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## Barriers of Psychosocial Services Use of White versus Latina Breast Cancer Survivors

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### Abstract

**Objective:** This study compares barriers to psychosocial services use between Latina and non-Latina White survivors after receiving a diagnosis of breast cancer and examines the association of these barriers with use of psychosocial services.

**Methods:** A sample of 265 Latina and non-Latina White survivors who received treatment in a comprehensive cancer center in New York City completed a mailed questionnaire. The questionnaire measured quality of life, interest in help for distress, psychosocial services use, and barriers to use of psychosocial services. Bivariate and adjusted logistic regression models were conducted to analyze the data.

**Results:** More than half of the sample reported preferring to return to their normal routine, felt that they could take care of their emotional problems themselves, and preferred to seek support from their family or friends. Latinas were more likely to seek counseling from a spiritual leader and report that there are no counselors who speak their language and understand their values or background and that mental health services are too expensive.

**Conclusions:** It is crucial to study and address potential barriers that contribute to health disparities and discrepancies in patient's access and use of psychosocial healthcare. Findings highlight the need to educate providers about patients' psychosocial needs; patients need to receive information about the benefits of psychosocial and mental health services, to normalize mental health service use and diminish stigma. Finally, culturally and linguistically sensitive services for Latina patients are warranted.

## Introduction

Individuals living with breast cancer, specifically Latinas, commonly experience poorer quality of life (QOL) and higher rates of depression than non-Latino Whites (1–4). Latinos diagnosed with cancer have poorer psychological outcomes than other cultural groups (5). Although Latinos have poorer mental health outcomes, they are less likely to receive psychological, psychiatric, and other psychosocial interventions than non-Latino Whites (5, 6). Moreover, Latinos often report unique concerns, such as socioeconomic, cultural, and linguistic issues, that impact their access to psychosocial and mental health services (7–9). A cancer diagnosis was associated with worsened mental health due to reduced income, especially for Latinos compared to non-Latino Whites (10).

There are many potential reasons for lower rates of psychosocial services use among Latinos diagnosed with cancer. In a prior study conducted with this sample of Latina breast cancer survivors demonstrated varying patterns of access to psychosocial services, one third of the survivors reported needing mental health or psychosocial services after their cancer diagnosis and of those only 40% received a referral (6). Non-Latina Whites were significantly more likely than Latinas to have contact with a social worker and to receive psychotropic medication (6), while 34% of Latinas discussed their emotional problems or needs post-diagnosis with their oncologist or cancer care provider. Latinos might face unique patient-, provider- and system-related barriers and challenges, such as lack of accurate identification of individuals with psychosocial needs, availability of culturally and linguistically appropriate services, insurance status, and individuals' beliefs and help-seeking behaviors, among others (11). Several studies with nationally representative samples have shown that ethnic minority individuals with mental health needs are less likely to receive mental health services than non-Latino Whites (11, 12). Alegria and colleagues (11) report that probable causes of this disparity in mental health service utilization are under-detection of depression by healthcare providers; stigma surrounding the utilization of mental health services; financial and employment constraints; previous experiences of discrimination; receipt of informal care from family, friends, or informal providers; and limited access to providers. However, research in this area has been restricted to community, psychiatric, and population-based samples (11–13).

Further multiple systematic reviews and meta-analyses published in the last decade demonstrated that receipt of psychosocial services, psychotherapy and/or mental healthcare have at least moderate effects on many psychosocial outcomes of cancer patients and survivors (e.g. distress, QOL, etc.) (14–24). Many psychotherapy studies showed promise in improving the psychological functioning of cancer patients with different disease types and stages and of cancer survivors (14–24). However most systematic reviews state that recommendations are made with caution given the suboptimal quality of most interventional studies (15, 16, 18–20, 23).

Barriers to use of psychosocial services among Latinos diagnosed with cancer have been understudied, as well as among the general cancer population. A systematic review identified ten quantitative studies reporting barriers to the use of psychosocial services in the general population (25). The most frequently reported barrier was 'no need for psychosocial

services and support,' followed by lack of information or wanting more information about services (25). According to this systematic review, health professionals reported that lack of time, insurance coverage, knowledge regarding the benefits, identification of patient needs, referrals systems, affordable cost, and resources were the most commonly reported barriers to distress management (25). This study examined differences between Latina and non-Latina White breast cancer survivors' self-reported barriers to the use of psychosocial services who received care at a New York City (NYC) comprehensive cancer center. The second objective was to examine associations between the barriers and use of psychosocial services following cancer diagnosis.

## Methods

### Sample and Setting

This retrospective cross-sectional study was conducted in a single NYC comprehensive cancer center. More information about the study methods and assessments included in the previous article by Costas-Muniz and colleagues (6). Eligible participants were adult survivors (age 21 or older) in remission from a breast cancer diagnosis (identified through their medical records), who had received cancer care at this center. After reviewing medical records, 409 Latinas and 5146 non-Latina Whites who were treated between 2009–2014 were identified. All 409 Latinas and a random sample of 10% of the non-Latina Whites were selected for this study to have a comparable number of patients in each group. Potential participants received a mailed questionnaire packet and a reminder letter two weeks later. All materials in the survey were anonymous. The process of informed consent involved participants reviewing a form with information about the study, their rights, and potential benefits. Participants provided implied consent by completing the survey. Two hundred and eighty survivors completed and mailed the packet back (see flow diagram in the online supplement), for a response rate of 30%. Questionnaires from 265 survivors completed psychosocial services use and barriers portion. This study was reviewed by Memorial Sloan Kettering Cancer Center's Institutional Review Board/Privacy Board and determined to be exempt research.

### Methods and Variables

The questionnaire packet captured demographics and assessed respondents' attitudes towards and history of using psychosocial services and perceived barriers to use. The demographic section included questions on age, education, religion, marital status, socioeconomic status, family composition, living situation, employment status, ethnicity, race, language preference, birthplace, and years living in the United States.

The psychosocial services section included questions about survivors' histories of psychosocial services usage prior to and after the cancer diagnosis. It also assessed patients' preferences for services, including type of counseling, delivery format, and type of mental health professional. The type of mental health professional was defined utilizing the National Comprehensive Cancer Network (NCCN) Distress Management Guidelines to include social workers, psychologists, psychiatrists, and religious counselors (i.e. priests, pastoral counselors, or ministers). Additionally, we assessed the use of type

of psychosocial services recommended by the NCCN Distress Management Guidelines including individual counseling, family therapy, couple therapy, support groups, group therapy, and pharmacotherapy.

The barriers to access section comprised questions about attitudes toward mental health and counseling services and patient-, physician- and system-related barriers to psychosocial services use. Fourteen barriers (Cronbach alpha = .83) were categorized as patient-related barriers or attitudes (self-reliance attitudes, lack of knowledge, stigma, preference for informal care, etc.). The remaining six (Cronbach alpha = .70) were categorized as physician- or system- related barriers (insurance issues, cost issues, lack of available providers, and lack of recommendation or referral). These questions were based on prior literature and the clinical experience of the authors with Latino populations in mental health and cancer disparities settings (26–29). Respondents were asked whether they faced each barrier with a response format of “yes”, “maybe”, or “no.” To ensure an adequate number of respondents to conduct the analyses, “yes” and “maybe” were collapsed into a single category, resulting in two categories (“yes/maybe” and “no”).

Statistical analyses were executed using the SPSS 19 software package. First, the demographic characteristics, self-reported use of psychosocial services after cancer diagnosis, and barriers to use of psychosocial services were described using descriptive statistics. The self-reported barriers were assessed for the full sample and for the two groups. Descriptive statistics were used to characterize the sample by ethnicity. Chi-squared analyses were used to evaluate differences in self-reported barriers between the two groups. A two-sided significance level of .05 was used.

Bivariate logistic regression models were used to determine the associations between the self-reported barriers with contact with mental health professionals and receipt of mental health services after a cancer diagnosis for the total sample. Analyses were not able to be conducted per ethnic subgroup because of a small sample size. The evaluable subsamples for the unadjusted models were between 240 and 261 due to missing data. Contact with mental health professionals (social worker, psychiatrist, or psychologist) and receipt of mental health services (individual, family, couple, or group counseling) after the cancer diagnosis were analyzed separately. These classifications were reduced to binomial outcomes for analysis (i.e. contact with mental health professionals, yes or no).

Adjusted logistic regression models were conducted to examine the association between self-reported barriers and (1) contact with psychosocial services professionals and (2) use of psychosocial services after the cancer diagnosis. Analyses were not able to be conducted per ethnic subgroup because of a small sample size. Models were adjusted for socio-demographic and medical factors such as age, marital status, ethnicity, education level, and time since diagnosis. Age, time since diagnosis, marital status and education level were dummy coded and entered in the models. The evaluable subsamples for the adjusted models were between 213 and 220 due to missing data. Adjusted ORs with 95 % confidence intervals were calculated to assess the relationships between the barriers with the use of services and contact with professionals. A two-sided significance level of  $p < .05$  was considered statistically significant.

## Results

Table 1 shows the breast cancer survivors' demographic profile. About two thirds of the sample was married or partnered (63%). Latinas had lower levels of education: 30% had high school education or less compared to 17% of the non-Latina Whites. One third of the Latinas preferred their care delivered in Spanish; 30% of the Latinas and 91% of the non-Latina Whites were born in the continental US; Latinas were frequently born in Puerto Rico (22%) and South America (22%). One quarter of the sample (25%) had been diagnosed with breast cancer less than two years ago. Recalling the time after the cancer diagnosis, 43% of the survivors (49% Latinas and 40% non-Latina Whites) expressed that they wanted or needed psychosocial services after the diagnosis. Of the survivors who reported needing services after the cancer diagnosis, two thirds (66%, 57% Latinas and 71% non-Latina Whites) reported having contact with psychosocial services providers and 61% reported using psychosocial services after the diagnosis (53% Latinas and 67% non-Latina Whites).

There were three barriers or attitudes that were endorsed by more than 50% of the sample of survivors (see Table 2): first, "I feel I can take care of my problems by myself" (63%), second "I prefer to go back to my normal routine rather than to see a therapist or counselor" (60%), and third "I prefer to seek counseling and support from my friends and family" (56%).

Latinas were more likely than non-Latina Whites to endorse the following statements: "Mental health services are too expensive" (43% vs. 30%,  $X^2 = 3.93$ ,  $N = 265$ ,  $df = 1$ ,  $p = .05$ ); "My doctor did not tell me about counseling or therapy" (36% vs. 24%,  $X^2 = 3.56$ ,  $N = 265$ ,  $df = 1$ ,  $p = .06$ ); "Using an interpreter for counseling or therapy would make me uncomfortable" (22% vs. 1%,  $X^2 = 14.11$ ,  $N = 265$ ,  $df = 1$ ,  $p < .001$ ); "There are no counselors or therapists who understand my cultural values or background" (21% vs. 7%,  $X^2 = 11.04$ ,  $N = 265$ ,  $df = 1$ ,  $p = .001$ ); and "There are no counselors or therapists who speak my language" (9% vs. 0%,  $X^2 = 6.61$ ,  $N = 265$ ,  $df = 1$ ,  $p = .01$ ).

In analyses adjusting for demographic characteristics (ethnicity, age, education, marital status, and time since diagnosis), wanting to return to normalcy, lack of information about where to seek services or how counseling can help, believing it is normal to be distressed after the cancer diagnosis, feeling embarrassment about seeking services, and believing that counselors will not understand the survivor's cultural background were significant predictors of lack of contact with counseling professionals and/or psychosocial services (see Table 3).

## Discussion

This study evaluated the barriers to psychosocial services use faced by Latina and non-Latina White breast cancer survivors at a comprehensive cancer center. Among the survivors who reported needing psychosocial services, Latinas were more likely to report that there were no counselors who could speak their language or understand their cultural values and background and to report that mental health services were too expensive. Our prior study demonstrated differences in the psychosocial services availability, acceptability, and help-seeking behaviors by Latina and non-Latina White survivors (6). This prior study

showed a third of breast cancer survivors reported needing mental health or psychosocial services post-diagnosis (6). However, ethnic differences in type of psychosocial service use were depicted, as non-Latina Whites were significantly more likely than Latinas to have contact with a social worker and to receive psychotropic medication while Latinas were significantly more likely to receive spiritual counseling than non-Latina Whites (11% vs. 3%, respectively). This study adds to these previous findings by illustrating and comparing the barriers Latina and non-Latina White cancer survivors face in accessing psychosocial services.

There is a scarcity of research examining the barriers to psychosocial care among people with cancer. In our sample of breast cancer survivors, the most commonly cited barriers to psychosocial care or reasons for declining services included beliefs about self-reliance, desire to return to normalcy, and a preference for receiving care from family and friends. However, the barriers that predicted lack of use of psychosocial services and/or contact with professionals among the survivors who reported having emotional problems or needs were 1) a desire to return to normalcy, 2) not understanding the overall or direct benefit of therapy, 3) not knowing where to receive services, 4) stigma around mental health services, 5) the belief that it is normal to feel distressed after a cancer diagnosis, 6) the belief that counselors might not understand their cultural values or background, and 7) feeling uncomfortable with medical interpreters, if they are needed. Dilworth and colleagues conducted a systematic review in 2014 with ten quantitative studies reporting psychosocial services barriers finding that the most frequently reported barriers were no need for psychosocial services and support, and lack of information or wanting more information about services (25). Moreover, other studies have reported as main barriers: uncertainty about the need for specialized mental healthcare and the cost of such treatment (30), receiving support from other sources outside the cancer clinic, lack of awareness of the service, and lack of provider referral (31). Our findings support that commonly reported barriers such as: lack of information or wanting more information about services and/or lack of awareness of the service and uncertainty about the need for specialized mental healthcare are associated to the use of psychosocial services and/or contact with professionals. However, it is unclear if other barriers frequently cited are associated to use of services and access to professionals, such as: no need for psychosocial services and support, cost of treatment, receiving support from other sources outside the cancer clinic, and lack of provider referral. In terms of perception of need of services, patients endorsing “I feel I can take care of my problems myself”, were as likely to use services as their counterparts. Further, perceiving that mental health services are too expensive, seeking counseling and support from friends and family, priest, pastor, or minister and not receiving a recommendation for counseling or therapy from their doctors were not associated to receipt of psychosocial care.

The NCCN Distress Management Panel published standards for psychosocial care of individuals with cancer, establishing a set of quality measures for screening and algorithms for managing distress and psychiatric disorders (e.g., adjustment disorders, depression, suicide and suicide risk, and cognitive disorders) (32). Despite ethnic and racial minority patients having less access to psychosocial services and facing more barriers to accessing services, these guidelines fail to include specialized recommendations for the distress screening and management of culturally and linguistically diverse patients. Our results

highlight the need to study and address this gap in national clinical guidelines. There is a necessity to educate patients, cancer care and mental health providers, administrators, and institutional leaders about patients' needs surrounding psychosocial issues and to create interventions that are sensitive to cultural and linguistic needs.

Future research efforts need to be refocused from documenting disparities in access to taking steps to reduce and address disparities (33). Interventions need to address not only the individual level, but also at the provider and institutional levels. Also given the emergence of the use of technology in the latest years, psychosocial care will need to draw increasingly on the use of information technology, such as the Internet, social media, text messaging, and other technology to engage patients and providers (33). The key barriers found in this study can be addressed with interventions that consider individual, provider, and institutional levels by building and/or supporting: 1) educational programs for patients, 2) educational programs for cancer care providers, 3) specialized training for psychosocial care (mental health) providers, and 4) institutional programs and policies to improve the cultural competency of healthcare institutions and access to programs, and 5) system-level interventions to promote screening and management. Educational interventions for patients could increase 1) awareness among patients about psychosocial services in terms of what services are available and who provide them, 2) normalize the use and provide information about the benefits of the use of psychosocial services, 3) provide information about where to receive services, and 4) provide information about availability of culturally congruent counselors and/or interpreters if needed. Given the limited information about effective stigma-reducing interventions in cancer (34, 35), these interventions should be based upon a theoretical framework informed by pilot work and targeted to an oncological population. Modalities using the internet, text messaging, social media, patient's portals (healthcare-related online applications) and patient navigation programs can be used to deliver these interventions (36).

Educational interventions are also needed for oncology providers and mental health providers. Cancer care providers could benefit from culturally sensitive training programs on communications skills to teach how to elicit patients' psychosocial needs and knowledge gaps and address patients' concerns and questions. These interventions can be embedded in the routine trainings of providers and be delivered using remote and/or hybrid formats. Specialized psychosocial providers also can benefit from receiving specialized training to provide culturally responsive services and address concerns about language interpretation in the context of mental health services delivery. Specialized training, virtual courses and seminars; and professional networks organizations (i.e. IPOS society, <https://www.ipos-society.org/>, FIPOL network, [www.fipol.info](http://www.fipol.info)) and are alternatives to facilitate advanced specialized training.

Healthcare institutions can also create policies, processes and programs to improve the institutional cultural competency (37) including to: 1) develop and support culturally sensitive training programs for providers and all supportive staff; 2) maintain a diverse workforce of bilingual and bicultural providers (cancer care and psychosocial providers) and supportive staff; 3) offer language assistance to individuals with limited English proficiency, at no cost, and make sure all patients and family members are aware of the

availability of the language assistance program; 4) translate all materials to the patients' preferred language; 5) conduct ongoing assessments of the policies regarding culturally and linguistically appropriate care; 6) collect and maintain accurate and reliable demographic data; 7) partner with the community implement psychosocial services to ensure cultural and linguistic appropriateness; 8) if psychosocial services are not available in the cancer clinic or institution, partner with community clinics and programs to ensure the effective transition of care for psychosocial needs; 9) provide case management and patient navigation to address logistical and psicosocioeconomic needs and if these services are not available in the cancer clinic or institution, partner with community programs to ensure the effective delivery of services via community partners; and 10) maintain cultural and community advisory boards to plan and monitor programs and policies to improve the cultural competency of the institution.

### Limitations

The study limitations include, first, the sample population was a cohort of breast cancer survivors retrospectively answering questions about barriers to psychosocial services use after receiving a cancer diagnosis. Since patients responded during remission, their responses might be influenced by time and memory. Also the institutional policies regarding psychosocial care might have changed during that time. Second, the non-Latina White response rate was higher than that of Latinas. Given that Latinas showed lower educational attainment, it is possible that the lower Latina response rate was due to lower literacy levels, which may have prevented participation in a self-administered survey, or lack of familiarity with completing or responding to surveys. Third, the sample was small and recruited from a comprehensive cancer center in NYC, limiting its generalizability, especially to participants receiving care in a safety net hospital who might have a greater number of uninsured or underinsured patients and/or greater barriers to psychosocial services. Fourth, these results might not reflect the experiences of uninsured patients as all participants were insured. Financial costs or uninsurance status might be a key important barrier for patients receiving care in public hospitals. Fifth, in the absence of a validated instrument measuring barriers to psychosocial services, the main study instrument was based on the literature and the research team's clinical and research experience, it is important to study the psychometric properties of the type of instrument used in the current study as it could be adapted for clinical settings.

### Conclusion

This study illustrates how cultural and linguistic access-related issues can become barriers to psychosocial service use. Our findings help inform future strategies to make psychosocial services more accessible to non-Latina White and Latina people with breast cancer and address their barriers to care. It is crucial to study and address potential barriers that contribute to health disparities and discrepancies in patient's access and use of psychosocial healthcare. Further, it is critical to examine and address the multilevel barriers that patients might experience when trying to access psychosocial care to help lessen the disparities in psychosocial outcomes seen in ethnic minority groups in the cancer setting. Finally, recommendations to address key barriers at the patient, provider (both cancer and mental health care providers), and institutional levels were provided.



## Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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### Highlights

- The two most critical barriers to psychosocial services usage in a sample of Latina and non-Latina White women who had survived breast cancer were not knowing where to receive psychosocial services and the belief that counselors might not understand their cultural values or background
- Latinas were more likely than non-Latina Whites to report that mental health services were too expensive, their doctor did not tell them about counseling or therapy, they felt uncomfortable with using an interpreter for counseling or therapy, and they did not think that a counselor or therapist would understand their cultural values or background or speak their language.
- Health care providers should be aware of the patient's potential barriers to seeking psychosocial support when screening for distress and psychosocial support needs.

**Table 1.**

Characteristics of individuals who had survived breast cancer, by ethnicity

	Participants, No. (%)						$\chi^2(df)$
	Total		Latinas		NL Whites		
	n	%	n	%	n	%	
Age <sup>1</sup>	61.16	11.20	60.38	11.40	61.65	11.08	-0.86 (244)
Marital Status							4.89 (4)
Married or partnered	166	62.9	55	57.3	111	66.1	
Single	19	7.2	8	8.3	11	6.5	
Separated	5	1.9	3	3.1	2	1.2	
Divorced	42	15.9	20	20.8	22	13.1	
Widowed	32	12.1	10	10.4	22	13.1	
Education							8.09 (3) <sup>*</sup>
12th grade/high school graduate	58	22.9	29	30.0	29	17.0	
Some college/ Associate's degree	60	22.6	21	2.1	39	22.9	
College Graduate	55	20.8	20	21.1	35	20.6	
Post college/Graduate school	92	34.7	25	26.3	67	39.4	
Employment							6.90(4)
Employed- Full Time	51	33.3	23	29.9	28	36.8	
Employed- Part Time	28	18.3	11	14.3	17	22.4	
Retired	58	37.9	32	41.6	26	34.2	
Unemployed	8	5.2	4	5.2	4	5.2	
Unable to work	8	5.2	7	9.1	1	1.3	
Birthplace							
US	182	69.0	29	30.2	153	91.1	
Puerto Rico	21	8.0	21	21.9	0	0	
Caribbean	16	6.0	16	16.7	0	0	
Central America	7	2.7	7	7.3	0	0	
South America	21	8.0	21	21.9	0	0	
Europe	17	6.4	2	2.1	15	8.9	
Preferred language							
English	202	76.2	34	35.1	168	100	
Both equally	32	12.1	32	33.0	0	0	
Spanish	31	11.7	31	32.0	0	0	
Health Insurance							1.893(1)
Private	38	31.7	13	25.0	25	36.8	
Medicare or Medicaid	82	68.3	39	75.0	43	63.2	
Time since diagnosis							1.80 (3)
0-11 months	12	4.7	5	5.8	7	4.2	
1-2 years	52	20.6	14	16.3	38	22.8	
3-5 years	152	60.1	52	60.5	100	59.9	
6 years or more	37	14.6	15	17.4	22	13.2	

Note.

<sup>1</sup>For age, mean and standard deviation (*t* test) are reported.

Percentages may not equal 100% due to rounding. Frequencies may not be based on a total of 265 participants due to missing data.

Abbreviation: NL, non-Latina.

\*  
 $p < .05$

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**Table 2.**

Barriers to use of psychosocial services, by ethnicity

	Response of Yes/Maybe						X <sup>2</sup>
	Total		Latinas		NL Whites		
	n	%	n	%	n	%	
I feel I can take care of my problems myself	157	63.1	57	62.6	100	63.3	0.1
I prefer to go back to my normal routine rather than to see a therapist or counselor	149	60.1	49	44.3	100	62.5	1.1
I prefer to seek counseling and support from my friends and family	137	56.1	45	52.3	92	58.2	0.8
I prefer to focus on the treatment for my cancer	118	48.6	41	47.1	77	49.4	0.1
I do not want to take medications for my emotional difficulties	97	40.1	30	34.5	67	43.2	1.8
Mental health services are too expensive	84	35.0	37	43.0	47	30.3	4.0*
My doctor did not tell me about counseling or therapy	77	31.7	21	24.1	56	35.9	3.6
I do not know how counseling or therapy would help me	73	30.2	24	27.9	49	31.4	0.3
I prefer to seek counseling and support from my priest, pastor, or minister	69	28.3	30	34.1	39	25.0	2.3
Mental health treatment is unnecessary because it's normal to be distressed after a cancer diagnosis	62	25.7	25	29.4	37	23.7	0.9
The location of the counseling center or clinic is inconvenient	60	25.0	26	30.2	34	22.1	2.0
I do not know where to receive counseling or therapy	58	23.8	21	24.1	37	23.6	0.1
It is embarrassing to seek counseling or therapy	48	19.8	13	14.9	35	22.4	2.0
My insurance might not cover the services	35	14.4	19	21.8	16	10.3	6.1
It is a weakness to take medications for mental health problems	32	13.3	14	16.3	18	11.6	1.1
Using an interpreter for counseling or therapy would make me uncomfortable	20	12.7	19	21.6	1	1.4	14.1**
There are no counselors or therapists who understand my cultural values or background	28	11.6	18	20.7	10	6.5	11.0***
If I seek mental health treatment my family and friends would think I'm crazy	27	11.2	14	16.5	13	8.3	3.7
My friends or family disapprove of the use of counseling or therapy	26	10.7	8	9.1	18	11.5	0.4
There are no counselors or therapists who speak my language	8	5.1	8	9.1	0	0	6.6**

\* p<.05,

\*\* p<.01,

\*\*\* p<.001

Degrees of freedom =1 for all the analysis

Abbreviation: NL, non-Latina.

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**Table 3.**

Unadjusted and adjusted logistic regression models predicting the likelihood that individuals who had survived cancer did not have contact with or receive services from psychosocial professionals after the cancer diagnosis

	Response of Yes/Maybe, OR (95% CI)							
	No Contact with professionals				No Receipt of services			
	Unadjusted		Adjusted		Unadjusted		Adjusted	
	OR	95% CI	AOR	95% CI	OR	95% CI	AOR	95% CI
I feel I can take care of my problems myself	1.75		1.73		1.34		1.13	
I prefer to go back to my normal routine rather than to see a therapist or counselor	2.72	1.21–6.09*	3.36	1.31–8.62**	2.08	0.96–4.51	2.26	0.93–5.49
I prefer to seek counseling and support from my friends and family	1.49		1.94		1.40		1.69	
Mental health services are too expensive	1.34		2.18		1.36		2.15	
I do not want to take medications for my emotional difficulties	1.10		1.35		0.80		0.90	
I prefer to focus on the treatment for my cancer	1.72		1.47		2.03		1.82	
My doctor did not tell me about counseling or therapy	1.17		1.52		1.21		1.55	
I do not know how counseling or therapy would help me	2.75	1.22–6.22*	3.15	1.13–8.77*	3.27	1.45–7.34**	4.44	1.55–12.72**
I do not know where to receive counseling or therapy	4.56	1.96–10.61***	5.22	1.79–15.21**	3.84	1.68–8.78***	4.08	1.44–11.58**
The location of the counseling center or clinic is inconvenient	0.87		0.65		0.79		0.52	
It is embarrassing to seek counseling or therapy	2.27	0.93–5.50	2.87	1.03–8.01*	1.73		1.92	
Mental health treatment is unnecessary because it's normal to be distressed after a cancer diagnosis	3.79	1.52–9.45**	3.16	1.09–9.16*	2.87	1.17–7.06*	2.23	
My insurance might not cover the services	0.89		0.66		0.94		0.64	
There are no counselors or therapists who understand my cultural values or background	3.96	1.39–11.28**	2.68		5.63	1.84–17.24**	4.96	1.31–18.71*
My friends or family disapprove of the use of counseling or therapy	1.66		1.39		1.77		1.62	
If I seek mental health treatment my family and friends would think I'm crazy	1.47		1.33		1.18		1.04	
It is a weakness to take medications for mental health problems	1.74		2.05		2.11		2.46	
Using an interpreter for counseling or therapy would make me uncomfortable	3.63	0.82–16.13*	1.38		5.51	1.06–28.70*	2.46	
There are no counselors or therapists who speak my language	2.03		0.46		5.18		1.57	

Note. Adjusted for ethnicity, age, education, marital status, and time since diagnosis

Abbreviations: CI, confidence interval; OR, odds ratio; AOR, adjusted odds ratio.

\*  $p < .05$ ,

\*\*  $p < .01$ ,

\*\*\*  $p < .001$



Samples size might vary due to missing data.

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