Published in final edited form as:

J Fam Nurs. 2011 August ; 17(3): 380–402. doi:10.1177/1074840711416119.

“Like a Mexican Wedding”: Psychosocial Intervention Needs of Predominately Hispanic Low-Income Female Co-Survivors of Cancer

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Abstract

Although recent work has recognized that the influence and consequences of cancer extend beyond the individual receiving the diagnosis, no studies have focused on the specific psychosocial intervention needs of female co-survivors in low-income populations. In this qualitative study, the co-survivors, 16 women, representing 10 low income families and predominately Hispanic, were interviewed about their experience of having someone in their family diagnosed with cancer. Several themes emerged from the data, including family stress, lack of skill in coping with the effects of cancer (e.g., depression of their loved one), a need for financial help, a willingness to share with others, and reliance on faith to see them through the cancer experience. Whereas no agreement existed as to where and how to provide an intervention, participants reported that tailoring an intervention to family needs and delivering it in a way that was accessible to them was important.

Keywords

low income; cancer; co-survivors; family; family experience of cancer; Hispanic; psychosocial intervention

In recent years, it has become widely recognized that cancer impacts not only the individual with the cancer diagnosis, but family members as well (Alferi, Carve, Antoni, Weiss, & Durán, 2001; Carter, 2003; Edwards & Clarke, 2004; Mokuau & Braun, 2007; Rothschild, 1992; Speice et al., 2000; Sutherland, Dpsych, White, Jefford, & Hegarty, 2008). It is important to note that the term “family” is used broadly in the literature and may refer to a close relative, a spouse, a life partner, or a primary caregiver/support person, among others. In addition to legal and biological factors that define family, persons define themselves as members of families, demonstrate commitment, and share a personal history (Gilgun, 1992). Increasingly, the importance of recognizing friends, partners, and caregivers as “family of choice” is understood in cancer intervention (Sample, 2010, p. 112).

Given the far-reaching effect of the cancer experience on multiple others, family members of those diagnosed with cancer have been referred to as *co-survivors*, thereby recognizing that the family members of an individual diagnosed with cancer are so affected by the cancer experience as to be considered survivors themselves (A National Action Plan for Cancer Survivorship, 2004). Although co-survivors may recognize themselves as caregivers, not all co-survivors identify with the term “caregiver” nor do they carry out the role as it is generally understood. Our work, therefore, while inclusive of caregivers, extends beyond those who readily identify as such to include those who identify as family members “giving care” (National Cancer Institute, 2007, p. 1). These family members, as co-survivors of cancer, attempt to carry out what Vandall-Walker and Clark (2011) referred to as the work of getting through a critical illness.

Review of the Literature

While co-survivors may give care to the family member diagnosed with cancer, not all co-survivors are adequately prepared to provide needed support to their loved one. They

themselves may well be stressed, or not have the needed knowledge or skills, at the time of the cancer diagnosis (Shields & Rousseau, 2004; Thorne, Bultz, Baile, & The SCRN Communication Team, 2005; Woods, Lewis, & Ellison, 1989). Much work remains in developing systematic and sustainable community-based and community-appropriate intervention for co-survivors affected by cancer. A report of the Institute of Medicine [IOM] (Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting, 2007) found that psychosocial intervention in cancer care for both patients and for their family members is “the exception rather than the rule” (p. 1) and recommended “that research address the use of tools and strategies to ensure delivery of appropriate psychosocial services to vulnerable populations, such as those with low literacy, inadequate income, and members of cultural minorities” (pp. 3–4). The IOM report identified problem areas which needed to be addressed in six psychosocial domains: 1) understanding of illness, treatments, and services; 2) coping with emotions surrounding illness and treatment; 3) managing illness and health; 4) behavioral change to minimize disease impact; 5) managing disruptions in work, school and family life; and 6) financial assistance. These represent the range of factors that have yet to be described and addressed in interventions, and provide a framework for the questions asked in this study.

Research indicates that income is important in understanding cancer prevention and control. In particular, health disparities data indicate that low socioeconomic status (SES) is a common denominator among those sharing the greatest cancer burden (Cella, et al., 1991; Singh, Miller, Hankey, & Edwards, 2003; Trans-HHS Cancer Health Disparities Progress Review Group, 2004). When compared to the general population, poor Americans in the United States have a 10 to 15% lower rate of survival regardless of race/ethnicity (American Cancer Society, 2003). This may be due in part to the fact that access to health care services such as cancer screening is largely an issue of SES (Leybas-Amedia, Nuño, & García, 2005).

Among vulnerable populations, one that has been neglected in research is female co-survivors in low-income populations. We chose to focus on these female co-survivors for several reasons. Learning what we can from the literature, we know that female partners of those with cancer reported more anxiety and depression than male partners (Gustavsson-Lilius, Julkunen, Keskivaara, & Hietanen, 2007), and more depression than the general population (Gaugler et al., 2009). We also know that across cultures, female caregivers are particularly burdened (Mittelman, 2005). Women most often function as carriers of a culture in addition to serving as caregivers during chronic illness or disability. Women, as wives, mothers, sisters, and daughters, have a great deal of influence in the health-related decision-making for the family, make substantial economic contributions to the family through their productivity, representing both paid and unpaid labor, and report significant caregiver roles (Evercare® study, 2008). With these multiple roles and burdens, the needs of low-income female co-survivors are important to define and describe for purposes of creating appropriate interventions.

Much of the relevant research has provided evidence based on White, well-educated populations with few studies representing the diverse reach of cancer (Andersen, 2002), or culturally diverse families (Chesla, 2010). We argue, along with others (e.g., Hiatt et al.,

2001; Pasick et al., 2009; Pasick, Stewart, Bird, & D'Onofrio, 2001; Rogoff, 2003) that it is not sufficient to use existing models based on individuals and families who are predominately affluent, well-educated, and White research participants, or who come only from middle-class communities in Europe and North America. The needs of these particular samples may be different than those of female co-survivors of low-income families. The theory and methods we used for this study are derived from a model that extends attention beyond typical individuals studied in the cancer literature, and in which co-survivors as research participants are considered within the context of both culture and social class/income (Marshall et al., in press).

Our overall purpose was to understand the needs and experiences of female co-survivors of cancer in low-income families. We wanted to use this information to better assist others like them via an intervention designed to support them through the cancer experience. In the current study, we fill an important gap in the research. The research reported here was conducted as a feasibility study to determine if it is realistic and prudent (Mertens, 1998) to document needs *based on SES*, bearing in mind that any subsequent needed intervention should be appropriate across the cultures of participants.

Method

Designed as an exploratory qualitative study (Sandelowski, 2000), we wanted to identify information and skill needs of low-income female co-survivors in meeting the needs of female family members with cancer in a large southwestern United States city with a significant Hispanic population. We chose qualitative methods for this work because our purpose was to gain in-depth understanding within a specific context: the lived experience of women (females from age 18 and older) who identified via self-report in a screening interview as being a part of a low-income family. Further, the women reported that they provided primary socioemotional and/or financial support to a family member with cancer.

We selected focus groups as our data collection method, reflecting the goal of exploring and describing the issues from the perspective of a group that had heretofore not been studied, and recognizing that focus groups can produce the detailed results similar to those obtained from larger scale surveys (Ward, Bertrand, & Brown, 1991). Our design called for two multi-family focus groups, one offered in Spanish and one offered in English, but with the capacity to be flexible in language use given the various combinations of monolingual and bilingual abilities that can exist within and across families. The forms and structures of focus groups are well-documented in the literature (Basch, 1987; Krueger, 1988; Ledeman, 1990) and are not repeated here. A range of 7–10 individuals per focus group is recommended (Mertens, 1998) and this recommendation guided our study in regard to participant recruitment. However, given the preference of research participants—specifically the difficulty in finding a common meeting time given work schedules, the focus group strategy was changed to individual family-based interviews. This change in data collection strategy allowed individual families/co-survivors to be interviewed in a place and time convenient for them.

We had originally planned to limit focus group participation of each family to 3 members (for instance, a generational composition of 3 mothers/aunts, 3 sisters, 3 daughters). This would have allowed for each focus group to have a minimum of 3 families represented or 9 individuals per group. Under this design, given two focus groups, we anticipated data representing a minimum of 6 families (if each family were represented by 3 members) and up to 20 families (if each family were represented by an individual). Though our modified strategy, we reached 16 co-survivors representing 10 families. Participants were accrued in the study on a volunteer basis. Two factors guided our decision to stop recruitment: 1) saturation of data was observed in our findings as analyses were ongoing and no new information was forthcoming, and 2) the number of participants were consistent with the number expected in the two focus groups we had originally planned.

Eligibility

Eligibility was determined via a screening interview and was based on the self-report of potential participants. Inclusion criteria required that research participants (co-survivors) be adult females 18 years of age or older, that the family be low-income, and that the cancer survivor would have been diagnosed with any cancer within 5 years of the study. Co-survivors of any race or ethnicity were eligible to participate. Co-survivors affirmed in the screening interview that they provided primary socioemotional and/or financial support to a female cancer survivor.

Human Subjects

Institutional Review Board approval was obtained prior to recruitment. Written informed consent was obtained from all participants.

Recruitment

Co-survivors living in the metro area of a mid-sized southwestern city were recruited via the staff of a university-affiliated cancer center and the health workers, including *promotores* [community health workers] of clinics that serve low-income women and their families. Flyers announcing the study were made available to the cancer center staff and the health workers. The principal investigator (PI) and research assistants presented information about the study to breast cancer support groups and in the trainings of health workers and professionals.

Data Collection

Data were collected from co-survivors via in-depth, personal interviews with each individual or family group (see Figure 1 for the makeup of each interview). The interviews were carried out by the PI (first author, fluent in both Spanish and English) in partnership with one of three trained bilingual, bicultural research assistants (fluent in both Spanish and English). The interviews were conducted in the home or selected environment and in the language of choice (Spanish or English) of the co-survivor. After each interview, participants were given contact information for cancer-related and family/caregiving resources, other relevant human services such as vocational rehabilitation, and a gift card of \$10 redeemable at a local grocery chain to thank them for their time.

Questions were asked using a semi-structured format, a blend of what Patton (2002) referred to as the interview guide approach and the standardized open-ended interview. In blending these approaches, the topics and questions were determined in advance (like one would expect in a standardized open-ended interview), but the interviewer decided on the “sequence and wording of questions in the course of the interview” (Patton, 2002, p. 349), as is suggested in the interview guide approach.

For instance, based on a co-survivor’s response to a given question, a subsequent question may be modified or explained in such a way so as to acknowledge the earlier response. Similarly the wording of the question might be changed if the co-survivor did not understand the standardized wording. Researchers also asked follow-up questions as appropriate to probe for more information (Patton, 2002). According to Patton, “probing is a skill that comes from knowing what to look for in the interview, listening carefully to what is said and what is not said, and being sensitive to the feedback needs of the person being interviewed” (Patton, 2002, p. 374).

Interview questions. Research participants were asked the following questions:

1. Please share, to the extent you are comfortable, about yourself and your family’s cancer experience.
2. What information and coping skills do families need [at the time of diagnosis]?
3. What resources are most needed [at the time of diagnosis]?
4. Where would [psychoeducational intervention] participants feel most comfortable meeting (church, clinic, public library)?
5. [Should psychoeducational intervention participants] meet face-to-face once a week for 2 hours over 6-weeks? (12 hours); weekend?
6. Did we cover everything? Would this group like to meet again?

Consent materials were translated to Spanish for those whose language preference was Spanish. In reviewing the consent materials with co-survivors prior to each interview, terms were clarified as needed with any questions being answered. The interviews were conducted in English or in Spanish, depending on the preference of those being interviewed and were digitally recorded.

Data Analysis

Thematic analysis was selected for our approach to qualitative data analysis. Thematic analysis, according to Boyatzis (1998), is based on the process of recognizing important messages in the data. The purpose of thematic analysis is to identify important concepts or categories and examine them in relation to the rest of the data and context. From these categories, themes are developed that provide explanation of the phenomenon under study (Coffey & Atkinson, 1996). The questions themselves gave us a starting point in identifying themes as our intent was to identify fundamental, or low-inference, descriptions determined to be important messages or concepts (Sandelowski, 2000). *NVivo7* [Non-numerical Unstructured Data: Indexing, Searching and Theorizing; <http://www.qsrinternational.com>], a

qualitative software program, was used to assist in the mechanical aspects of analyzing the data.

As a method of strengthening the credibility of qualitative data analysis, Patton (2002) recommends that researchers apply analyst triangulation. Using this procedure, two or more people independently analyze the same data and compare findings. In our analyses, after the PI completed the initial thematic analysis, the seventh author (fluent in both Spanish and English) without knowledge of the initial findings completed a second round of independent thematic analysis. Results were discussed with coauthors to determine whether similar themes emerged during the second round of analysis. Consensus was reached that the selected exemplars were representative of the identified themes, although all labels for themes were not the same via the independent analyses.

Results

Sample Characteristics

A total of 16 female co-survivors representing 10 low-income families were interviewed. The co-survivors were, on average, 44 years of age, with a range in age of 28–80 years. Of the 10 families represented, the majority reported the cancer diagnosis of as breast cancer (7 families), followed by ovarian cancer (2 families), and colon cancer (1 family). Figure 1 provides demographic information regarding the family relationship of research participants in regard to the individual with cancer. Regarding ethnicity, 13 of the co-survivors reported being Hispanic, representing 8 of 10 families (see Figure 2). If identifying as Hispanic in terms of ethnicity, participants were generally perplexed during our screening interview as to how to respond to a demographic question regarding their race; most simply repeated again that they were Hispanic. When pressed to identify a race, roughly a third of Hispanic participants reported they were unsure, were of mixed race, or were White.

Themes Reflecting the Cancer Experience

Five overarching themes were identified in data resulting from the opening question or invitation for families to “share, to the extent you are comfortable, about yourself and your family’s cancer experience.” Themes included *Lack of Skills*, *Need for Financial Help*, *Family Stress*, *Advice for Others*, and *Reliance on God or Faith*. Selected exemplars for each theme are given below and provide direction for the psychoeducational program to be developed.

Theme #1: Lack of Skills

As these quotes reveal, co-survivors did not have the skills, for instance, to deal with the depression that they and/or their family member with cancer was experiencing. A lack of communication skills, of problem-solving skills, was compounded by a lack of cancer-specific knowledge—also a factor as reported below under *Family Stress*.

A sister said I believe that we don’t have the skills as family members to deal with people that have depression. And the cancer created a lot of depression in her life [sister with cancer] and it still happens to be there.... I’m not the kind of person that sits and cries over

that fact that they're ill. I'm more the kind of person that wants to fix it... I wish there was ... more help for their depression, that there was more focus on their depression, because I didn't have the Ph.D. to deal with that. That to me was the most stressful part of the cancers that affected my life with my family members.

A daughter said She was very depressed, very depressed and, well, we were with her, but we did not show her a lot of our feelings so that she wouldn't suffer. But, for example, when I was home, I would think about it and I would cry, but I never did so in front of her. She used to say, "I'd rather be dead than continue to suffer with this." Because she could not conceive of herself without her breast; she did not want to be mutilated.

Theme #2: Need for Financial Help

As stated earlier under *Method: Eligibility*, all participants self-reported to be low income. They would have, for instance had a family annual income below 250% of the federal poverty level, or had a family member with cancer who received health services via state aid for low-income residents or through a health care agency devoted to uninsured/underinsured residents. Therefore, it is not surprising that a theme which emerged from data included the need for financial help.

A sister said I wish there was more financial help for these people who cannot work during this time.

A mother said And many people, I have learned, that if given a diagnosis, they would just stop. Why? because they have no money to get going and go to have analysis done.

Theme #3: Family Stress

A variety of topics were identified under the overarching theme of stress. As one example, co-survivors voiced *fears of their own cancer* based on the cancer of their loved one.

A daughter said In my experience, because when my mom was just diagnosed, I also felt bad. I felt influenced, meaning, it hurt—my breasts hurt or something and I also used to say—I can also get sick. Even now-a-days [5 years after mom's diagnosis] things are not the same. I am still thinking it can also happen to me....

Family stress at diagnosis was also reported.

A daughter said When they diagnosed her with cancer, for me it was like... my mom is going to die.... When I heard the word—cancer—it was like saying she is going to die—there are no solutions. It was so hard, very hard for me, and because she became a tough person, very tough, it was very hard, really. She did not want to talk about anything. She was all shut down

Theme #4: Advice for Others

While not all families offered advice for others, in telling their own stories of their cancer experience, co-survivors either explicitly or implicitly offered advice for families that would come after them.

A sister said I think if I could any advice to anybody, is to actually go to the doctor with them. And I think that by going to the doctor, the one time that I went to the doctor with her two Friday's ago was so good for me. It was such a good visit. Even though the doctor never directly spoke to me except to answer a few questions I asked, I was extremely comfortable in knowing that she was in good hands, the doctor was excellent and the doctor took the time to answer the questions that I had even though she would speak to her (patient) and she (patient) would know what the doctor was talking about. I would then say well what does that mean. The doctor would then explain it to me and still direct her attention to her (patient) totally, which was amazing to me. I came away with an excellent feeling of how the doctor was caring for her.

A granddaughter said I would say to research—do your own research to know what it is that's going on. ... We throw out a lot of "what-ifs." Well, if this doesn't work, then what, if that doesn't work, then what. Everybody has different ideas, different thoughts to the process.

Theme #5: Reliance on God or Faith

No questions and no probes were asked regarding faith or religion. However, faith emerged both as a theme reflecting a co-survivor's impotence, as well as belief in the power of God to impact the outcome of a cancer diagnosis.

A mother said I just depended on God to watch over her because I couldn't do nothing, I felt helpless.

A granddaughter said "Of course, we're all spiritual so we're always praying—I'm praying for you. Our prayers are going up, blessing are coming down. We know that God is good; you are doing what you need to be doing....So you try to take that and give whatever direction that you can to people.

Meeting Time and Structure

Responses to our questions regarding information and coping skills families needed, as well as resources needed, were typically given in response to our first question and reflected in the five major themes related to the cancer experience. When probed, participants tended to reinforce their previous comments and little new information was forthcoming.

There was consensus that the needs of co-survivors and family members should be addressed throughout the cancer experience. When asked about a best meeting time and structure for subsequent psychoeducational participants, there was no agreement as to where and how to provide an intervention. Rather, family members stressed that tailoring an intervention to family needs and delivering in a way that was accessible to them was their most important concern—and to begin—to actually provide an intervention—the end point was of less importance. An exemplar capturing both the content and tone of participant responses comes from a mother of a daughter with breast cancer: "Vamos a empezar a tales horas y a ver hasta dónde.... como las fiestas, como en las bodas. Poner un horario de empezar y hasta que se acabe" [Let's start at such and such time and see where it goes Like we do for parties, like we do for weddings. Stating a start time and go until it ends].

Discussion

Our research was conducted as a feasibility study to determine if participant recruitment could be *based on SES*, yet lead to intervention appropriate across the cultures of participants. Our overall purpose was to understand the experience of female co-survivors of cancer in low-income families in order to confirm program components of a psychosocial intervention tailored to their needs. Viewing the community in which this research was carried out, Tucson, Arizona, from a low-income lens brings into focus the particular needs of an underserved and under-studied population, Spanish-speaking Hispanics. It is here, given their numbers in our population, that one finds most often underinsured and uninsured family members, as co-survivors of cancer, attempting to bring their minimal resources to bear on both understanding and supporting their loved one with cancer. We were successful in recruitment and data collection in this largely Spanish-speaking population, using low SES as an eligibility requirement, because culturally-specific and culturally-respectful community processes were utilized.

Among the predominate themes we identified in our results and across participants, co-survivors reported being stressed. They also reported lack of skill in coping with the effects of cancer, for instance, the depression of their loved one; a need for financial help; a willingness to share with others based on their own cancer experience; and frequent reliance on faith to see them through the cancer experience. Co-survivors reported that an intervention was needed to address concerns common to their experiences in facing cancer, in particular, the need at diagnosis for information and resources. However, there was no agreement as to where and how to provide an intervention other than to begin—an agreement that intervention was needed. The intervention participants themselves would contribute to decisions about meeting structure and timeframes.

While inclusive of caregivers, our work extends beyond those who readily identify as such to include those who identify as co-survivors, thereby expanding beyond the population for which there is a dedicated body of literature. In developing our work, we drew on work inclusive of families facing any chronic illness as well as caregiver research. Recently Wells and colleagues (2008) as well as Northfield and Nebauer (2010), have contributed to the literature in regard to families and cancer.

Wells and colleagues (2008) looked at the experience of female Mexican-American caregivers but did not specifically address their socioeconomic status. Income was not considered in their study's inclusion criteria. Their findings were that Mexican-American women who are socialized to be caretakers and have strong feelings of duty to family and belief in God, often emphasized their emotional, cognitive, and spiritual growth through assumption of caregiving. However, they also reported that although caregivers denied caregiver burden, if the researcher rephrased questions addressing the difficulties of caregiving, participant responses clearly reflected caregiving burden. Reasons suggested for caregivers denying burden included the cultural inappropriateness of acknowledging caregiving burden when the cultural norm is obligation to care, as well as the "absence of a word in the Spanish language" that conveys the caregiving burden construct. Of particular relevance to our population of interest, low-income co-survivors of cancer, the researchers

found that while small in number in their study, those “with significant lack of financial or family resources ... reported that the negatives of caregiving exceeded the positives” (p. 231).

Similar to our findings, Wells and colleagues (2008) found that caregivers “looked to God to meet their emotional needs,” yet wanted information in regard to providing emotional support and dealing with side effects of cancer treatment. Caregivers wanted to increase their understanding of both the patient cancer experience and caregiving. In summarizing their findings, Wells and colleagues suggested that an “emerging theoretical model of female MA [Mexican-American] cancer caregiving offers evidence to change current cancer care approaches from patient-focused to family-focused care for this ethnic group” (p. 223).

Following their extensive review of 70 articles in the existent caregiving and cancer literature, Northfield and Nebauer (2010) found that “Family members often receive no preparation for their role as a caregiver and often need support from others to develop their skills and find their way through the confusion of watching their relatives receive treatments (e.g., chemotherapy) and suffer from a disease of which they have little understanding” (p. 570). Northfield and Nebauer concluded that caregivers struggle at the time of a cancer diagnosis and called for “individualized and phase-specific” interventions (p. 575). Their findings support our results and are consistent with our own review of the literature.

Limitations and Future Research

Our small sample size could be considered a limitation of the study. However, our sample size was appropriate for the initial phase of a feasibility study. In considering the results and drawing conclusions from this study, it is important to remember that the results apply to the volunteers who participated in the study. As with any small descriptive study, we cannot draw conclusions regarding those who did not participate in the study but believe our method as reported here and findings can be instructive to others interested in a similar population who would also conduct a local verification of need prior to providing an intervention with co-survivors. Much of our time and resources were focused on ensuring that the low-income population of our community this is Spanish-speaking was included in our recruitment efforts. With additional time and resources, our focus on low SES could have carried our work to other populations in other locations which may, in fact, have produced different results.

In the current study, we interviewed one co-survivor whose loved one with cancer was deceased. Because our study was based on understanding the needs and cancer experiences of family members as co-survivors, there was no requirement that the person who had been diagnosed with cancer be alive at the time of the family interview. Given that, apart from their needs at diagnosis, experiences for low-income co-survivors whose loved one died from cancer may be unique from those with a family member who is surviving cancer, studying the former individuals would be an important avenue of future research.

Conclusion

Psychosocial intervention is needed among low-income families facing cancer. In addition to results of this study, we take direction for intervention from the literature. Family members, as co-survivors, are affected by cancer and benefit from educational interventions (Northouse, Kershaw, Mood, & Schafenacker, 2005; Sandberg, 2005). We also know from the extant caregiving literature that men and women appear to approach the practice of caregiving in somewhat different ways (Boeije & van Doorne-Huiskes, 2003; Corcoran, 1992).

Given that the IOM report (Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting, 2007) identified understanding of illness, treatments, and services as a psychosocial domain which needed to be addressed, we suggest that the psychosocial needs low-income co-survivors of cancer might be served via a psychoeducational format (Gaugler et al., 2009). Psychoeducational interventions can take different forms, involving something as simple as giving a booklet of information, to providing the same information in a didactic and/or experiential format in face-to-face meetings that allow for facilitator-directed and/or peer instruction (Chesla, 2010; Ehrmann & Herbert, 2005). Even given wide variation in format, psychoeducational interventions have been consistently shown to effectively reduce caregiver burden, improve coping skills, and well-being. These interventions can be flexible, to include telephone-based interventions (Badger, Segrin, Meek, Lopez, & Bonham, 2006), thus meeting the different needs and circumstances of different individuals (Erwin, Johnson, Feliciano-Libid, Zamora, & Jandorf, 2005; Weihs, Fisher, & Baird, 2002).

Participants in this study stressed that tailoring an intervention to their family needs and delivering it in a way that was accessible to them was important. As co-survivors, participants reported needing to understand what cancer was and needed skills to address the cancer-related concerns of their family members and of themselves. They needed financial assistance and they needed assistance in accessing resources. They needed information and support for their own cancer-related fears.

Low-income co-survivors of cancer and their families exist across America. We would hope that our lessons learned regarding method and our results provide guidance for others hoping to add to our knowledge regarding other understudied populations such as low-income ethnically-diverse co-survivors of cancer. In our results, preferences for meeting time and structure of the intervention (e.g., where [home, health clinic] or how [individual, group sessions] were not specified by participants; that is, in analyzing our interview data, no clear theme or direction for meeting time and structure emerged. However, given the results of our local study where needs also matched needs those identified nationally (Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting, 2007), we feel comfortable in moving forward. Intervention participants will be asked to determine the meeting time and structure of interventions tailored for them. Research participants agreed that the important factor is to provide the needed information and “como en las bodas” –to focus on beginning, and see where we end.

Acknowledgments

Acknowledgement: This work was supported in part by a Ruth L. Kirschstein National Research Service Award for Individual Senior Fellowship (Grant Number F33CA117704), the U.S. Department of Health and Human Services National Institutes of Health, National Cancer Institute. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Cancer Institute or the National Institutes of Health.

Bios

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Figure 1.
Family Research Participants

Figure 2.
Family Make-Up