

An Interpretive Description of Chemotherapy-Induced Premature Menopause Among Latinas With Breast Cancer

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Latinas in the United States attain lower education levels, are more likely to live in poverty, and are less likely to have health insurance (American Cancer Society [ACS], 2014a). Socioeconomic status is identified as a critical factor affecting health and longevity (ACS, 2014a). Cancer disparities in Latinas are influenced by cultural factors such as language, beliefs, values, and traditions. Latinas with low acculturation and English as a second language report the greatest unmet needs for information and support (Hamilton et al., 2009; Janz et al., 2008).

Breast cancer is the most commonly diagnosed type of cancer and the leading cause of cancer death among Latinas in the United States. About 17,100 Latinas were diagnosed with breast cancer in 2012, and 2,400 deaths occurred (ACS, 2014b). About 33% of new cases of breast cancer occurred in women of any ethnicity aged 35–54 years (ACS, 2014a; National Cancer Institute [NCI], 2014), with about 25% in premenopausal women (ACS, 2014a; Jemal et al., 2007; Jemal, Siegel, Xu, & Ward, 2010).

A breast cancer diagnosis for Latinas is associated with aggressive disease patterns and less favorable outcomes because of negative prognostic factors at diagnosis (NCI, 2014). Factors include larger tumor size, higher grade lesions and proportion of *BRCA* gene mutations (John et al., 2007), more positive lymph nodes, and higher incidence of hormone-receptor negative and triple-negative breast cancers (Hill et al., 2010; Patel, Colon-Otero, Bueno Hume, Copland, & Perez, 2010; Voelker, 2009). Latinas diagnosed with cancer face widespread barriers to accessing health care (ACS, 2014b) and receiving standardized treatment (Hawley, Fagerlin, Janz, & Katz, 2008; Molina, Barton, & Loprinzi, 2005); inadequate information related to diagnosis, treatment, and survivorship (Fu et al., 2009; Im, Lee, Chee, Dormire, & Brown, 2010); and lower satisfaction with care (Thind, Hoq, Diamant, & Maly, 2010).

Chemotherapy is standard treatment for early-stage breast cancer and reduces recurrence and mortality risk (Gradishar, 2003; Kelly & Hortobagyi, 2010); however, it is also associated with short- and long-term physiological

Purpose/Objectives: To describe the experience of chemotherapy-induced premature menopause (CIPM) among Latinas, explore how CIPM was assimilated into the breast cancer experience, and relate measured acculturation levels to the CIPM experience.

Research Approach: Interpretive descriptive method from a feminist inquiry lens.

Setting: Telephone interviews with participants from 12 states in the United States.

Participants: 20 Latinas who experienced CIPM after treatment for breast cancer.

Methodologic Approach: In-depth interviews and the Brief Acculturation Scale for Hispanics were used to elicit data, with interpreter assistance as needed.

Findings: One overarching theme, Bigger Than Menopause, and three subthemes, Experiencing Menopause, Ever-Changing Landscape, and Working Through the Experience, were found. Participants' ability to assimilate CIPM into the breast cancer experience was affected by the magnitude of physiologic and psychosocial effects, access to health care, information and support, sense of control, and acculturation level.

Conclusions: The CIPM experience for Latinas with breast cancer is multifaceted, with less acculturated Latinas facing multiple barriers in accessing health care, treatment, information, and support.

Interpretation: Participants described CIPM as part of a larger context that included physiologic and psychosocial effects and affected participants' ability to assimilate CIPM into the breast cancer experience. The impact of low acculturation and barriers experienced were elucidated as factors associated with assimilating CIPM into the breast cancer experience.

Key Words: breast cancer; chemotherapy; cultural competence; Hispanic; menopausal symptoms; survivorship

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and psychosocial effects (Ganz, 2008; Helgeson, Snyder, & Seltman, 2004). Chemotherapy toxicity in pre- and perimenopausal women includes ovarian damage, which may result in amenorrhea (reversible or irreversible)

or chemotherapy-induced premature menopause (CIPM) (Bines, Oleske, & Cobleigh, 1996; Stroud et al., 2009). Patients younger than age 40 with breast cancer who experience CIPM report distress related to early onset of menopause, abrupt onset of menopause, loss of fertility, and cessation of menstruation (Avis, Crawford, & Manuel, 2004; Schover, 2008).

Menopausal symptoms are commonly assumed to be universal regardless of ethnicity and culture. However, the experience for Latinas has rarely been studied (Im et al., 2009; Villarruel, Harlow, Lopez, & Sowers, 2002). No studies were found regarding Latinas' experience with breast cancer and CIPM despite the potential negative influence on quality of life that was previously reported in non-Latina Caucasian women (Knobf, 2002). The purpose of this study was to describe the experience of CIPM among Latinas with breast cancer. The specific aims were to describe the experience of Latinas with CIPM, explore how Latinas assimilate CIPM into the breast cancer experience, and relate measured acculturation levels to the CIPM experience.

Methods

A qualitative interpretive description research methodology design (Thorne, 2008; Thorne, Kirkham, & MacDonald-Emes, 1997) from a feminist inquiry lens was used. Combining interpretive description as a flexible methodology with feminist inquiry allowed the stories of Latinas with CIPM to be heard and interpreted from social, structural, cultural, socioeconomic, and historic contexts (Garrick, 1999; Powers & Knapp, 2006). Interpretive description was used because not enough was known about CIPM in Latinas to develop nursing knowledge and inform practice likely to be explicated by an interpretive lens (Oliver, 2012; Thorne et al., 1997).

Initial recruitment efforts took place in UMass Memorial Medical Center, an academic health center cancer clinic in Worcester, Massachusetts. Because of low enrollment, information was posted on social media networks, local newspapers, and television stations. Study fliers in Spanish and English were displayed in Latino neighborhoods and at Latino festivals. Final recruitment was through the Dr. Susan Love Research Foundation–Army of Women database.

Eligibility requirements included self-reported English- or Spanish-speaking Latinas with a diagnosis of breast cancer (stages I–III), chemotherapy within the past 10 years, menses three months prior to start of chemotherapy, and CIPM described as amenorrhea following treatment. The final sample included 20 Latinas aged 38–60 years (see Table 1). Fourteen participants had stage II or III breast cancers. The average number of years since initial diagnosis was 4.6 years (SD = 2.6, range = 0.17–11). Thirteen participants had a combination of

Table 1. Participant Characteristics (N = 20)

Characteristic	n
Age (years)	
30–40	3
41–50	10
51–60	7
Marital status	
Married	11
Separated or divorced	5
Single	3
Widowed	1
Employment	
Full-time	12
Part-time	3
Disabled	2
Retired	2
Other	1
Education level	
GED	2
High school diploma	4
Associate's degree	5
Bachelor's degree	3
Master's degree	5
Doctoral degree	1
Annual income (\$)	
Less than 10,000	2
10,001–30,000	–
30,001–50,000	3
50,001–70,000	2
70,001–90,000	5
90,001–110,000	1
More than 110,000	4
Missing data	3
Adequacy of income for needs	
Less than adequate	5
Adequate	12
More than adequate	3
Insurance	
Private	14
Public	4
Uninsured	2
Country of birth	
United States	12
Mexico	2
Puerto Rico	2
Brazil	1
Cuba	1
Guatemala	1
Spain	1
Years of residence in the United States (N = 8)	
10–20	2
21–30	1
31–40	4
41–50	1

chemotherapy, surgery, and radiation treatment. Two participants requested an interview in Spanish. Two participants reported recurrence of breast cancer, but the data on recurrence were comparable to other participants.

Institutional review board approval was obtained from the University of Massachusetts Medical School in Worcester. The researcher or Spanish interpreter

obtained verbal consent. Telephone interviews were conducted with assistance from a professional Spanish interpreter when requested by the participant. Consent forms were mailed to enrolled participants with a token honorarium following the interviews.

Instruments

The **Brief Acculturation Scale for Hispanics (BASH)** (Marin & Gamba, 1996) was administered via telephone. The BASH contains four items and uses a five-point Likert-type scale with responses ranging from “only Spanish” to “only English” that correlate highly with generation, length of time in the United States, country of birth, and language (Norris, Ford, & Bova, 1996). Acculturation is a process of cultural learning and behavioral adaptation with exposure to a new culture (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987). The 12-item BASH scale has an internal consistency of 0.9 (Marin et al., 1987). Cronbach alpha coefficient for the BASH in this study was 0.92.

Participants were asked questions via semistructured interview format (Polit & Beck, 2011) and probes using the following key questions: (a) What was it like to experience menopause from your chemotherapy treatment? and (b) What made this experience easier or harder?

Data Analysis

Interpretive description methodology was used to analyze data through an iterative process of collection and analysis (Thorne, 2008) with support from the researcher’s dissertation committee through final analysis. Data were broken down into segments, closely examined, and compared. Emerging results were reviewed, and dialectic methods were addressed between individual cases and common patterns (Thorne et al., 1997) until interviews were completed and the research questions were reasonably answered and saturation was reached (Thorne, 2008). At the final stage, emergent themes were examined against existing literature. Two participants were contacted to clarify previous discussions and to review the emerging patterns and themes. Following final theme revision, three participants were emailed a summary of results for feedback.

Lincoln and Guba’s (1985) techniques of prolonged engagement, peer debriefing, clarifying researcher bias, and member checking were used. Collateral data sources (support groups, key informants, social media, and news), as used in interpretive description, supported interview data through triangulation. The collateral data sources were used to identify common patterns through use of inductive analytic techniques. A continuous process of reflexivity through field

notes was used for discussion with the researcher’s dissertation chair and a colleague.

Findings

One overarching theme entitled **Bigger Than Menopause** was interpreted from the data, in addition to three subthemes entitled **Experiencing Menopause**, **Ever-Changing Landscape**, and **Working Through the Experience** (see Figure 1). The names of the themes and subthemes came from participant interviews. Elucidating physiological effects from psychosocial effects was difficult, with overlapping characteristics noted between Knopf’s (2002) study and participants’ recollections.

The mean participant BASH score was 4.2 (SD = 1.1, range = 1–5). Seventeen participants scored greater than 2.9, indicating they were highly acculturated. Three participants scored less than 2.9, indicating they were less acculturated. Participants born in the United States had a mean score of 4.79 (SD = 0.29, range = 4.25–5). Those born outside of the United States had a mean score of 3.31 (SD = 1.28, range = 1–4.75) and described themselves as “struggling” or “being held back.”

Bigger Than Menopause

Participants described physiological effects of CIPM and their ability to manage these effects. The participants also described the impact of physiological and psychosocial effects as being a “complex experience” with “many things going on at the same time.” This included maintaining relationships with healthcare providers (HCPs), changing family roles, upholding work obligations, garnering information and support, respecting cultural norms, and addressing spirituality. Participants described practices regarding breast cancer as different from their cultural beliefs, traditions, religious practices, and use of complementary and alternative medicine (CAM). One participant said, “There was

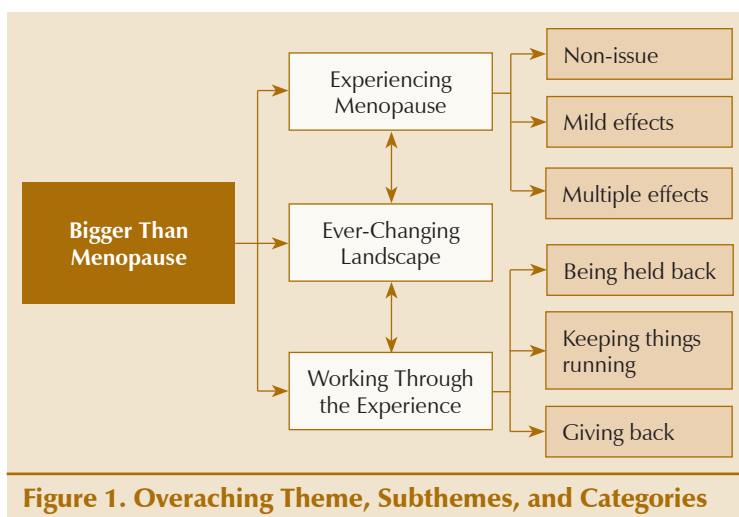


Figure 1. Overarching Theme, Subthemes, and Categories

always a conflict between that understanding of the way it is done here [in the United States] and the way it's done in our culture and country." The current article explains how participants assimilated a cancer diagnosis, treatment course, and CIPM into their lives. One participant stated, "The cancer was worse than the menopause. I mean, I could have menopause and be just fine."

Experiencing Menopause

Participants described a variety of physiological effects from the CIPM experience (see Table 2), with 12 reporting they received information from their HCPs regarding CIPM. Amenorrhea was common among all women, with hot flashes and changes in mood being the most pronounced side effects. Hot flashes varied in time of onset, intensity, frequency, and duration. Characteristics of hot flashes were described as being like "an oven," "something burning from the inside out," and "a feverish kind of thing." For some, hot flashes were prominent "immediately upon starting chemotherapy," and for others, they began after "a month or two." The strength of hot flashes was reported as being "not that bad" to "intense," "really hot," or "uncomfortable." Women described having "two to three episodes of hot flashes per day," and others described them as being "very, very frequent." One participant described her CIPM experience when she said,

It turned out to be surprisingly upsetting, just because it was another thing outside of the norm and not a choice, not that menopause is a choice for anyone. But I just felt it was difficult to deal with, and then I had hot flashes and that sort of thing. It was quite challenging.

Decrease in appetite was also noted. Fatigue was described as having a short-term effect as well as a prolonged effect in different participants. One partici-

part said, "I don't have my get-up-and-go like I used to," and another participant said, "There's still some fatigue. It was really bad when you're going through it, but they did say it takes years."

Sexual dysfunction was noted by nine women. They described it as decreased libido with "no sex drive whatsoever" or "issues with sex because of the menopause."

Sleep disturbance was described by some as intermittent. For others, the negative impact of sleep disturbance was noted. One woman stated, "I had a lot of trouble sleeping during treatment. I didn't sleep at all." Another described difficulty with sleeping when she said, "You know how you feel so tired, but you cannot sleep and you feel like screaming? That's how I felt."

Women described cognitive impairment (e.g., memory, thinking, concentration) as a result of CIPM. Some described this as a short-term effect. One woman stated, "I had quite a bit of difficulty thinking or remembering things." Women (n = 4) with home responsibilities or careers requiring them to remember information or think critically described being cognitively impaired as a negative effect.

Women described muscle, bone, and joint pain as effects attributed to pegfilgrastin injections they received to reduce infection risk related to neutropenia. Whatever its origin, pain had a negative impact on exercise and work. Women stated that they experienced headaches and nausea that they attributed to chemotherapy or medications given in combination with chemotherapy. They also noted weight gain post-treatment.

Seven women found CIPM easier because of perimenopausal status at the time of treatment, or they minimized it in relation to the cancer diagnosis. One woman stated, "The fact that I didn't have a period was really not a big dot on the radar. It was truly a non-issue for me." Four women described CIPM effects as few in number and self-managed. One participant said, "Even my hot flashes weren't that severe. It was very minor. They would last, like, maybe 20 seconds." Seven participants described complications that they attributed to chemotherapy and radiation treatment, viewing menopause as secondary. One woman explained, "I didn't know if all this other stuff [complications] was more important for me, but I forgot I was in menopause."

Nine women described the impact of multiple effects that were not self-managed. They described their transition as "emotional," "uncomfortable," "harsh," and "difficult."

Ever-Changing Landscape

Participants described this as a "complex" point in time, and they described themselves as "uncertain" and "vulnerable." They stated feeling like being "in way over my head," and "brand new to this world of

Table 2. Reported Physiologic Effects of Chemotherapy-Induced Premature Menopause (N = 20)

Effect	n
Amenorrhea	20
Hot flashes	18
Appetite change	9
Fatigue	9
Sexual dysfunction	9
Night sweats	8
Sleep disturbance	7
Cognitive impairment	6
Pain	6
Headache	5
Nausea	4
Weight gain	4
Genitourinary	2

cancer.” One participant stated, “It ain’t over until it’s over, and then it’s still not over.”

In addition, participants included the impact of psychosocial effects, as well as barriers they encountered as part of their diagnosis and treatment experience that comprised the Ever-Changing Landscape subtheme. One participant said,

I keep worrying about what the outcome was going to be. I found that, at the beginning of the diagnosis, it’s an ever-changing landscape. And so, just the anxiety of being on sort of a roller coaster was very anxiety provoking.

Psychosocial effects (see Table 3) included depression among 15 participants, but it was not known if their depression was diagnosed by a HCP or self-diagnosed. Statements relating to depression ranged from, “I was never depressed” to feelings of “sadness” to, “I did experience depression because there were so many things going on at the same time.” Others stated that symptoms of depression weren’t reported to their HCP.

Fear was described and related to the diagnosis of cancer, disease recurrence, death, and addiction to prescribed medications. Several participants described Hispanics as being “scared” regarding a cancer diagnosis because it has a connotation of death. One woman said,

I was scared. This was new to me, being scared to that extent. This was a new feeling, a feeling of, “I have no answer.” What am I going to do? I don’t know what to do. I can’t turn that way; I can’t turn this way. There’s no one I can call. There’s nothing I can do to fix this.

Several women described fear of a recurrence of disease as “overwhelming” or were unaware that a recurrence could happen after treatment. Fear of death was mentioned by several women. One participant said, “It is hard to allow yourself to think, ‘Am I going to be here in 10 years?’” Women also described avoiding prescribed medication to lessen treatment effects because of fear of “becoming addicted.”

Anxiety was commonly used to describe the women’s experience. It was not known whether participants were diagnosed with anxiety by their HCPs. Some women described being “very jumpy,” “antsy,” or “fidgety.” Others described “true despair” and “shock” as a reaction to their cancer diagnosis. One participant shared how she would “cry for everything.” She said,

I was supposed to be okay, but I was crying. I couldn’t be alone, like, on my days off. I was, like, panicked to be alone. I guess I didn’t want to deal with what’s going on and finally, you know, I thought I was crawling out of my skin. Anxiety attacks. I would just start eating my nails and the skin

Table 3. Reported Psychosocial Effects of Chemotherapy-Induced Premature Menopause (N = 20)

Effect	n
Depression	15
Fear or anxiety	14
• Disease relapse	7
• Death	6
• Addiction	2
Frustration or anger	12
Mood change	10
Isolation	8
Insurance or work concerns	8
Loss of self, self-esteem, identity, control, or hair	8
Body image	7

on my nails to where it would make me bleed, and I didn’t realize it. I think it was that I was so stressed, and I would never do that before.

Frustration or anger were common reactions described by women from different perspectives. Participants stated being “mad and short and pissed” and “irrationally angry.” Other participants expressed frustration with Latinos’ lack of information and education, denial regarding breast cancer, dealing with innumerable symptoms simultaneously, lack of financial assistance and support programs, and anger at God.

Ten participants described changes in mood as a side effect of CIPM. They described being “moody,” “emotional,” and “going up and down.” Some described this as a new experience. Eight women vividly described isolation coinciding with CIPM. Like with other effects, there were varying degrees of isolation reported. Although 18 participants had insurance, they expressed concerns about coverage, inability to select their HCP, and lack of reimbursement for services paid out of pocket.

This period was identified as a time of significant losses: self, self-esteem, identity, control, and hair. Loss of self was described by several women as being “not me anymore.” One participant said, “I’ve never been the same.” Loss of self-esteem was described when one participant said, “It made me feel older, less attractive. It definitely, you know, hit my self-esteem.” One participant described loss of identity when she said, “Whatever you were before the diagnosis, whether you were funny or smart or whatever, it was that you just become ‘cancer girl,’ and that’s what everybody thinks when they see you, and I certainly came to dislike that.” Loss of control was described when one woman said, “Everything changed.” Another said, “I had not depended on anyone before,” and another said, “I always took my own decisions.” One participant explained, “I feel dependent with no choices.” Another

participant described her experience with losing her hair as the “first of many losses.”

Women also noted alterations in body image. One participant recalled body image when she said, “Not a big issue, but sure, I hated being bald. I hated losing my eyebrows and eyelashes. And I hate that my breasts are two different sizes and I have scars, yeah.” Regarding body image following surgery, one participant said,

After the surgery, for a long time, I kept bandaged because I didn’t want to look at myself. I had to learn to look at myself in the mirror, to accept that I did not have a part of my body.

Working Through the Experience

Participants described their ability to assimilate the cancer diagnosis, treatment course, and CIPM into their lives through three categories: being held back, keeping things running, and giving back. Characteristics of categories were subtle and overlapped, with shifting between subthemes depending on the participant’s ability to adjust to vulnerability and uncertainty, and to find support or information to overcome barriers. The more information, access to care, appropriate support, higher acculturation level, and sense of control participants had, the more likely they would progress through these categories.

Being held back: This category describes three participants who faced barriers to receiving adequate information and care because of language, had unresolved physiological and psychosocial effects, and lacked access to health care and support. They had the lowest acculturation scores and described a loss of control. They described themselves as “struggling” or “being held back.”

Keeping things running: This category includes 10 participants who accessed health care with few challenges, were more acculturated, faced few barriers, had adequate income to meet household needs, were aware of physiological and psychosocial effects, exercised spiritual behaviors, received support, and felt a sense of control. They were able to “keep things running” by upholding work and family roles, self-advocate, and establish normalcy in their daily lives.

Giving back: This category involves seven participants who readily accessed health care, received support, were highly acculturated, described no barriers, and had minimal effects from treatment or were able to self-manage or seek help for effects. Recognizing the importance of telling their stories, they participated in research studies to “make the best of the situation” and hoped for “more of us, Latinas, be the face of breast cancer in our culture because we identify with each other.” Several women started their own support groups and provided emotional and educational support within

Knowledge Translation

Nurses must learn to understand Latina perspectives regarding a breast cancer diagnosis and treatment, particularly in patients who are less acculturated.

Supportive care for patients with breast cancer can be improved through focused implementation of interventions that lessen the physiologic and psychosocial effects of treatment.

Provision of information and support that is culturally, spiritually, and linguistically appropriate is necessary for women younger than age 40 years to reduce uncertainty and vulnerability.

their communities. They were empowered to “reach the woman that hides, who doesn’t want to be found.”

Discussion

The main finding from this study was one overarching theme that described participants’ CIPM experience as Bigger Than Menopause and their ability to assimilate CIPM into the breast cancer trajectory. This was affected by the magnitude of physiological and psychosocial side effects, access to health care, information and support, a sense of control, and acculturation level.

The literature reviewed suggests that breast cancer survivors describe CIPM, sexual dysfunction, and infertility as the most distressing aspects of the experience (Avis et al., 2004; Schover, 2008). However, participants in the current study described CIPM as part of a larger context and not as the most distressing part of the cancer experience.

From Latinas’ perspectives in this study, their world was seen through a different lens when compared to Knobf’s (2002) sample of 27 Caucasian women with CIPM. In Knobf’s (2002) study, demographic data included a mean age of 40.2 years (SD = 3.7) compared to 48.2 years (SD = 6.84, range = 38–60) in the current study. The majority of women in both studies were well educated, married, insured, and employed. Knobf (2002) described vulnerability as the basic social problem, with vulnerability and uncertainty reported in both studies, and abruptness of menopause and associated effects similar in course and intensity. Both studies described age related to perceived cancer recurrence, focus on long-term effects, and collaborative relationships with HCPs. Younger women felt earlier age at diagnosis predisposed them to a future diagnosis. The participants in the current study described experiences related to treatment complications, barriers, low acculturation level, integration of CAM, and spirituality to augment support. These variables, along with minimal cancer-related information for the participants and the

larger Latino community, may affect Latinas' ability to assimilate CIPM into the breast cancer experience and work through it.

Limitations

Limitations involved the challenge in recruiting study participants. Most participants were recruited through a national breast cancer database; they were highly educated, highly acculturated, and economically stable, and had Internet access, which may not be indicative of all Latinas. In addition, interviews were completed via telephone, making participant observation difficult. This method of interviewing may have affected the author's ability to discern nonverbal cues from participants. Finally, two participants were Spanish-speaking and requested interviews in Spanish. It is unknown whether their experience can be translated to other Latinas or if the presence of a professional Spanish interpreter during telephone interviews had an effect on their responses.

Implications for Practice

HCPs must develop trusting relationships and view patients from physical, psychosocial, emotional, spiritual, and cultural domains to ensure their needs and concerns are addressed. This includes providing strategies for minimizing physiological and psychosocial effects. Women should be screened for social isolation, depression, and anxiety throughout the cancer trajectory. They should be offered tailored interventions that include support group referrals, building family networks, and enhancing spirituality. In addition, identifying women with low acculturation who were not born in the United States may indicate a vulnerable group facing barriers that may need additional support.

HCPs should disseminate appropriate information in English and Spanish via a professional interpreter, trained peer, community health worker, or patient navigator as an essential component of high-quality care. Information geared toward young survivors (aged 40 years or younger) that is culturally, spiritually, and linguistically appropriate and includes family members, treatment choices, and CAM options was identified as essential.

Referral to Latina support groups tailored to specific needs and age as well as needs of partners and children

may be beneficial. Attending small groups with positive messages and self-care strategies may be valuable, with attention to local support groups to address transportation barriers.

Because this study is the first to explore the experience of CIPM and breast cancer in Latinas, it expands a narrow evidence base. Of note, this study described the experience of long-term quality of life, self-management, symptom management, elimination of health disparities, and survivorship issues for women with breast cancer, which are high-priority areas identified by the Institute of Medicine (Hewitt, Greenfield, & Stovall, 2005) report, *From Cancer Patient to Cancer Survivor: Lost in Transition*, the 2009–2013 Research Agenda by the Oncology Nursing Society (Berger, Cochrane, & Mitchell, 2009), and the National Institute of Nursing Research's (2011) areas of research emphasis.

Conclusions

The overarching theme and subthemes from this study clearly demonstrate that the CIPM experience for Latinas with breast cancer is complex. Findings were compared and contrasted with Knobf's (2002) study results. Although women in both studies were able to assimilate CIPM into the breast cancer experience, participants in the current study who had low acculturation scores expressed the impact of barriers (i.e., information, language, and support), which were described as "being held back." Latinas with CIPM may benefit significantly from improved trust with HCPs; minimized treatment effects; screening for social isolation, anxiety, and depression; comprehensive support and information; and measuring acculturation levels to reduce uncertainty and vulnerability and support assimilation of the CIPM experience.

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