Published in final edited form as:

Psychooncology. 2021 January ; 30(1): 127–133. doi:10.1002/pon.5552.

Practice of Psycho-oncology with Latino Patients: An International Study

Rosario Costas-Muñiz[1,2], **Eida Castro-Figueroa**[3], **Normarie Torres**[3], **Maria Claros**[1], **Oscar Galindo-Vazquez**[4], **Bharat Narang**[1], **Francesca M. Gany**[1,2]

[1]Department of Psychiatry & Behavioral Sciences, Memorial Sloan Kettering Cancer Center, New York, NY, US

[2]Weill Cornell Medical College

[3]Department of Psychiatry and Human Behavior, Ponce Research Institute, Ponce Health Sciences University

[4]Service of Psycho-Oncology, Mexican Cancer Institute

Keywords

Cancer; Culturally Competent Care; Evidence-based practice; Hispanic Americans; Latin America; Mental health; Oncology; Psycho-oncology; Psychotherapy; Survivorship

BACKGROUND

Cancer is the second leading cause of death globally, approximately 70% of deaths from cancer occur in low- and middle-income countries.[1] About 1.3 million new cancer cases and 666,000 cancer deaths were estimated to have occurred in 2018 in Latin America and the Caribbean. Cancer is also the leading cause of death of Latinos in the U.S., accounting for approximately 42,700 deaths/year in the U.S. Latino population.[2]

Latin American and Caribbean countries have been underrepresented in previous cross-cultural surveys of implementation of psycho-oncology services.[3–4–] Two international surveys have documented the need for psycho-oncology services worldwide, highlighting a lack of trained professionals as major obstacle[3–4] and the lack of Latin American representation (only Brazil, Argentina, Chile, Peru, and Uruguay were represented).

Furthermore, there is a dearth of information about how psycho-oncology services are delivered and implemented by psycho-oncologists worldwide, specifically in Latin America.

Corresponding author: Rosario Costas-Muñiz, PhD, Memorial Sloan Kettering Cancer Center, Department of Psychiatry and Behavioral Sciences, 485 Lexington Avenue, 2nd floor, New York, NY 10017, Phone: (646) 888 – 8062, Fax: (929) 321-1520, costasmr@mskcc.org.

Editorial assistance: The manuscript was edited by Sonya J. Smyk, Memorial Sloan Kettering Cancer Center. She was not compensated beyond her regular salary.

Conflict of interest: The authors declare no relevant conflicts of interest.

Data availability statement: The datasets generated and/or analyzed during the current study are not publicly available due to MSK's Data Sharing Policy but are available from the corresponding author on reasonable request.

Despite the international support for the provision of psycho-oncology[3], information about therapeutic needs and competence in addressing cancer-related distress remains limited. Along these lines, Chochinov and colleagues[5] developed an empirical model, providing detailed insights regarding the elements of effective psychosocial care for cancer patients. However, culture-specific implementation of psycho-oncology practice is understudied. Little is known about the preference and practice of psycho-oncology with Latino patients. This brief report examines training and practice-related factors of mental health providers of Spanish-speaking cancer patients in Latin America and the U.S.

METHODS

Data was obtained from a web-based survey sent via email (with a link), with open- and closed-ended questions, administered to a convenience sample of mental health providers of Latino cancer patients from the U.S., Latin America and Spain. Providers in the mental health field (i.e. psychiatrists, psychologists, social workers, counselors and other mental health professionals) who were actively providing mental health services to Latino or Hispanic cancer patients in Spanish were eligible. We invited 154 providers to participate from July 2015 to July 2017; 112 accessed the survey. Fifty-three providers either did not complete the survey or were ineligible. The final sample consisted of 59 providers, for an acceptable response rate of 38%, comparable to most web-based surveys. Participants reviewed an information sheet about the study and implied consent by completing the survey. This study was reviewed by the author’s institutional review board and determined exempt.

The bilingual (Spanish and English) survey comprised of questions about demographic characteristics (i.e. age, gender), practice (i.e. range of years of experience), training background (i.e. specialized training or courses), and open-ended questions exploring providers’ opinions about therapeutic themes relevant for patients, types and goals of therapy provided, methods or strategies they found useful when providing counseling to this population. Atlas.ti was used to analyze the qualitative data. Qualitative analyses of open-ended responses were completed by four independent coders; the first 25% of the interviews were coded using an open coding approach to develop a coding dictionary. The coders coded all transcriptions using the coding dictionary and meetings were held to reach consensus about applied codes.

RESULTS

The sample was comprised of 59 mental health providers, 80% females (n=40), and 20% males (n=10). Almost half (49%) of respondents practiced in the U.S., and 51% practiced in 10 countries/regions in Latin America (10% Argentina, 10% Puerto Rico, 5% Peru, 5% Colombia, 5% Costa Rica, 3% Mexico, 3% Panama, 3% Cuba, 2% Guatemala, and 2% Venezuela) and Spain (2%). Further, almost half, 46%, also received their degrees in the U.S., followed by Puerto Rico (10%) and Argentina (10%). Half of the sample (49%) had a master’s degree, 34% reported less than five years of clinical practice, 26% six to ten years, and 40% reported more than ten years. About one third, 34%, treated 11 to 30 patients per week and 33% treated more than 30 patients per week.

The themes reported and addressed by providers when counseling Latino patients are shown in Table 1. Forty providers reported themes that they address during therapy; the most frequent were: family-related issues (i.e. communication, dynamics, dealing with children) (n=21), end-of-life concerns (i.e. beliefs, fears, planning, unfinished businesses) (n=14), emotional responses (i.e. grief, fear of suffering, concerns about quality of life, cancer stigma concerns) (n=11) and coping strategies (i.e. acceptance, self-care, resilience, maintaining hope and existential coping) (n=10). Providers in Latin America more frequently reported addressing themes related to emotional responses, physical issues, patient's autonomy and decision making and cancer experience after diagnosis, during treatment, and survivorship. U.S. providers more frequently reported addressing issues related to cancer education, communication with provider and healthcare team, access to health and psychosocial services, family communication and impact, and religious and spiritual beliefs and concerns.

Table 2 shows the therapeutic approaches reported by providers, which included: acceptance and commitment, cognitive behavioral, problem-solving, psychodynamic, narrative, mindfulness, humanistic, meaning-centered, patient-centered, supportive, motivational interviewing and integrative therapies. The types of service they provided included medication management, individual psychotherapy, transdisciplinary management and consultation, crisis management, couple therapy, family therapy, family psychoeducation and group therapy. Goals of therapy encompassed building distress tolerance, empowerment, resilience, self-care, and addressing physical needs and symptoms (i.e. pain, sleep). Therapeutic methods included process techniques (initial assessment, testing and goal setting), communication strategies (empathic listening, active listening, normalizing, refraining, reflecting, validation, using hopeful language). Other therapeutic techniques included breathing exercises, behavioral interventions, decisional balance, existential strategies, here-and-now, relaxation, visual techniques, written techniques and psycho-education.

The most common therapeutic approach reported by providers was cognitive behavioral therapy or strategies (see Table 2). The most commonly endorsed types of service were individual psychotherapy, followed by group therapy or support groups. Self-care was mentioned by at least three providers as a goal of therapy and the most frequent therapeutic process technique was goal setting.. Other therapeutic techniques frequently reported included relaxation, visual techniques, existential strategies and psycho-education.

DISCUSSION

This sample of providers reported important insight about processes, themes and strategies used when counseling Latino cancer patients, which have been highlighted by previous research as relevant therapeutic approaches in cancer-related psychosocial care.[6] These therapeutic approaches and techniques have been adapted for the cancer setting and are more effective than others.[7]. Cognitive behavioral therapy has been the treatment approach with the strongest research support for the improvement of quality of life in cancer survivors, followed by mindfulness-based interventions, acceptance and commitment therapy, and dignity therapy.[6–7]. However, few therapeutic interventions have been culturally-adapted and tested with Latino populations[8]. It is unclear if these providers take into consideration evidence-based practice to decide what therapeutic approach to implement or if they have been trained in the most effective therapeutic approaches.

Furthermore, cultural competency in supportive care and psychosocial oncology approaches is recognized as key to reducing health disparities at local and global levels Culture influences patients' perception of cancer risk, their trust in the practice of oncology, but most importantly, their approach to cancer care[3–4]. To have a culturally responsive approach, research highlights multiple factors (i.e. ethnicity, socioeconomic position, culture) to adapt psychosocial interventions[9], as most psychosocial interventions and evidence-based interventions in cancer have been developed and tested for Euro-American patients.[8] Research efforts are needed to culturally adapt these interventions for Latino patients considering linguistic, cultural, contextual factors, as well as intervention strategies, concepts and theoretical models.[9] Among these factors, language is key cancer information and psychosocial interventions are needed to be develop, tailored and disseminated for Spanish-speaking Latinos.[9] Many programs have been developed for Latinos in the areas of cancer prevention and screening[10]. However, other areas of supportive and psychosocial oncology remain understudied and underdeveloped.

Training opportunities need to be culturally responsive with attention not only to the cultural and psychological needs of other Latino populations, but also to the socio-economic and political context, as well as the health care system context of different regions. Furthermore, there is a need to train psychosocial professionals in evidence-based interventions according to the patients' needs and prognosis.

This brief report is the first study to examine the practice of psycho-oncology among providers serving Spanish-speaking Latino patients. This assessment was developed to assess the practice and delivery of psycho-oncology primarily with patients. This is a limitation since the scope of psycho-oncology should include caregivers, family members and health care professionals, as well. Future research should include more comprehensive assessments to explore the practice and delivery of psycho-oncology services with these other groups in Latin America. Future studies should also focus on the characteristics of patients and family members that access supportive services in Latin America, and ways to decrease these disparities. Future work should include larger and more representative samples, more structured, specific questions about psycho-oncology practice and delivery, and a thorough assessment of the implementation and delivery of psycho-oncology services in Latin America with an ecological perspective considering country-, institutional-, provider-, family- and patient-level data. Furthermore, although small, this sample represents a good number of the few psycho-oncologists practicing in Latin America. It is imperative to study the practice of psycho-oncology with underserved and understudied populations to address global disparities in access to psychosocial oncology services and support the use of evidence-based practice.

Acknowledgements

This research was supported by the National Institutes of Health: U54-13778804 CCNY/MSKCC Partnership, Clinical and Translational Science Center grant (UL1 TR000457), National Center for Advancing Translational

Science UL1TR002384, training grant T32CA009461, R21 CA180831-02 (Cultural Adaptation of Meaning-Centered Psychotherapy for Latinos), and the Memorial Sloan Kettering Cancer Center grant (P30 CA008748). Eida M. Castro-Figueroa received support from the National Cancer Institute (2U54CA163071 and 2U54CA163068) and the National Institute of Minority Health and Health Disparities (5G12MD007579-33, 5R25MD007607, and R21MD013674). The funding sources have not been involved in the development of this manuscript or its study design, data collection, analysis and interpretation of data, writing of the report, and/or in the decision to submit the paper for publication. The contents of this article are solely the responsibility of the authors and do not necessarily represent the views of the awarding agencies.

REFERENCES

1. Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2018; 68(6): 394–424. [PubMed: 30207593]
2. American Cancer Society. Cancer Facts & Figures for Hispanics/Latinos 2018–2020. 2018.
3. Grassi L, Watson M and co-authors IFoP-OS. Psychosocial care in cancer: an overview of psychosocial programmes and national cancer plans of countries within the International Federation of Psycho-Oncology Societies. Psycho-Oncol 2012; 21: 1027–1033. Review 2012/10/03. DOI: 10.1002/pon.3154.
4. Mehnert A and Koch U. Psychosocial care of cancer patients--international differences in definition, healthcare structures, and therapeutic approaches. Support Care Cancer 2005; 13: 579–588. Review 2005/03/02. DOI: 10.1007/s00520-005-0779-6. [PubMed: 15739056]
5. Chochinov HM, McClement SE, Hack TF, et al. Health care provider communication: an empirical model of therapeutic effectiveness. Cancer 2013; 119: 1706–1713. 2013/01/24. DOI: 10.1002/cncr.27949. [PubMed: 23341092]
6. Hulbert-Williams NJ, Beatty L and Dhillon HM. Psychological support for patients with cancer: Evidence review and suggestions for future directions. Current opinion in supportive and palliative care 2018; 12: 276–292. Review. DOI: 10.1097/SPC.0000000000000360. [PubMed: 30074924]
7. Duncan M, Moschopoulou E, Herrington E, et al. Review of systematic reviews of non-pharmacological interventions to improve quality of life in cancer survivors. BMJ open 2017; 7: e015860 Review 2017/12/01. DOI: 10.1136/bmjopen-2017-015860.
8. Yanez B, Thompson EH and Stanton AL. Quality of life among Latina breast cancer patients: a systematic review of the literature. J Cancer Surviv 2011; 5: 191–207. 2011/01/29. DOI: 10.1007/s11764-011-0171-0. [PubMed: 21274649]
9. Bernal G, Scharrón-del-Río M Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. . Cultur Divers Ethnic Minor Psychol. 2001;7:328–342. [PubMed: 11759270]
10. Escriba-Aguir V, Rodriguez-Gomez M, Ruiz-Perez I. Effectiveness of patient-targeted interventions to promote cancer screening among ethnic minorities: A systematic review. Cancer epidemiology. 2016;44:22–39. [PubMed: 27459464]

KEY POINTS

- Latin American countries have been underrepresented in previous research of implementation of psycho-oncology services.
- A survey of 59 mental health professionals treating Latino cancer patients from Latin America and the United States was conducted to shed light on the practice of psycho-oncology with Latino patients.
- Providers reported the themes they address when counseling Latino patients: 1) emotional responses; 2) coping strategies; 3) patient's autonomy and decision making, 4) cancer experiences after diagnosis, during treatment and survivorship; 5) end-of-life concerns; 6) education about cancer and treatment process; 7) communication with provider and healthcare team; 8) access to health and psychosocial services; 9) physical issues; 10) family-related issues; 11) socioeconomic issues; and 12) religious and spiritual beliefs and concerns.
- Providers also reported using a variety of therapeutic approaches, types of service, and therapeutic methods and techniques. Goals of therapy included building distress tolerance and empowerment and improving resilience and self-care and managing physical symptoms.
- It is important to study the practice of psycho-oncology with underserved populations and in low-resource settings to address disparities in access to psychosocial oncology services and support the use of evidence-based practice.

Table 1.

Important themes to address when providing counseling services to Latino cancer patients

Categories	Themes	Illustrative quotes
Emotional and distress symptoms	Concerns about quality of life Grief (G) Fear of suffering (FS) Cancer stigma (CS) Emotional response	G: "The mourning for the loss of personal and economic independence. Feeling useless." FS: "Fear of physical and emotional suffering." CS: "Many of these patients have been reluctant to share information with family/friends due to sense of shame about illness."
Coping strategies addressed during counseling	Acceptance (A) Self-care Existential coping (EC) Resilience Maintain hope	A: "In the acceptance of the physical limitations that progress with the disease, which creates difficulty in being able to let oneself be helped by their relatives or loved ones." EC: "Carry out an elaborative synthesis of what life has been like to say goodbye slowly."
Patients' autonomy and decision-making	Patients' autonomy (PA)	PA: "Fulfill the wishes of the patient, that the patient makes the decisions while able to and not the family, that the decisions made by the patient are respected."
Experience with cancer and disease trajectory	Prognosis Cancer treatment (CT) Survivorship Changes after diagnosis (CAD)	CT: "Managing treatment expectations." CAD: "Losses and changes after diagnosis."
Palliative care needs and issues	Advanced directives Palliative care (PC) Hospice care (HC)	PC: "Goals of care discussions is also an important topic." HC: "For many, hospice does not have a good connotation." HC: "Preparing patients and families for hospice care."
End of life	Fear of death and dying (FD) Talking about death (TAD) Dying End of life planning Unfinished business (UB)	FD: "Fear of death, particularly fear if suffering from physical symptoms or bedridden." TAD: "For my culture in particular, talking about the issues of death is the biggest challenge, about grief, the farewell." UB: "Pending issues: family, economic, legal and emotional problems." UB: "Take care that the main relationships of the patient are resolved."
Education and knowledge	Education and access to resources (EAR) Understanding or knowledge about the cancer (UKC) Nutrition/diet information	EAR: "Education about these resources." UKC: "Quality information about cancer and its treatment." UKC: "Some patients are unclear about diagnosis, staging, or the name of their particular cancer."
Communication with health care team	Communication with medical team Mental health provider communication (MHPC)	MHPC: "Importance of venting emotions with provider."

Categories	Themes	Illustrative quotes
Access to health and psychosocial services	Geographic barriers	AHPC: “Challenging where patients can locate services in the area to meet their needs (both medical and psycho-social).” MHS: “I think there is already stigma among many members of this community about receiving formal mental health treatment and now adding medical problems further adds to perceived stigma of seeking treatment.”
	Access to health and psychosocial care (AHPC)	
	Mental health treatment stigma (MHS)	
Physical issues	Physical limitations	PM: “Offer alternatives and remove stigmas about pain.” PM: “The connection body-mind-spirit in dealing with pain.”
	Pain management (PM)	
	Self- and body image	
Family and caregiver issues	Dealing with children	FI: “I have found that Latinos often want to focus on their actual cancer diagnosis, treatments, prognosis, and how this is impacting their family and social relationships, work situations, and financial situations.” FD: “It they discuss these issues, it seems often in the context of their family relationships/ situations. For example, ‘what will happen to my family after I’m gone?” FC: “How and when they communicate with their loved ones about death and dying. How and when they communicate about their loved ones about needs and expectations at end of life.” FS: “Think focusing on the family being diagnosed is pivotal and not just focus solely on the patient with the cancer diagnosis. Many times, the pt. is equally worried about their family and their health/prognosis.”
	Family impact (FI)	
	Family dynamics (FD)	
	Family communication (FC)	
	Family support (FS)	
Socioeconomic issues	Socioeconomic issues (SEI)	SEI: “They do not have the financial resources to pay for some mental health services.” SEI: “I have found that Latinos often want to focus on their actual cancer diagnosis, treatments, prognosis and how this is impacting their … financial situations.”
Religiosity and/or spirituality issues	Religiosity and/or spirituality issues (RS)	RS: “Fear of being punished by a higher power.” RS: “Desire for spiritual connection.”

Table 2.

Psycho-oncology practice approaches and techniques

Categories	Themes	Responses
Therapeutic approach (n=22)	Acceptance and commitment therapy	1
	Cognitive Behavioral Therapy or strategies	10
	Problem solving therapy	2
	Psychodynamic therapy	1
	Narrative therapy	1
	Mindfulness	3
	Humanistic therapy	3
	Meaning Centered psychotherapy	2
	Patient Centered therapy	3
	Supportive therapy	3
	Motivational interviewing	1
	Integrative therapy	2
Type of mental health service (n=21)	Medication management	1
	Individual psychotherapy	9
	Transdisciplinary management and consultation	1
	Crisis management	1
	Couples therapy	1
	Family therapy	4
	Family psychoeducation	3
	Group therapy or support groups	8
Goals of therapy (n=8)	Distress tolerance	2
	Empowerment	1
	Building resilience	1
	Self-care	3
	Address physical needs of patient	1
Therapy process techniques (n=9)	Goal setting	4
	Initial assessment	2
	Testing	1
	Periodic reassessment of goals	1
	Assessment with oncology thematic apperception test	1
Communication techniques (n=15)	Empathetic listening	2
	Active listening	2
	Normalizing	3
	Reframing	2
	Reflecting	1
	Validation	3
	Hopeful language	2
Therapeutic techniques (n=39)	Breathing exercise	2
	Behavioral intervention	3

Categories	Themes	Responses
	Decisional balance	1
	Existential strategies	5
	Here and now	3
	Life review	2
	Relaxation	7
	Visual techniques	6
	Written techniques	3
	Musical techniques	3
	Psycho-education	4