293. [PubMed: 26464428]
16. Iqbal J, Ginsburg O, Rochon PA, Sun P, Narod SA. Differences in Breast Cancer Stage at Diagnosis and Cancer-Specific Survival by Race and Ethnicity in the United States. *JAMA*. 2015;313(2):165–173. doi: 10.1001/jama.2014.17322. [PubMed: 25585328]
17. Nedjat-Haiem FR, Carrion IV, Ell K, Palinkas L. Navigating the Advanced Cancer Experience of Underserved Latinas. *Support Care Cancer*. 2012;20(12):3095–104. doi: 10.1007/s00520-012-1437-4. [PubMed: 22418600]

18. Pérez-Stable EJ, Sabogal F, Otero-Sabogal R, Hiatt RA, McPhee SJ. Misconceptions about cancer among Latinos and Anglos. *JAMA*. 1992;268(22):3219–23. doi:10.1001/jama.1992.03490220063029 [PubMed: 1433762]
19. Castillo A, Mendiola J, Tiemensma J. Emotions and Coping Strategies During Breast Cancer in Latina Women: A Focus Group Study. *Hisp Health Care Int*. 2019;1540415319837680. doi: 10.1177/1540415319837680.
20. Carrion IV, Nedjat-Haiem F, Macip-Billbe M, Black R. “I Told Myself to Stay Positive” Perceptions of Coping Among Latinos With a Cancer Diagnosis Living in the United States. *Am J Hosp Palliat Care*. 2017;34(3):233–240. doi: 10.1177/1049909115625955. [PubMed: 26764346]
21. Leyva B, Allen JD, Tom LS, Ospino H, Torres MI, Abraido-Lanza AF. Religion, Fatalism, and Cancer Control: a Qualitative Study among Hispanic Catholics. *Am J Health Behav*. 2014;38(6):839–49. doi: 10.5993/AJHB.38.6.6. [PubMed: 25207510]
22. Flórez KR, Aguirre AM, Viladrich A, Céspedes A, De La Cruz AA, Abraido-Lanza AF. Fatalism or destiny? A Qualitative Study and Interpretative Framework on Dominican Women’s Breast Cancer Beliefs. *J Immigr Minor Health*. 2009;11(4):291–301. doi: 10.1007/s10903-008-9118-6. [PubMed: 18253833]
23. Lee MM, Lin SS, Wrensch MR, Adler SR, Eisenberg D. Alternative Therapies Used by Women With Breast Cancer in Four Ethnic Populations. *J Natl Cancer Inst*. 2000;92(1):42–47. doi: 10.1093/jnci/92.1.42. [PubMed: 10620632]
24. Owens B. A Test of the Self-Help Model and Use of Complementary and Alternative Medicine among Hispanic Women during Treatment for Breast Cancer. *Oncol Nurs Forum*. 2007;34(4):42. doi: 10.1188/07.ONF.E42-E50.
25. Owens B, Jackson M, Berndt A. Complementary Therapy used by Hispanic Women During Treatment for Breast Cancer. *J Holist Nurs*. 2009;27(3):167–176. doi: 10.1177/0898010108330801. [PubMed: 19372389]
26. Rush CL, Lobo T, Serrano A, Blasini M, Campos C, Graves MD. Complementary and Alternative Medicine Use and Latina Breast Cancer Survivors’ Symptoms and Functioning. *Healthcare (Basel, Switzerland)*. 2016;4(4):80. doi: 10.3390/healthcare4040080.
27. Lockhart JS, Oberleitner MG, Nolfi DA. The Asian Immigrant Cancer Survivor Experience in the United States: A Scoping Review of the Literature. *Cancer Nurs*. 2020;43(3):177–199. doi: 10.1097/NCC.0000000000000797. [PubMed: 32195706]
28. Wang JH, Adams IF, Tucker-Seeley R, Gomez SL, Allen L, Huang E, Wang Y, Pasick RJ. A mixed method exploration of survivorship among Chinese American and non-Hispanic White breast cancer survivors: the role of socioeconomic well-being. *Qual Life Res*. 2013;22(10):2709–2720. doi: 10.1007/s11136-013-0347-0. [PubMed: 23591710]
29. Yi EG. Does acculturation matter? End-of-life care planning and preference of foreign-born older Immigrants in the United States. *Innov Aging*. 2019;3(2):igz012. doi:10.1093/geroni/igz012. [PubMed: 31206041]
30. Jaramillo S, Hui D. End-of-life care for undocumented immigrants with advanced cancer: documenting the undocumented.” *J Pain Symptom Manage*. 2017;51(4):784–788. doi:10.1016/j.jpainsymman.2015.11.009.
31. Coyne JC, Pajak TF, Harris J, Konski A, Movsas B, Ang K, Watkins Bruner D. Emotional Well-being does not Predict Survival in Head and Neck Cancer Patients: a Radiation Therapy Oncology Group Atudy. *Cancer*. 2007;110(11):2568–2575. doi: 10.1002/cncr.23080. [PubMed: 17955501]
32. Nakaya N, Bidstrup PE, Saito-Nakaya K, Frederiksen K, Kosenvuo M, Pukkala E, Kaprio J, Floderus B, Uchitomi Y, Johansen C. Personality Traits and Cancer Risk and Survival Based on Finnish and Swedish Registry Data. *Am J Epidemiol*. 2010;172(4):377–385. doi: 10.1093/aje/kwq046. [PubMed: 20639285]
33. Silva MD, Genoff M, Zaballa A, Jewell S, Stabler S, Gany FM, Diamond LC. Interpreting at the End of Life: A Systematic Review of the Impact of Interpreters on the Delivery of Palliative Care Services to Cancer Patients with Limited English Proficiency. *J Pain Symptom Manage*. 2015;51(3):569–580. doi: 10.1016/j.jpainsymman.2015.10.011. [PubMed: 26549596]

34. Schenker Y, Fernandez A, Kerr K, O’Riordan D, Pantilat SZ. Interpretation for Discussions about End-of-Life Issues: Results from a National Survey of Health Care Interpreters. *J Palliat Med*. 2012;15(9):119–1026. doi: 10.1089/jpm.2012.0032.
35. Garcia ME, Bindman AB, Coffman J. Language-Concordant Primary Care Physicians for a Diverse Population: The View from California. *Health equity*. 2019;3(1): 343–349. doi: 10.1089/heq.2019.0035. [PubMed: 31312781]
36. Kale HP, Carroll NV. Self-Reported Financial Burden of Cancer Care and its Effect on Physical and Mental Health-Related Quality of Life among US Cancer Survivors. *Cancer*. 2016;122(8):283–289. doi: 10.1002/cncr.29808. [PubMed: 26991528]
37. Ramsey SD, Bansal A, Fedorenko CR, Blough DK, Overstreet KA, Shankaran V, Newcomb P. Financial Insolvency as a Risk Factor for Early Mortality Among Patients With Cancer. *J Clin Oncol*. 2016;34(9):980–986. doi: 10.1200/JCO.2015.64.6620. [PubMed: 26811521]
38. Blinder V, Eberle C, Patil S, Gany FM, Bradley CJ. Women With Breast Cancer who Work for Accommodating Employers More Likely to Retain Jobs after Treatment. *Health Aff (Millwood)*. 2017;36(2):274–281. doi: 10.1377/hlthaff.2016.1196. [PubMed: 28167716]
39. Pallok K, De Maio F, Ansell DA. Structural Racism - A 60-Year-Old Black Woman with Breast Cancer. *N Engl J Med*. 2019;380(16):1489–1493. doi: 10.1056/NEJMp1811499. [PubMed: 30995369]
40. Hansen H, Metzl J. Structural Competency in the U.S. Healthcare Crisis: Putting Social and Policy Interventions into Clinical Practice. *J Bioeth Inq*. 2016;13(2):179–183. doi: 10.1007/s11673-016-9719-z. [PubMed: 27178191]

Table 1:

Patient Demographics

Characteristics	N (%)
Age	
Range: 40–67 years	
Mean: 56 years (SD 8.4 years)	
Country of Origin	
El Salvador	3 (23)
Guatemala	3 (23)
Mexico	3 (23)
Nicaragua	3 (23)
Peru	1 (8)
Educational Level	
Some College or College Degree	5 (38)
Completed High school	4 (31)
Grammar School	4 (31)
Total Household Income	
Less than \$10,000 Annually	3 (23)
\$10,000 - \$20,000 Annually	4 (31)
\$20,000 - \$30,000 Annually	3 (23)
\$30,000 Annually	2 (15)
Not reported (patient unsure)	1 (8)
Medical Coverage	
Medicaid	5 (38)
Medi-Cal/Medicare Combined	3 (23)
Private insurance	3 (23)
Medicare	1 (8)
Reliance on free clinics	1 (8)
Educational Level	
Some College or College Degree	5 (38)
Completed High school	4 (31)
Grammar School	4 (31)
Religion	
Catholic	10 (77)
Other Christian	3 (23)

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2:

Demographics of Support Network Members

Characteristics	N (%)
Informal Caregiver Relationship to Patient	
Child	4 (33)
Friend	3 (25)
Sibling	2 (17)
Spouse	1 (8)
Extended family member	1 (8)
Employer	1 (8)
Informal Caregiver Country of Origin	
Mexico	4 (33)
El Salvador	2 (17)
Guatemala	2 (17)
United States	2 (17)
Nicaragua	1 (8)
Peru	1 (8)
Physician Race/Ethnicity	
White/European American	3 (75)
Latina	1 (25)
CM Practitioner Race/Ethnicity	
White/European American	6 (100)

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 3:

How Staying Positive Functions for Latina Immigrants with Advanced Cancer and Members of their Support Networks

Patients

- Stay positive as a primary coping mechanism
- See staying positive and fighting as part of their role in their illness
- Believe that negative thinking contributes to poor health outcomes
- Sometimes appreciate when others stay positive
- Sometimes project false positivity to protect loved ones from suffering, which can result in isolation

Informal Caregivers

- Stay positive to help patients stay positive
- Believe that negative thinking contributes to poor health outcomes
- Stay positive for their own coping and to mitigate stress related to caregiving

Physicians

- Encourage patients to stay positive while numerous treatment modalities remain
- See patients' ability to stay positive as a sign of resilience
- Reserve EOL * discussions for when there is a new metastasis or a treatment has failed

CM[†] Practitioners

- Strive to create a positive, arm environment during patient encounters
 - Focus on positive physical touch and helping patients to “be present” in their bodies
 - Believe that positivity is reinforced by a strong sense of community at the CM clinic
-

* EOL: end-of-life

[†] CM: complementary medicine

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript