

# Impact of a Bilingual Education Intervention on the Quality of Life of Latina Breast Cancer Survivors

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**B**reast cancer disproportionately affects Latinas living in the United States and is the primary cause of cancer-related deaths in that population (Siegel, Naishadham, & Jemal, 2012). Compared to Caucasians, Latinas are diagnosed at younger ages with less favorable prognoses and have a lower survival rate (Wu et al., 2012). The five-year survivorship rate is 83% for Latinas compared to 89% for Caucasians (DeSantis, Siegel, Bandi, & Jemal, 2011). The type of treatment Latinas and other ethnic minorities receive involves an increased risk for treatment delays, less access to care, and lower quality of care (Freedman, He, Winer, & Keating, 2009; Parise, Bauer, & Caggiano, 2012). The differences in treatment may have important negative effects on quality of life (QOL). Despite some preliminary studies in that area, intervention testing that addresses physical, psychological, spiritual, and social aspects of QOL in Latina breast cancer survivors (BCSs) has not occurred (Ashing-Giwa & Lim, 2009; Lopez-Class, Gomez-Duarte, Graves, & Ashing-Giwa, 2012).

In 2011, more than 2.6 million BCSs were living in the United States (DeSantis et al., 2011). Improving the QOL of cancer survivors has been identified as a public health priority by the Institute of Medicine (IOM) and numerous other organizations. An IOM report by Hewitt, Greenfield, and Stovall (2006) also highlighted the need to evaluate QOL following the end of initial diagnosis and treatment. Latinos are the largest and fastest-growing ethnic minority group in the United States (Pew Hispanic Center, 2010); therefore, as the Latino population continues to grow, so will the cohort of Latina BCSs living with the effects of cancer and cancer-related treatment. Although a large body of research addresses breast cancer QOL, relatively few studies have focused on the post-treatment experience of Latina BCSs.

The Latino population does not have access to the same quality of care as Caucasians (Bradley, Given, & Roberts, 2002). Access to care can be influenced by many

**Purpose/Objectives:** To test the effectiveness of a bilingual education intervention to improve the quality of life (QOL) of Latina breast cancer survivors (BCSs) after completing primary treatment for breast cancer.

**Design:** A two-group prospective, longitudinal, randomized, controlled trial.

**Setting:** An ambulatory-care setting of a designated comprehensive cancer center in southern California.

**Sample:** 52 English- and Spanish-speaking Latina BCSs.

**Methods:** Women were randomly assigned to the experimental or attention control group and completed measures of QOL, uncertainty, distress, and acculturation at baseline, and at three and six months postintervention.

**Main Research Variables:** QOL, uncertainty, and distress.

**Findings:** After controlling for acculturation, the four dimensions of QOL increased slightly in the groups or remained unchanged without significant group-by-time interaction. The social and psychological well-being subscales had the lowest scores, followed by physical and spiritual well-being. Although the group-by-time interaction was not statistically significant, the post-hoc difference for total QOL between time 2 and time 3 in the experimental group approached significance, with a slight increase in total QOL.

**Conclusions:** Latina BCSs have multiple survivorship and QOL concerns that might put them at risk for poor QOL.

**Implications for Nursing:** More culturally congruent intervention studies are needed to address the paucity of intervention research with Latina BCS.

**Knowledge Translation:** Core values must be incorporated in the development of health education programs. Those programs also should be linguistically appropriate and available to non-English-speaking Latinas. In this way, the informational and supportive needs of all BCSs can be met.

factors, including insurance status, linguistic isolation, education, insufficient information, language barriers, immigration status, racism, acculturation, lack of understanding of the U.S. healthcare system, and scarcity of ethnically and culturally sensitive healthcare facilities (Bradley et al., 2002; Guidry, Torrence, & Herbelin,