MULTICULTURALLY CONSCIOUS ACCEPTANCE AND COMMITMENT THERAPY: A PROPOSED TREATMENT INTERVENTION FOR LATINO AND MEXICAN-AMERICAN FAMILIES AFFECTED BY CHILDHOOD CANCER

A dissertation presented to the faculty of

ANTIOCH UNIVERSITY SANTA BARBARA

In partial fulfillment of the requirement for the degree of

DOCTOR OF PSYCHOLOGY

In

CLINICAL PSYCHOLOGY

By

MERUSHKA BISETTY, M.A.

APRIL 2018
MULTICULTURALLY CONSCIOUS ACCEPTANCE AND COMMITMENT THERAPY: A PROPOSED TREATMENT INTERVENTION FOR LATINO AND MEXICAN-AMERICAN FAMILIES AFFECTED BY CHILDHOOD CANCER

This dissertation, by Merushka Bisetty, M.A., has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University Santa Barbara in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

Dissertation Committee:

____________________________________
Betsy Bates Freed, Psy.D.
Chairperson

____________________________________
Daniel Schwartz, Ph.D.
Second Faculty

____________________________________
Daniel Greenfield, M.D.
External Expert
Abstract

Childhood cancers remain the number one cause of death by disease in children across the world (National Cancer Institute, 2018). Childhood cancers affect children and families of all ages, cultures, and socioeconomic demographics. Although literature exists on various styles of therapeutic and emotional support for families affected by childhood cancer, the data are extremely sparse and a comprehensive meta-analysis of culturally relevant psychosocial support efforts specific to Mexican-American and Latino children and families does not exist. This paper will provide thoroughly researched psychosocial interventions and best practices specific to families affected by childhood cancer. The paper will build on Acceptance and Commitment Therapy (ACT), a transdiagnostic and third wave branch of behavioral intervention. The writer proposes a treatment approach that incorporates culturally sensitive themes for use with Latino and Mexican-American families impacted by childhood cancer. An emphasis will be placed on concepts related to *familismo*, *personalismo*, *respeto*, *simpatia*, and the belief in fatalism as a means of dealing with the cancer experience. The intervention will focus on religion, spirituality, and family narratives, as well as curative and traditional foods found to provide a sense of healing and nurturing to most individuals and families within the Latino and Mexican-American cultures. These constructs and values will be interwoven into each of the six weekly sessions of the culturally conscious ACT modality. This will be done to emphasize the unique needs and constructs of the Latino and Mexican-American cultures in hopes of creating efficacious psychosocial treatment. This Dissertation is available in Open Access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu and OhioLink ETD Center, http://www.ohiolink.edu/etd
Keywords: childhood cancer, culture, psychosocial, intervention
Acknowledgments

I dedicate this paper to my parents who supported me in pursuing this adventure by bringing my brother and me to the United States in pursuit of bigger and brighter opportunities. I would like to pay sincerest gratitude to my dissertation committee: Dr. Betsy Bates Freed, Dr. Daniel Schwartz, and Dr. Daniel Greenfield, for supporting me through this rigorous and empowering process by providing words of encouragement as well as immeasurable wisdom and expertise to this body of work. It is my hope that this treatment proposal adds to the field of research related to cultural inclusion. I am hopeful that my work will provide a great sense of insight into the need for culturally sensitive psychosocial supports fundamental to supporting and holistically healing underserved and multicultural families affected by childhood cancer.
# TABLE OF CONTENTS

Abstract ..................................................................................................................... iii
Acknowledgments ................................................................................................. iv

CHAPTER I: Introduction ....................................................................................... 1
  Statement of Purpose ..................................................................................... 3
  Overview of Problem .................................................................................... 4
  Cultural Inclusion .......................................................................................... 6
  Impact on Family ............................................................................................ 13
  Introduction to ACT ....................................................................................... 17

CHAPTER II: Literature Review ........................................................................... 19
  Children and Cancer ....................................................................................... 19
  Latino Children and Cancer .......................................................................... 22
  Cultural Implications ....................................................................................... 23
  Spirituality and Religion ................................................................................ 27
  Family Systems Model ..................................................................................... 29
  Socioecological Model ................................................................................... 31
  Online Psychoeducation .................................................................................. 32
  Art Therapy ..................................................................................................... 33
  Phenomenological Approach ........................................................................... 34

CHAPTER III: Treatment Proposal .......................................................................... 37
  Culturally Conscious Version of ACT ........................................................... 44
  Intervention Protocol ....................................................................................... 46
  Limitations ....................................................................................................... 60
  Conclusion ......................................................................................................... 62

REFERENCES ....................................................................................................... 64
Chapter I

Introduction

The topic of childhood cancer and the disparities that exist in efficacious and culturally conscious psychosocial treatment interventions first captured my interest through my role as the Family Resource Specialist at a childhood cancer non-profit organization in Santa Barbara, CA. In my work advocating for families, seeking to secure fundamental resources for them, and providing emotional support in times of an initial diagnosis, recurrent relapse, death of a child, divorce, and/or loss of home, I learned just how debilitating and pervasive is the disease and how much of an all-encompassing experience it is for everyone in the family to withstand. I heard countless narratives of families struggling with the emotional and financial burdens that come with caring for a sick child; many parents – and often, grandparents - were unable to provide food, clothes, diapers, toys, and in some cases, shelter to their children. Some caregivers continued to work full-time, while in some households one parent, typically the mother or grandmother, stopped working entirely in order to tackle the multitude of hospital visits (including but not limited to lab work, checkups, chemotherapy, and surgery); extended emergency room stays; and to stay close to their bedridden child who was experiencing side effects related to chemotherapy. Along with this extended task list came the responsibility of taking care of other non-sick children in the home (preparing food, ensuring that school assignments were completed, and seeking to ensure a relative sense of normalcy despite the emotional turmoil). During routine phone check-ins or unexpected office drop-ins, I heard harrowing stories of separations and impending divorce due to high levels of stress that were placed on an intimate relationship during the
cancer experience. Hopelessness and a sense of feeling “stuck” were phrases I often heard. After completing an initial intake with a new family, the mother of a 2-year-old Latino boy shared through bouts of tears: “How could this happen to us? We’re good people, I don’t know how we’re going to get through this.” Although this narrative is heart wrenching, it elicited a sense of urgency within me to provide a warm and inviting space for parents, siblings, and grandparents to share their stories and experiences while feeling supported. I wanted this feeling of validation and encouragement to extend beyond my office and I hoped to include families from all walks of life who were experiencing hardship due to a cancer diagnosis. Tough times were frequent for these families; however, one constant was the unwavering time, energy, and devotion they directed toward caring for and unconditionally supporting their child. I was fortunate enough to witness love, courage, fear, and with that, a sense of resiliency, that families impacted by a form of childhood cancer encompassed and embraced.

Latino and Mexican-American children and families formed the majority of the recipients of services received at the non-profit. I was able to contribute my clinical training and skills through daily conversations via telephone, in the field, in the office, and/or in hospital waiting rooms while children received medical interventions. Additionally, I had the privilege of working with medical social workers, nurses, and grief therapists during the monthly support groups held for family members who wanted and needed a space to share similar experiences and collectively attempt to heal and grow.

From my experience of reviewing surveys, engaging in conversations with parents and teenagers, and as a result of collaborative discussions with medical healthcare
teams (i.e. medical social workers, oncologists, nurses, grief therapists, etc.), as well as via my review of the existing literature (which revealed a lack of culturally-rich and inclusive research studies), it became evident that a need was prevalent: core cultural concepts relative to the Latino and Mexican-American culture were not typically or consistently being openly discussed in support groups and mental health treatment. In addition, family members themselves expressed a strong need for a more individualized approach to the support services they were receiving. Therefore, I began researching culturally sensitive psychosocial interventions for use with the Mexican-American and Latino population and found the literature to be inadequate based on the need and demand relative to this expanding demographic in the United States.

I feel a strong desire to advocate for this population due to my personal connection to the children and families who have experienced trauma directly related to a childhood cancer diagnosis. Therefore, I am introducing a new modality which encompasses cultural sensitivity and efficacious outcomes in relation to post-traumatic stress symptoms (PTSS) found to be present among children and families directly and indirectly impacted by childhood cancer.

**Statement of Purpose**

The purpose of this review is to explore the various therapeutic modalities used to treat children and families affected by various forms of childhood cancer in America. This chapter of my paper will examine cultural similarities and differences within the Latino, Mexican-American, and dominant cultures in American society in an attempt to decipher how the currently available binary and culturally insensitive forms of therapeutic interventions hinder overall emotionally curative outcomes. A second
concept that will be explored is the predominant form of psychological and psychosocial treatment including modalities and interventions with the pediatric and childhood cancer population in today’s society. Finally, Acceptance and Commitment Therapy (ACT) will be introduced and modified based on key cultural norms, concepts, traditions, and values as a culturally conscious intervention for use with Latino and Mexican-American families affected by childhood cancer. For the purpose of this research study, the term Latino is used to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, and Spanish descent.

A Brief Overview of the Problem

Childhood cancers remain the number one cause of death by disease in children across the world (National Cancer Institute, 2018). The American Cancer Society states that 43 children are diagnosed with a form of cancer each day. Additionally, there are estimated to be 1,180 deaths linked to this malady in 2018. (ACS, 2018). Cancers affect children and families of all ages, cultures, and socioeconomic demographics. Furthermore, children and their caregivers, predominantly mothers, have been found to endorse symptoms consistent with posttraumatic stress soon after a cancer diagnosis and for the duration of medical treatments (Bruce, 2005). These symptoms include: anxiety, depression, a sense of helplessness, persistent avoidance of hospitals – sometimes even in emergency situations - or talking about cancer, as well as withdrawal from certain activities, symptoms that may in the case of the children studied subsequently impair their psychological functioning continuing into adulthood (Bruce, 2005; Fletcher, 1996; Salmon & Bryant, 2002). Each family member of a child diagnosed with cancer has a unique perspective on the shared familial, societal, and cultural experience of what cancer
means to them (Buchbinder, Casillas, & Zeltzer, 2011). Therefore, psychological and psychosocial support for the collective family is a necessity that requires attention in the appropriate settings and at the appropriate times.

In 1998, the survival rate for Acute Lymphoblastic Leukemia (ALL) in children was estimated to be 73% (Eiser, 1998). Estimates today conclude that the survival rate for this cancer has reached an impressive 90% (ACS, 2018). Child and adolescent cancer survivors typically attend follow-up care for 5 to 10 years after treatment completion in order to screen for reoccurrence, late-effects, and subsequent health issues linked to oncological treatment (Mellblom et al., 2017). Follow-up care appointments may not include discussion of the level of psychological and emotional distress experienced by children and adolescents affected by cancer. Mellblom et al., (2017) found that when the topic of emotional distress was posited within the context of these follow-up sessions, child and adolescent survivors endorsed difficulties with anxiety, depression, change in physical appearance related to treatment, difficulties at school, sleeping problems, cognitive problems, and a myriad of health concerns. Additionally, Sloper (2000) found that high levels of parental distress have been found to exist at the initial time of diagnosis and during the arduous process of treatment and caregiving upon discharge back to the family home. Parental distress is especially prevalent among caregivers whose children are exposed to longer treatments and hospital stays, and clinically significant symptoms tend to persist throughout the lifetime trajectory of impacted parents (Sloper, 2000). Thus, it is common for psychosocial efforts to be recommended in early stages of the diagnosis in the hospital or clinic setting in order to provide critical support and guidance.
Due to the growing population of Latino and Mexican-American individuals and families in the United States (PEW, 2017), a sense of core cultural constructs that directly address these families’ specific cultural concerns should be imbued into psychosocial and psychological approaches when treating childhood cancer. Mental and medical healthcare providers are tasked with the difficult job of determining how to appropriately care for children and families who identify with varying races, cultural beliefs, languages, and viewpoints regarding the illness they are facing (Wiener et al., 2013). Latinos seek out mental health care less frequently than non-Latino white individuals (Cook et al., 2014). Despite this, the opportunity exists to reach Latino families by making contact at the specific and immediate time of need, that is, when the child receives the initial cancer diagnosis. Individuals and families impacted by childhood cancers are in a better position to receive mental health treatment services while in the hospital care setting due to the prevalence of medical social workers and other such mental health care providers.

**The Need for Cultural Inclusion in Treatment**

Culture has been defined as the shared beliefs, values, norms, behaviors, and attitudes shared among a predominant group of people (Smith, 1966). The Latino population in the U.S. continues to grow at an exponential rate each year (PEW, 2017). Furthermore, ACS (2018) reports that Latino and Mexican-American children and adults are at a greater risk for chronic illnesses and diseases, including cancer. However, this demographic underutilizes psychosocial treatment for support linked to the illness (ACS, 2018). Therefore, it is imperative that psychosocial treatment interventions - targeted at alleviating mental health symptom distress relevant to the cancer experience - utilize and implement core cultural constructs that are pertinent to the target demographic, which in
the case of this dissertation includes Latinos and Mexican-American children, teenagers, young adults, and their immediate and extended family members. A literature review of EBSCO and PsycINFO revealed that research pertaining to Mexican-American and Latino individuals and families impacted by childhood cancer seem to have excluded specific cultural considerations. Furthermore, Rodríguez et al., (2011) notes that few published examples exist regarding how to systematically implement core cultural considerations into psychosocial and psychological treatment interventions for ethnic populations. Such cultural considerations, if implemented appropriately, will further promote positive impacts on the emotional concerns of patients and families who are experiencing distressing symptoms stemming from childhood cancer. Specific aspects of the Latino and Mexican-American culture and traditions that will be helpful and important to highlight when working with families of this culture include: 1) migration history, 2) acculturation and acculturative stress, 3) employment, 4) primary language and language barriers, 5) importance of family and social support, and 6) spirituality and religion. Smith (1966) identifies five cultural elements that have been found essential to Latino and Mexican-American culture and which support a greater sense of comfort when incorporated into discussion of their experiences; 1) material objects consistent with the culture, 2) social and religious organizations found to offer support, 3) belief systems, 4) art, dance, music, and theater which is rich in culture and which fosters pride, and 5) and verbal and non-verbal communication styles that are effective in providing a cohesive sense of community. Based on a comprehensive literature review, this author finds that the currently utilized psychosocial and psychological therapeutic interventions aimed at alleviating distressing symptoms of childhood cancer do not appropriately
address these significant issues. As a result, this researcher concluded that there exists a lack of cultural sensitivity and awareness from the literature in relation to what is important to families within this population. Based on parental report from conversations with Latino and Mexican-American families at the non-profit at which I worked, there appeared to be a scarcity of culturally sensitive mental health care professionals available to the minority and under-served communities. These factors play a tremendous role in determining how various societal and cultural factors influence the overall psychological well-being of this population.

Pew Research Center reported in 2017 that the Latino population growth accounts for 50% of the national population growth in the U.S. As of 2016, there were nearly 58 million Latino individuals living in the United States. This number is projected to grow to 107 million by 2065 (Pew, 2015). The Mexican-American and Hispanic population in California reached 15.2 million in 2016 (Pew, 2017). This staggering escalation in population size should provide a sense of urgency that culturally-informed interventions for current non-dominant cultures are essential to the therapeutic outcomes of patients, if not already, certainly in future years. McGoldrick, Giordano and Garcia-Preto (2005) emphasized that clinicians should acknowledge and incorporate culture into the therapy provided in order not to displace and alienate racially and culturally diverse patients and families. It is vital for practitioners to be competent and knowledgeable in how contextual, psychological, and emotional aspects unique to the individual and/or family actually have a profound impact on treatment efficacy. Additionally, these areas may have an influence on how the individual and/or the family is assessed, conceptualized,
and treated within the mental health system (Imada & Schiavo, 2005; Woidneck et al., 2012).

When working with Latino and Mexican-American families, it is important for the clinician and medical staff to be aware of culturally appropriate and significant factors, beginning with the initial intake and ending with the last session of the treatment intervention. The American Psychological Association (APA) (2006) recommends asking the following pertinent questions during the assessment: generational and migration history, citizenship or residency status, fluency in languages, degree of family support, accessibility to resources, level of education, level of social status, employment status and history, and acculturative stress. Attention to these issues demonstrates to families that the clinician acknowledges their unique culture and tradition, thus helping to build a therapeutic alliance that enables the clinician to provide effective therapeutic support. In terms of the medical team, Watts et al., (2017) found that some oncologists and nurses at a teaching hospital in Australia shared finding it difficult at times to work with families who brought forth a family-centric approach. This was found to be due to the medical team feeling as though a comprehensive discussion of diagnosis, treatment, and aftercare – in relation to the patient – was a breach in doctor-patient confidentiality (Watts et al., 2017). Gleason et al., (2009) states that treatment decisions made by patients are affected by the alliance that they have with their oncologist. If the patient and oncologist have a good relationship based on mutual respect, then the patient feels empowered to ask questions and follow recommendations, which will increase rate of treatment effectiveness (Gleason et al., 2009). According to the APA (2006), clinicians taking an emic perspective to treatment interventions – one which includes an
understanding of culture-specific norms, traditions, and values - are more likely to
provide a culturally-sensitive context and efficacious psychosocial support for the
immediate and extended family. The emic perspective acts to facilitate a comprehensive
narrative of the individual’s actual experience based on their own explanation and self-
report (Helfrich, 1999). This phenomenon - of healing through verbal expression and the
experiential narrative - is congruent with the Latino value of cultural narratives, also
referred to as consejos and dichos (Delgado-Gaitan, 1994). A sense of cultural
congruency becomes prominent when utilizing this approach within a culturally-attuned
intervention. The individual who identifies with Latino culture will find it easier to
reflect on the cancer experience in a manner which places emphasis on family, culture,
and traditions (Delgado-Gaitan, 1994). Dana (1993) states that taking an emic
perspective allows the clinician to consider the client’s behaviors, feelings, and thoughts
in a culturally attuned manner. This way the clinician and the client are working
collaboratively to understand the client and his or her experience from under the umbrella
of the client’s culture rather than from the perspective of the dominant culture’s
predisposed norms and values.

Empirical research demonstrates that underserved ethnic populations, such as
Latino and Mexican-American individuals and families, can benefit from culturally-
sensitive psychosocial treatment interventions (Barrera et al., 2013; Lau, 2006; Smith et
al., 2011). Cultural adaptations within treatment frameworks involves the conjoining of
cultural values and experiences of the intended audience (Castro et al., 2004). A meta-
analytic study found evidence showing that interventions which have been culturally
adapted have a 49% higher efficacy rate when compared to traditional treatment
approaches (Smith et al., 2011). Additionally, the meta-analysis states that increased usage of cultural constructs consistent with ethnic minority values and traditions were met with higher treatment outcomes (Smith et al., 2011). Having a deep understanding of the cultural context consistent with Latino and Mexican-American values will create a strong working therapeutic alliance and help with building a collaborative treatment framework, which will bring about positive changes due to family acceptance, or in some cases, initial acquiescence (APA, 2006).

An effective treatment intervention should encompass culturally-adaptive psychosocial support for families, based on specific differences in demographics of impacted families accessing mental health care support, relative to PTSS derived from the cancer experience. In Latino culture, some elders believe that physical and mental illness and difficulties are due to an imbalance between the person and their environment (Kemp & Rasbridge, 2004). It is essential to the integrity of the treatment intervention outcome for the therapist to become aware of and attuned to how an individual or family expresses the physical and emotional symptoms of their experiences—also known as the presenting issue (Spector, 1996). In doing so, the clinician is able to work collaboratively with the family to determine how to assist in their healing. For instance, Smith (2000) states that Latino families sometimes express illness as either “hot” or “cold” within the body. This becomes important in then encouraging the family to consume foods or herbs embodied with the opposite quality—if the body feels cold, the suggestion is to consume a warm or hot food (Smith, 2000).

The expression of emotional pain is diverse and one that is securely linked to specific cultural and ethnic groups. Zborowski (1969) proposed that each cultural group
has a unique manner of expressing emotional pain. These expressions are formed through rituals, narratives, and generational trends regarding how to view, manage, and tolerate the concept of distress and emotional pain based on the specific difficulty being encountered (Zborowski, 1969). Following this notion, Mexican-American and Latino individuals and families may express emotion and attitudes related to the experience of physical and emotional pain in a manner that is unfamiliar or which may seem unusual to the mental and/or medical healthcare worker from the dominant culture providing care. If this is the case, specific barriers to treatment might arise and hinder successful psychosocial outcomes. This might be due to a disconnect between the perceived emotional pain that the clinician understands the family to be experiencing versus the actual emotional pain that the family is experiencing, but which goes unexpressed and unrecognized due to cultural dissonance.

Childhood cancer patients are faced with medical treatment approaches that range from six months to ten years (Castellano-Tejedor et al., 2015). Due to the potential longevity of the medical treatment, medical healthcare and mental healthcare providers may be called on to provide psychosocial treatment interventions to children and families for quite some time. The longer the medical treatment, the more a family’s psychosocial adjustment becomes relevant and meaningful. In part because families spend extensive periods of time in medical centers and hospital rooms, PTSS risk may be increased. Thus, adaptive psychosocial interventions become necessary to provide families with a sense of resilience, which is needed to overcome such extended traumatic experiences. Childhood literature has indicated that mental health care providers will benefit in achieving higher levels of emotional connectedness with their client in treatment if there
is an apparent awareness or even an open curiosity of how and why the client expresses emotional pain. Surbone (2008) finds that cultural competence and the ability to provide efficacious treatment requires clinicians foster an awareness of their individual constructs of bias and beliefs relative to the diagnosis, culture, and practices of patients. For this reason, medical and mental health care workers will benefit from being aware of the Latino and Mexican-American cultural definition of emotional pain and how this is expressed within these cultures (Kristjansdottir et al., 2012).

**Impact on the Family**

The impact of a diagnosis of childhood cancer quickly spreads far beyond the child her/himself to potentially create a profound burden on the family emotionally, financially, and even in its social functioning (Beale, 2006). The emotional impact may include disruptions and difficulties in the family’s communication, an increase in interpersonal conflicts linked to the pain around feeling helpless and hopeless, increased isolation, depression, anxiety, as well as other psychological symptoms (Bruce, 2005). Additionally, problems within relationships and the parental marriage may occur due to shifts in dynamics and a lack of normalcy (Pai et al., 2007; Shortman et al., 2013). Financial difficulties may include the astronomical cost of oncological treatment, hospital stays due to medical concerns and recovery related to surgeries, and the cost of travel and hotel stays for families living far from their treatment centers. Furthermore, it is not uncommon for one or more parents to either lose a job due to an inability to maintain a regular work schedule or due to the desire to leave their job to focus on the needs of their child (Patterson, Holm, and Gurney, 2003). This lack of income can cause further financial and emotional distress. These sources of stress and distress greatly impact every
member in the household, including even secondarily the child diagnosed with cancer. It is for this reason that psychosocial services need to be provided to every member of the child’s support structure, both individually and collectively, in order to be most impactful.

Caregivers of a child with cancer typically include parents, grandparents, and in some cases, siblings. Latino caregivers show greater positive feelings related to taking on the role of caregiver when compared to their white counterparts (Barber, 2014). The author cites subsequent positive links to this supportive approach, including Barber’s study demonstrating strengthened family relationships and an increase in, and support for, greater social connectedness in families where a child has been diagnosed with cancer (Barber, 2014). On the other hand, Racine et al., (2018) highlight that parents and siblings have been known to report an increase in their own psychosocial difficulties after a child in the family proves to be a cancer survivor. Due to the heavy and complex needs with which such ill children present, even shortly after a diagnosis parents report experiencing the following psychological symptoms: difficulty coping with their own emotions and thought patterns, worry, sadness, and/or depression (Maurice-Stam et al., 2008). The parental distress negatively weighs on the already fragile ego of the childhood cancer survivor in addition to creating a negative homeostasis – a balanced state of less than ideal family functioning. For instance, parental levels of distress have been found to trickle down to the child’s perception of distress through mechanisms such as a tendency to display lowered sensitivity, increased hostility, and withdrawal tendencies towards their child (Long and Marsland, 2011). Therefore, it is essential that
caregivers are provided with appropriate psychosocial interventions to facilitate their own healing as well as the healing and growth of the patient.

In addition to parental distress, siblings of children with cancer have been found to exhibit higher frequencies of distress and psychological impairments directly related to the cancer diagnosis of their sibling (Alderfer & Kazak, 2006). Siblings of brothers and sisters diagnosed with cancer have been found to experience PTSS in various forms. Some of these forms include: increased negative emotional reactions at home and in school settings, a sense of shock and despair in relation to illness, fear concerning the well-being of their sibling, a sense of helplessness, and a poor quality of life linked to changes in the family’s dynamics and social components of everyday life (Alderfer et al., 2010). Rourke and Alderfer (2016) put forth that some siblings witness their brother or sister fighting for their lives in a hospital bed. They are faced with having to see their sibling struggling with the physical and emotional pain that comes from being diagnosed with cancer and having to endure sometimes painful medical treatments. This experience elicits a sense of fear in relation to the potential death of a sibling. Furthermore, disruptions among the cohesive family dynamic have been found to exist due to extended separations from the parents during medical treatments of the impacted child (Rourke & Alderfer, 2006). Samson, Rourke, & Alderfer (2004) interviewed 33 siblings impacted by childhood cancer. The siblings were between the ages of 8 and 15 and lived at least 50% of the time with a brother or sister diagnosed with cancer. The child with cancer had to currently be living with cancer and diagnosed in the past two years or be in treatment within the past two years. The results from the qualitative interviews indicated the following: 36% of siblings had less time for school and schoolwork upon sibling
diagnosis, 6% of siblings stated that peers at school engaged in a verbally aggressive and insensitive manner with them at school related to their sibling with cancer - such as laughing and making jokes about the ill child. Additionally, 36% of siblings noted having less time for engaging in extracurricular activities such as dance class and track. Furthermore, 55% of siblings reported a reduction in time allowed to spend with peers and friends outside of school due to family obligations related to medical treatments and having to take care of the ill child. Interestingly, 27% of siblings reported wanting to spend more time at home with their family rather than spending time with same-aged peers (Samson, Rourke, & Alderfer, 2004). These findings highlight the negative impact that a cancer diagnosis has on all family members. This makes a compelling argument for the introduction of culturally-inclusive psychosocial interventions focused on supporting the family and the support network of the child diagnosed with cancer.

Siblings impacted by the childhood cancer experience are far more likely to internalize and minimize their own emotional needs when compared to the general sibling population (Sidhu, Passmore, & Baker, 2006). As a result of feeling as though they have to suppress their inner feelings in order to allow the child with cancer to have their needs met, siblings reported spending less bonding time and less overall time engaging in communication with their parents. Thus, siblings withdrew so as to allow parents to focus on their ill brother or sister but ended up feeling alone and neglected after doing so (Alderfer et al., 2010). Parents overall are acutely aware of the need for emotional support for siblings as well, especially during this emotional experience. However, they divulged that providing this support proved to be one of the hardest and most demanding responsibilities throughout the experience (Alderfer et al., 2010). This
is due to feelings of inadequacy and a lack of knowledge of how to provide appropriate and compassionate support to their non-ill child. Feelings of guilt seem to be prevalent among parents who find themselves unsuccessful in their effort to support siblings. Furthermore, additional research indicates that these siblings may continue to be impacted by this lack of parental support as they continued to develop into early adulthood—potentially even impacting the type of parents they become themselves (Svavarsdottir, 2010). Thus, widespread emotional support for all family members is encouraged.

Due to the many types of psychological and psychosocial strain placed on the families of children with childhood cancer, a widely based, multi-focused, and efficacious form of psychosocial treatment is essential in addressing the impact of childhood cancer. Rodríguez et al., (2011) highlight the following pertinent information relative to culturally-conscious psychosocial treatment interventions: “Tailoring intervention programs is essential to accommodate the diversity of experiences, traditions, and circumstances of those seeking services” (p.183). The intervention should incorporate unique cultural constructs extracted from the literature, in addition to input from family members who have experienced psychosocial suffering related to the cancer experience. This culturally sensitive approach should be provided to children and families at appropriate times to decrease the emotional and psychological impairments that we know begin to be present soon after the cancer diagnosis and continue for years.

**Introduction to Acceptance and Commitment Therapy**

The literature reveals that ACT has proved to be a successful intervention approach for many psychiatric and psychological problems. This behavioral intervention
emphasizes psychological flexibility, contextual factors, and values and beliefs to allow the patient and/or family to accept cognitions rather than allow these perceptions to take over their being, leading to greater psychological distress. ACT seeks to directly target distressing thoughts and emotions by making patients aware of individual and family core values while promoting psychological flexibility (Hayes, Strosahl & Wilson, 1999).

The core concept is to engage distressing thoughts while aligning the mind with core values. Acceptance will therefore come about through recognition and a heightened awareness of values and what is essentially important to the life of the client while finding ways to accept unpleasant thoughts and feelings in order to overcome challenges and elevate quality of life (Ruiz, 2010; Feros et al., 2013). ACT does not propose expelling core beliefs and values from the mind; the philosophy is that these ideas are important to the individual.

ACT is essentially concerned with the function and impact of psychological experiences rather than what the experiences are (Woidneck et al., 2012). Building on the core principles of ACT by incorporating cultural modifications pertinent to Latino and Mexican-American cultures will help to further promote mental well-being and accomplish short and long-term goals for the patient and the family. Ideals such as spirituality, religion, family, migration, and language might be essential core values for certain populations. However, these concepts may not be commonly discussed in a typical therapeutic environment, particularly for the population discussed in the present paper.
Chapter II

Literature Review

This literature review reveals that children and families belonging to cultural minority groups in the United States require a more comprehensive and culturally integrative approach for mental healthcare and psychosocial management of PTSS. Latino and/or Mexican-American individuals and families who require medical treatment for childhood cancer, and subsequently, mental healthcare treatment, may not be accustomed to Western healthcare practice standards. In order to provide a higher level of psycho-social care for these families, medical and mental health care professions may be called on to provide Latino/a families some measure of psychoeducation as a foundation that would enable standardized treatments to be more effective (Kristjansdottir et al., 2012).

The following literature review focuses directly on the current psychosocial and psychological interventions that are being utilized to treat PTSS in cancer patients their families. It acknowledges the work that has been created and highlights the necessity for culturally-modified approaches to specifically target the intended recipients and their unique cultural backgrounds.

Children and Cancer

According to the American Cancer Society (2018), children impacted by childhood cancer undergo vastly different experiences compared to those of adults with cancer. When a child is diagnosed with cancer, the research states that it is highly unlikely that the disease was caused by a lifestyle or environmental risk factor.
Furthermore, only a small percentage of childhood cancers are caused by familial and parental genetic mutations (ACS, 2018).

Despite the complex nature of pediatric and childhood cancer, children typically achieve higher rates of success and remission when provided with oncological medical treatment interventions. More than 80% of children who receive some form of medical intervention for cancer have been found to survive for at least five years after the initial treatment (ACS, 2017). However, in some cases, children affected by childhood cancer are at risk for relapse or will endure a second and different form of cancer (ACS, 2017). Although the success rate has been found to be higher for this demographic, some medical treatments, like radiation and chemotherapy, have a high risk of negatively impacting and impairing various domains of a child’s life. Children, teenagers, and young adults are likely to suffer from long-term medical, psychological, and social side effects which may continue throughout their lives.

**Cancer in Childhood and Adolescence**

Prevalence rates of cancer differ depending on whether the diagnosis occurs during childhood (birth to age 14) or adolescence (ages 15-19). The Surveillance, Epidemiology, and End Results program (SEER, 2016) examined cancer trends from 1930 through 2013 for incidences, and through 2014 for mortality rates. This program notes that the most common forms of cancer during childhood include leukemia (29%), cancers of the brain (26%), lymphomas and reticuloendothelial neoplasms – Hodgkin lymphomas and non-Hodgkin lymphomas (11%), soft tissue sarcomas (6%), neuroblastoma (6%), and renal tumors (5%) (SEER, 2016). The most common forms of cancer during adolescence include: lymphoma (21%), cancer of the brain and other
nervous systems (17%), leukemia (14%), germ cell and gonadal tumors (12%), thyroid carcinoma (11%), and melanoma (5%) (SEER, 2016).

The most commonly diagnosed form of childhood cancer is leukemia, which is a cancer of the bone marrow and blood (ACS, 2018). This form of cancer accounts for 30% of all childhood cancer diagnoses. There are two types of leukemia: acute lymphocytic leukemia (ALL) and acute myelogenous leukemia (AML). ALL is more common than AML, with 3 out of 4 children diagnosed with ALL. The typical age of onset for ALL is between 2 and 4 years of age and it is more typical among boys than girls. AML is common during the first two years of life and during adolescence. Additionally, it is equally prevalent among boys and girls of all races. Both types of leukemia form rather quickly, and medical professionals agree that it should be treated as soon as possible following initial screening and diagnosis. Howlader et al., (2017) asserted that the treatment of choice for ALL is chemotherapy and patients with ALL are typically given systemic and intrathecal (spinal space infusion) chemotherapy. However, some patients will receive cranial irradiation, or in rare cases, hematopoietic stem cell transplantation. Survivors of ALL are the largest group of childhood cancer survivors; however, their risk for later effects is high (Vetsch et al., 2018). According to the American Cancer Society, these forms of leukemia can cause numerous medical and somatic effects such as: bone and joint pain, fatigue, weakness, pale skin, bleeding and bruising, fever, and weight loss (ACS, 2018). Survival rates for ALL are among the highest of all cancers, with 5-year survival rates now assessed to be within 80–90% (Vetsch et al., 2018). A research team compared patients diagnosed with cancer in the mid-1970s with those diagnosed during the years of 2006 to 2012. The study found that
the 5-year survival rate had increased from 41% to 71% for ALL and from 22% to 66% for chronic AML (Howlader et al., 2017).

Brain and central nervous system tumors are the second most common cancers in children (26%). These include masses of abnormal cells in the brain or spinal cord. The main concern with this form of cancer is related to how fast tumors grow and how rapidly they spread through the brain or spinal cord (ACS, 2018). Symptoms caused by a brain tumor include: seizures, difficulty speaking, a change in mood and personality, weakness of the body, and changes in senses. Forms of treatment include surgery, chemotherapy, radiation, and targeted drugs. The ACS (2018) notes that there is no current clear cause for these tumors. However, one risk factor includes radiation exposure to the head. Only 5% of brain tumors are linked to a genetic predisposition.

Lymphomas start in the immune system, beginning in lymph nodes or other lymph tissues. Chemotherapy, surgery, and radiation are the medical interventions of choice. The ACS (2018) states that a neuroblastoma begins as nerve cells in an embryo or fetus. The occurrence rate for this form of cancer is 6% and it is rarely found in children older than 10 years old. The tumor is typically formed in the abdomen and begins as a swelling. There are currently no known risk factors for neuroblastoma, other than a 1-2% genetic predisposition. Oncological treatments for this form of cancer include: surgery, chemotherapy, radiation therapy, retinoid therapy, and immunotherapy - the use of medicines to help the immune system recognize and destroy cancer cells (ACS, 2018).

**Latino Children and Adolescents with Cancer**

The American Cancer Society notes that ALL is more prevalent among Hispanic and white children than any other race in the United States. Leukemia is the most
common cancer in Hispanic children, followed by cancers of the brain/central nervous system and lymphoma (ACS, 2018). The ACS (2018) has determined that germ cell tumors are the most common cancer for Latino adolescents, followed by leukemia and lymphoma. Additionally, Latino children and adolescents have higher rates of leukemia than any other racial and ethnic groups in the United States (ACS, 2018).

**Cultural Implications and Core Constructs**

The Latino population in America is growing. According to the U.S Census Bureau 55 million Americans identified as Hispanic or Latino in 2014 (Census Bureau, 2014). An estimated 2,700 Hispanic children between the ages of 0-14 were diagnosed with childhood cancer in 2015 (ACS, 2015).

Mental and medical health care professionals will benefit from becoming well-versed in the relevant factors that are essential to working effectively with and supporting Latino and Mexican-American families affected by childhood cancer. Gleason et al., (2009) finds that patients are more likely to comply with treatment recommendations and requirements if they perceive their oncologist as being warm, informative, and caring. Andres-Hyman et al., (2006) examined the role of culture in Latina and non-Latina American mothers in relation to childhood cancer. The researchers discovered that certain cultural constructs seemed to predominantly exist within the Latino culture. Some of these included; *familismo*, meaning the interdependent nature of the family; *personalismo*, referring to a personal determination of relation; *machismo*, defined as positive and negative traits of traditional masculinity in the Latino culture; *marianismo*, referring to positive and negative traits of traditional femininity in Latina culture; and religion and spirituality (Andrés-Hyman et al., 2006). In terms of spirituality and
resiliency, Latino caregivers are more likely to use prayer as a way of creating hope and resiliency in times of grief and despair (Barker, 2014). The author notes that a relationship with God is a primary factor from which hope and a sense of acceptance is received (Barker, 2014).

A study by Marín & Marín (1991) explored the cultural belief of fatalism specific to the Latino community, suggesting that this may contribute to thoughts and feelings related to the child’s cancer being out of their control and predetermined. This viewpoint heightened Latino families’ sense of acceptance and willingness to deal head-on with tangible issues that could be “fixed,” so to speak. However, Latina mothers and caregivers, when compared to Caucasian mothers and caregivers, have been found to be at risk for higher levels of distress related to language barriers, cultural factors, and economic, immigration, and acculturation stressors in medical healthcare settings in the United States (Johns et al., 2009). Thus, although there is a sense of predetermination, which allows for healing and acceptance at an accelerated rate when compared to most other cultural groups, distress linked to the aforementioned issues is rather prevalent.

The literature suggests that interventions adapted to the culture of the targeted and underserved populations and that are responsive to the unique needs of parents of different ethnicities are beneficial for the child impacted by cancer, the caregiver and family, and for professionals providing medical and mental health care services (Johns et al., 2009). Matos et al., (2006) ascertains that interventions incorporating cultural themes consistent with the identified culture have been found to reduce levels of distress inherent among parents and children given the cultural intervention.
Culturally-sensitive treatment approaches have been defined by Bernal et al., (2009) as techniques found to be compatible with the cultural patterns consistent with the client. They found that it is important to include an understanding in the intervention of the client and his/her cultural values, patterns, and meanings regarding their worldview in order to achieve a successful outcome and increase attendance and engagement (Bernal et al., 2009). Gearing an intervention towards a specific cultural group, such as Latino and Mexican-American families, will allow the family to determine that their values and traditions are being acknowledged and this will provide a heightened willingness to cooperate and engage in services (APA, 2006). Whaley and Davis (2007) suggest that modifications to a non-culturally adaptive intervention be made. The researchers encourage distinct changes be made to the therapeutic relationship in order to include a sense of cultural-consciousness. This is done to accommodate the unique cultural needs of the client and will foster a greater therapeutic alliance. For instance, Klein (1969) notes that interpersonal warmth and a level of connection is highly revered in therapeutic settings when working with Latino families. If a therapist is seen as cold and distant, the client might not feel comfortable with expressing their feelings and might not allow the family to participate in therapy. Paniagua (1998) introduce the aspect of formalismo – or formalism – acknowledges that an initial level of formal greetings is imbedded in the sessions while first getting to know the family. For instance, the facilitator will benefit from acknowledging that the patriarch of the family might have reservations in attending a therapeutic session and this might be dealt with by easing them into a sense of comfort by initially using formal titles and showing a sense of respect in regard to non-verbal mannerisms. This is done to show respect for the cultural customs of this family. One
example of this might include lowering the gaze and not making direct eye contact with this family member until it has been deemed appropriate and respectful to do so (Paniagua 1998).

The cultural construct of *simpatia* is a central component that is imbedded in the everyday lives of Latino individuals and families. *Simpatia* is a cultural value which emphasizes a sense of social harmony and the notion of avoiding conflict in order to have a fulfilling life (Triandis et al., 1984; Merz et al., 2016). Components consistent with this value include: being polite, respectful, and showing an ability to agree with people (Merz et al., 2016). According to Johns et al. (2009) “*simpatía* might help Latino families cope with their child’s cancer through seeking support from each other and having positive and empathic perceptions of health care providers. *Simpatía*, in combination with language barriers and deference to authority, may also contribute to Latino families agreeing with and conforming to medical team goals without expressing possible doubts or asking questions" (p.173).

The concept of fatalism has been identified as a dominant belief among Latinos and Mexican-Americans and is thought to act as a barrier to cancer prevention (Espinosa de los Monteros and Gallo, 2011). The belief underlying fatalism is one of general sacred acceptance that events, actions and occurrences throughout life are determined by fate. This belief has the potential to negatively impact the health of a Latino individual in that appropriate screenings targeted at seeking out efficacious medical interventions might not be completed because the idea exists that cancer is predetermined. Espinosa de los Monteros and Gallo (2011) contend that Latinos are more likely than non-Latino Whites to hold the belief that a malady such as cancer cannot be prevented or treated and
that death is inevitable after diagnosis due to a belief and value that this illness was sent
to the person for a particular reason at this particular time. The idea is that there is no use
in undergoing treatments when fate is already predetermined.

**Spirituality and Religion**

Spirituality and religion are multifaceted constructs that exist within most
collectivist and individualistic cultures. Religion has been defined as holding a set of
beliefs, practices, ideas, languages, concepts, and traditions that are predominantly held
by a specific community, tribe, family, etc., (Herbert et al., 2006). In terms of cancer,
research suggests that spirituality, religion, and having a reason for holding on and
coping with the changes that come from a cancer diagnosis have been found to reduce
distress in seriously ill individuals (Folkman, 1997; Lazarus, 1984). Sixty Latino
individuals participated in a semistructured interview regarding coping methods when
faced with a breast cancer diagnosis. The results indicate that both men and women
relied on God for coping with the cancer diagnosis and that when a reliance on God was
cemented, the individuals were able to surrender to their illness and gain a sense of hope
and strength to continue on in other aspects of their lives (Carrion et al., 2017). For most
cultures, religious beliefs are created and embraced in the hope of achieving a higher
level of functioning and meaning within unique and collective worlds. There is a belief
and understanding that a higher power exists above or within us, which is sacred and
omniscient. Belief in this higher power and internalizing a sense of religiosity and
spirituality has been shown to improve the overall sense of well-being and increase hope
and motivation levels within adolescents (Sabatier, 2011). Religious participation has
been found to be associated with reductions in overall depressive symptomology among Mexican-American family members (Levin, Markides & Ray, 1996).

Spirituality has been described by (Kashani, Vaziri, Akbari, Jamshidifar, Mousavi, & Shirvani, 2014) as a desire to learn more and to connect with the human soul and spirit versus a physical presence. When religion and/or spirituality are included in the daily lives of those affected by childhood cancer, a substantial decrease has been found in the degree of distress those affected experience in everyday life (Kashani et al., 2014). Children, teenagers, and young adults seek out spiritual support in hospital care settings in order to make sense of the cancer diagnosis and associated distressing cognitions (Moore et al., 2015). Anxiety, depression, and guilt can burden children and families stressed by rigorous treatment protocols, tense relationships with familial groups due to an overwhelming need to focus solely on the treatment and health of the child, and financial burdens related to the cancer experience.

When exploring the relationship between spirituality and Latina mothers who were caregivers it was determined that religious and spiritual engagements were effective coping strategies in that Latina mothers took time in the midst of their emotionally-driven days of caregiving to create a spiritual relationship with God (Coon et al., 2004). A deep sense of inner peace and acceptance were the predominant feelings that mothers of children with cancer were found to exhibit soon after engaging in a spiritual or religious intervention and well into the treatment and caregiving years (Kashani et al., 2014). A sense of spirituality will enhance one’s ability to cope effectively with a cancer diagnosis and subsequent health-related issues by finding purpose and meaning from the illness itself.
REVIEW OF CURRENTLY UTILIZED PSYCHOSOCIAL MODALITIES

Family Systems Models

As previously mentioned, childhood cancer affects the entire family and a network of additional systems surrounding the family. It has been noted that health care professionals should examine and interpret how various systems are interconnected and the complex manner that they work together (Kazak, Simms, & Rourke, 2002). It is vital to examine the family, health care, school, and community systems and determine how these systems intersect as professionals prepare to implement specific strategies for psychosocial interventions with the family of a child with cancer (West et al., 2015).

When a child is diagnosed with cancer, parents may take on a different role of caregiving for the sick child, which may result in siblings being faced with doubts, fears, and questions that are sometimes left unanswered (Buchbinder, Casillas, & Zeltzer, 2011). Siblings may be so affected by the associated changes that they begin to feel depressed and complain of somatic symptoms and PTSS. In this case, a family systems approach has been found to be beneficial in that it helps families become aware of the necessary adaptations that will need to occur in the system in order for homeostasis to be achieved. The model notes that all involved parties are in a larger system of networks, which include family, work and or school, and social structures. It is emphasized that each family has either adaptive or maladaptive modes of functioning during the initial diagnosis, shaped by pre-existing demands as well as changes in the family system (Buchbinder, Casillas, & Zeltzer, 2011).

A therapeutic concept known as the reflecting team has been found to increase the effectiveness of interventions aimed at the family system. The use of a reflecting team in
family therapy was found to decrease emotional suffering when new and unbiased interpretations from the team were offered to the family members (West et al., 2015). The role of the reflecting team is to explore and inquire about the illness in a manner that the family may not have been able to achieve on their own because of the perilous realization that someone in the family has cancer. A group of clinicians work together to provide interpretations in a group format amongst each other while the family is watching from another room. West et al., (2015) states that this approach has been found to be effective due to the modeling provided by the facilitators, meaning that while the family is viewing the reflecting team work to identify pros and cons of the family session, they are also learning how to effectively communicate among themselves in a manner that is productive and conducive to overall cohesive family dynamics. West et al. (2015) concluded that families found it beneficial when the team, (1) discussed specific strengths that they saw in the family, (2) acknowledged the notion of family suffering in a sensitive manner, and (3) when family members were allowed to discuss out loud issues that were real to them. One particularly important intervention used in the reflecting team included clinicians verbally expressing the issue of a split family dynamic in order to make the issue come alive for the family watching behind the mirror. Clinicians then discussed that due to the diagnosis, the family needed to acquire a new normal in order to reach homeostasis. According to the family systems perspective, any one problem that affects a member of the family will in turn affect the entire system to which the child belongs (Kazak, 1989).

Both the reflecting team and the family systems model have been found to be effective psychosocial interventions when working with families affected by pediatric
cancers. The literature shows, however, that there is a gap in terms of multicultural awareness and sensitivity when working with culturally diverse populations. For instance, a lack of cultural competence and culturally-sensitive treatment interventions has been found to be a leading cause for underserved populations to engage in mental health services (Kirkmayer, 2012). Rathod and Kingdom (2014) state that many countries have become multicultural due to globalization trends, however, understanding and accepting the concept of cultural adaptation within treatment approaches has not yet been fully achieved. Latino and Mexican-American individuals and families may feel like outsiders if core cultural constructs relevant and found to be significant to their culture are not integrated into the various models.

**Socio-ecological Model**

Social ecology has been defined as the study of the relationship between the developing human being and the multitude of complex contexts that the individual and/or family belongs to and grows from (Kazak, 1989). This model proposes that the affected child is at the center of a complex network of systems. Societal values and norms are considered to exist in the outer rings of the system, whereas family, peers, and the community exist at a closer level and in the inner rings of the system (Kazak, 1989). With regard to childhood cancer, the child is at the center of the concentric circle as they are directly physically and emotionally experiencing the imposed upon cancer diagnosis along with its co-occurring and residual medical and psychosocial side-effects. Immediate and extended family networks, peers, church groups, and similar supportive networks appear next on the circle. This implies the high and significant level of importance that these supportive figures have in working collaboratively with the child to
deal with their psychosocial distress and difficulties. The outer ring includes the child and/or family’s uniquely identified values, morals, beliefs, traditions, and ways of viewing their surrounding environments. The socioecological model proposes that each concentric circle acts on its own when faced with a life stressor and/or event. However, subsequent surrounding circles work in unison at some point to contribute to overall successful outcomes.

This integrative and interactive model suggests that the child’s and family’s perceptions, cognitions, and values should be taken into account in order to elevate awareness regarding how individual perceptions influence communal and larger networks (Kazak, 1989). I propose to take this model one step further by incorporating the individual and cultural constructs with the intent to show an elevated success rate in terms of effective care for Latino and Mexican-American individuals and families.

**Online Psychoeducation and Group Support**

Online platforms have become especially advantageous in reaching out to younger generations in recent years. Culture brings with it various languages and ways of speaking within intimate relationships as well as between professional practitioners. Because of this, patients who may not speak the same language as the predominant culture may come across issues in accessing appropriate online cancer communication. It has been found that online communication through support groups and other forms of online emotional support is effective in reaching a wider and more culturally relevant and sensitive audience who may not have had adequate access in the past (Neuhauser & Kreps, 2008).
Although online forms of communication, education, and support have grown rapidly, it is important to note that the language used on these platforms may prove to be a confounding barrier to providing families with adequate information. In some cases, it may prove to be frustrating when an individual from a particular monolingual cultural heritage tries to access cancer psychoeducation or emotional support but is thwarted due to the language and linguistic barriers. An additional barrier includes the fact that some households may not be able to afford a computer or internet access. Furthermore, some might not understand how to navigate the internet or how to use a computer or technological device. It is simply not enough to change the language of resources from English to Spanish because text sometimes does not fluently translate. The individual and/or family may feel discouraged and misunderstood and potentially disregard these helpful and relatively easily accessible platforms.

**Art Therapy**

Over the years, art therapy for use with children and teenagers affected by childhood cancer has been shown to be a creative approach to a complex medical and psychological disease. One case study found that healing and processing the cancer experience was facilitated by utilizing art therapy techniques (Baerg, 2003). It is common when working with children and teens for there to be a sense of initial insecurity, discomfort, and an unwillingness to participate in therapy. Therefore, art therapy may provide an opportunity for affected children and adolescents to explore their intimate cancer experience in a nontargeting manner. The study found that engaging in art therapy brought about a sense of peace and eventual willingness to discuss their work
and cancer experience with peers whereas this might not have been an option prior to this (Baerg, 2003).

This study appeared to present with various limitations in that it made no mention of components relative to diversity and culture. The reader might assume how these constructs could produce varied results among different cultures. It might be interesting to observe how art therapy and expressions from the constructed pieces are portrayed among children and adolescents among Latino and Mexican-American cultures. For instance, in support groups facilitated at the local non-profit where I worked, children from this particular culture often included their family members in their art work. It might therefore be beneficial to analyze and interpret the significance of this, and so build upon art therapy techniques to include cultural representations that are significant to individuals.

**Interpretative Phenomenological Approach**

The interpretive phenomenological approach seeks to gain an understanding of an individual’s experience as it is lived by that person. This understanding is derived solely from the individual’s perspective and unique frame of reference (Griffiths, Schweitzer, & Yates, 2011). By taking this approach professionals will allow for a factual and effective treatment approach specific to the needs of the child (Griffiths et al., 2011). Additionally, this approach allows nurses, social workers, and pediatric psychologists to grasp more vividly the severity of distressing thoughts, feelings, and behaviors that are caused by the physical pain and cancer-related distress ill children experience. This will allow for the team to better guide their interventions to and provide an appropriate level of care (Griffiths, Schweitzer, & Yates, 2011).
Children and families who are faced with a serious medical condition such as pediatric cancer have individualized medical, psychosocial, and sometimes religious and spiritual needs that should be dealt with in an appropriate manner (Jones & Weisenfluh, 2003). Because of the level of individualization needed for each case, it is essential for professional healthcare workers to question children about how they think and feel about their particular symptoms – in a sense to develop a narrative of their pain.

The interpretive phenomenological approach has articulated five core elements in approaching the treatment of childhood cancer: (1) paying close attention to the child’s experience of the illness, (2) noting positive attributes of being sick, (3) a reframe and refocus on important aspects in life, (4) gaining new perspectives, and (5) returning to a state of “normalization” prior to becoming ill (Griffiths, Schweitzer, & Yates, 2011). In utilization of this approach, it was determined that the children held an inaccurate notion that they would soon be able to return to their pre-cancer state of well-being and not have to attend routine medical check-ups or be at risk for relapse in the future. Another finding was that children have core positive cognitions and beliefs that may aid in their ability to overcome negative thoughts and depressive-like symptomatology (Griffiths, Schweitzer, & Yates, 2011).

The findings of this study recommend effective and wraparound delivery of healthcare services to families affected by childhood cancer (Griffiths, Schweitzer, & Yates, 2011). Although this article makes various valid points and recommendations it lacks conclusive consideration of the cultural context. It is important for staff to be aware of how the child and the family feel in the context of their family and culture if they are to effectively support the family in a time in which individualized assistance is necessary.
However, the researchers touched on the idea that when children were questioned about their thoughts related to the diagnosis, pain, and treatment it was found that they identified fundamental family religious beliefs that helped to support them while in the hospital (Griffiths, Schweitzer, & Yates, 2011).
Chapter III

Treatment Proposal

Acceptance and Commitment Therapy

ACT is a behavioral intervention that promotes psychological flexibility - and ultimately a sense of acceptance - within the mind of an individual experiencing symptoms of distress. This is done by working with the individual to change their relationship with their thoughts. There is an emphasis on moving away from focusing on changing the actual content of the thoughts or to change the experience that has been linked to the maladaptive thoughts and behaviors. This goal of acceptance is achieved by guiding the client and family to select and work with values that are consistent with their uniquely identified cultural beliefs in order to support the promotion of healing and foster a sense of growth from a once-negatively viewed experience (Feros et al., 2013; Hayes, 1999). A study sought to uncover if this intervention worked in a population consisting of adults with various forms of cancer. It was hypothesized that patients would increase psychological flexibility through acceptance and that distressing symptoms would decrease over time (Feros et al., 2013). Four ACT modules were implemented over nine therapy sessions. The modules as asserted by Feros et al., (2013) include the core components of; “increasing effective action orientation”, “mindfulness”, “self as context”, and “formal value clarification and commitment” (p. 161). The study found that symptomology related to distressful thoughts and feelings, mood and affect, and quality of life significantly improved as assessed pre- and post-intervention. Additionally, a 6-month follow up was conducted. The results indicated that these
reductions in distressing symptoms remained consistent across this time period (Feros et. al., 2013).

The core principle constructs of ACT appear to be the most versatile and flexible form of behavioral intervention across cultural platforms (Hayes et al., 1999). Cultural norms and values related to the subjective viewpoint of the individual and/or family when emphasized in the intervention will bring with it positive changes in behavior and actions. Weekly implementation of ACT, when reformulated within a culturally-conscious lens, will allow for families who identify with the Latino and/or Mexican American culture to accept emotionally the profound changes that childhood cancer has brought to their lives. Core beliefs and values, consistent with Latino and Mexican-American traditions, whether related to religion, spirituality, family, or purpose will be used and encouraged throughout each weekly session. This will be done so that the patient and family are able to feel a sense of acceptance and peace with their current medical, physical, and emotional state of being. Individualized goals needed to accomplish a state of “acceptance and commitment” will be set at the beginning of the intervention. These goals will be created collaboratively and in accordance with culturally-informed values and the unique perspective of each family members.

Acceptance and mindfulness are the core components of ACT intervention. Individuals are encouraged to consider and contextualize their cognitions and to act on cognitions that promote adaptive behaviors and to disengage from cognitions that lead to maladaptive behaviors (Woidneck et al., 2012). The goal is to reduce the power that maladaptive cognitions have on the individual and their world view and instead
consciously to choose actions that are in accordance with their core values (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

There are six fundamental elements of ACT; acceptance, defusion, self-as-context, present moment awareness, values, and committed action. Acceptance is seen as enabling the individual to experience cognitions without a desire to change or control them. Defusion is aimed at decreasing the impact and meaning an experience or cognition has for an individual. Self-as-context encourages the individual to appreciate that their mind and body are the tools that allow for experiences to occur rather than focus on the content. Present moment awareness urges people to allow themselves to experience cognitions as they appear in the internal and external world. Values will serve as motivation to change maladaptive behaviors. Lastly, committed action suggests that it is necessary for people to take action towards their values if they are to truly change their maladaptive behaviors (Hayes et al., 2006).

**Culturally-Conscious Acceptance and Commitment Therapy**

This writer advocates and provides evidence for the utilization and integration of culture-specific questions, concepts, themes, language, and statements when facilitating a psychosocial treatment intervention directed towards individuals and families impacted by childhood cancer who identify as Latino and/or Mexican-American.

ACT is a form of acceptance-based behavioral therapy (ABBT), which works to alter the relationship with the thoughts rather than alter the behaviors that induce distressing cognitions. An overarching goal of this approach is to guide the client to understand the context in which they are experiencing emotional or physical distress.
The clinician works to support the client in understanding, normalizing, validating, and accepting the cognition or behavior linked to the distress.

This writer suggests that the culturally-inclusive version of ACT may resonate with clients from marginalized and minority backgrounds who frequently mistrust the mental health system. The writer purports that most behavioral interventions targeted at alleviating distressing symptoms and impairments encourage the client to change a specific behavior in order to elicit an adaptive cognition. In the mind of an underserved, marginalized, and minority patient and/or family, this approach is often seen as one more circumstance by which an authority figure is attempting to promote overall change and assimilation leading towards the dominant culture. In addition, ACT identifies “acceptance” of the situation or event and learning how to cope with distressing thoughts as being the goal. Thus, an approach with the intention of dismantling or eliminating the event, rather than learning how to accept and adaptively cope, may lead patents and families to feel as though they are being blamed and held directly accountable for their current circumstance (Fuchs et al., 2013).

Childhood cancer is a medical malady that cannot be remedied, altered, or shifted by the patient or the family alone; it requires medical treatments that are performed solely by trained professionals. The particular challenges of this context—one which forces families to depend on an often hostile and mistrusted dominant culture—make the ACT appear to be a particularly efficacious, culturally conscious approach to treatment. This approach involves developing a process that allows clients to accept the painful event they face, while actively working to sit with distressing cognitions, because once cancer has been diagnosed, it is a force to be reckoned with—a condition that cannot be
changed or undone. There is a sense of consonance between cancer and ACT due to the following premise: the ACT model promotes psychological flexibility with the aim of helping people get through difficult experience by sitting with uncomfortable thoughts, realities, and experiences rather than seeking to undo what is inescapable. A mentioned earlier, patients and family members are unable to change the distressing and maladaptive situation that is cancer. Rather, the goal is to achieve a state of acceptance while accumulating a core set of coping skills and creating a positive space from which to expel and transform negative and distressing emotions. Moreover, this theoretical model is congruent with the widely-held Latino belief of fatalism: acceptance of an event due to predetermination. When providing psychosocial treatment, it might be helpful to make this link in order to build rapport and invite patients and families to warmly receive the intervention.

Healthcare practitioners are encouraged to become aware of cultural differences and similarities when working with Latino and/or Mexican-American families affected by childhood cancer. Some concepts and cultural constructs that the newly adapted version of ACT will emphasize include; *familismo, personalismo, respeto, simpatia*, and the idea of fatalism as a means of dealing with the cancer experience. Additionally, family narratives related to unique perspective of the cancer experience and their importance to the healing process will assist in providing a cohesive family dynamic due to a shared experience. The intervention will include the incorporation of family pictures both prior and during life with cancer, letters to children and/or parents or siblings, poems related to the emotional experience of having and living with cancer, and rituals consistent with cultural traditions. In addition, there will be a focus on language factors...
and other such barriers to effective psychosocial treatment during the first session in order to directly target obstacles and provide ways of collaboratively overcoming these hindrances.

As previously discussed, the concept of *personalismo* in the Latino and/or Mexican-American family can be likened to the therapeutic alliance that we have come to learn in Westernized schooling. However, contrary to how sessions are conducted in some approaches to western psychology, the research highlights the essential nature of listening to the patient’s and/or family’s story immediately after making introductions and prior to completing the intake and assessment paperwork (Gelman 2004). This core concept related to *personalismo* will establish sense of respect for the family and showcase an understanding of critical cultural dynamics. Gelman (2004) contends that the practitioner should acknowledge that these families are made up of real individuals who have or who are currently experiencing a sense of fear, shame, and pain related to a distressing situation. Acknowledging why the family is present and what their story is will aid in creating the therapeutic alliance.

Family or *familismo* is another key construct that is associated with Latino and/or Mexican-American culture. This construct builds upon the importance when dealing with hardships of family support, availability, comfort, and an overarching sense of unity versus a sense of independence (Hernandez and Bamaca-Colbert, 2016). In the context of childhood cancer, Latinos and Mexican-American families might prefer the abundant support of immediate and extended family members while they are stationed in hospital settings as opposed to dealing with the illness on their own or with immediate family members only. Gelman (2004) notes the importance of asking questions about
immediate and extended family members-- if there is a separation from the family, this may mean that there is separation from the cultural traditions that exist within the family. The literature states: “it is more culturally syntonic for Latinos than for Anglos to bring the family in as an adjunct to treatment” (Gelman 2004, p. 94). Childhood cancers affect the entire family and the level of cohesion and support among family members within the Latino and Mexican-American cultural groups have been found to provide children, teenagers, and young adults with more positive emotional outcomes (Leidy et al., 2010). Thus, the concept of *familismo* is especially important and the clinician should therefore make a clear effort to incorporate the entire family into the treatment and explore ways in which family dynamics play a role in the overall therapeutic outcome (Gelman, 2004). This writer suggests that staff encourage parents to introduce generational and intergenerational narratives in order to bring the family together during the cancer experience.

This proposal supports the theory that culturally inclusive modifications to the ACT model will alleviate common barriers to treatment and aid in assessing the family’s degree of psychosocial support in order to help reduce PTSS and co-occurring mental health issues. Emotional support efforts are particularly essential to the overall mental well-being of individuals and families dealing with adversities related to childhood cancer. Informing the treatment by implementing cultural concepts from Latino and Mexican-American traditions will strengthen the therapeutic process and allow for positive emotional and psychological outcomes for the entire family.
Culturally Conscious Treatment Intervention Protocol

Program Background

The writer recommends that the present treatment intervention be utilized during the time children and teenagers are actively receiving medical services (screenings, surgeries, chemotherapy, and other oncological services). This intervention will serve as a group and/or individual program for the family members of children affected by childhood cancers. The intervention will be provided over a course of six weeks. Each session will be 90-minutes long and will occur in the primary care facility i.e., the clinic or hospital where medical treatment is completed. Children and teenagers aged 6 and above will benefit from participating in this intervention. Family members of infants and toddlers will benefit from participating. Parents, siblings, caretakers, grandparents, cousins, and/or any person deemed supportive and close to the patient are encouraged to participate in this intervention.

The following key concepts as well as the above-mentioned constructs found in the literature that are pertinent to Latino and Mexican-American culture will be implemented in each weekly 90-minute session of the intervention under each of the different six ACT processes. The concepts discussed by Gelman (2004) include: 1) relationship alliance, 2) individuality, 3) flexibility, 4) reality, and 5) modifications, all of which come together to encompass cultural sensitivity. These models will integrate open and axial categories and be utilized in the proposed modified framework of ACT.

The five processes are broken down further: the first concept of “alliance” includes incorporating curative factors that are specific to Latino and Mexican-American culture, shared worldview such as culture and language, transference and
countertransference issues and a sense of obligation from the practitioner to work with
the Latino and/or Mexican-American population. The second issue of “individuality”
includes an awareness by the practitioner of the importance of family and spirituality, of
the significant difference between the concepts of class and culture, and that allows the
patient and family to see that stereotypes are not entering into the treatment process. The
third concept explores the notion of “flexibility” and allowing for adaptation within the
session in order for the family to feel that they have a say in their work. “Reality”
encompasses the fourth core concept of cultural sensitivity and encourages discussion of
case management and immigration issues during treatment sessions if they are relevant
concerns for the family. Fatalismo (fatalism) refers to the belief that an individual cannot
control or prevent adversity (Paniagua, 1998). Negative and unjust situations are going
to occur -- they are perhaps predetermined. It is worth exploring an individual’s possible
"magical explanations" of mental or emotional problems, as emotional problems may be
seen by some as being caused by bad spirits or witchcraft.

The last adjustment in the approach proposed involves modifications in terms of
self-disclosure by the practitioner, the acceptance of gifts, physical contact between the
family and practitioner such as hugging one another, increased levels of activity within
the sessions such as taking a hands-on approach and getting more involved than
practitioners are typically trained to, and lastly use of language, ideally the primary
language of the family (Gelman, 2004).
Who Will Benefit from this Intervention

Family members and the children and adolescents affected by childhood cancer will directly benefit from the proposed culturally-conscious therapeutic services. Family members may include parents, grandparents, siblings, and/or aunts, uncles, and cousins.

A Culturally-Conscious ACT

Week One

Focus on the “Present”

Goal: The first component of this ACT model focuses on an openness and responsive awareness of the present moment. The goal is to have the family slowly transition from focusing on the past to focusing on present moment awareness. One example of this might be to have the family describe to the facilitator what the day looked like when they found out about the cancer diagnosis. The re-expression of this day risks inducing a feeling of anxiety and distress. Rather than focus and hold on to this past experience or event that led to the feeling of anxious distress (one symptom of PTSS linked to the cancer experience), the goal is to focus on current thoughts and feelings occurring in the present moment and focus the mind and body on alleviating these present distressing concerns.

• During this first session, the facilitator is encouraged to warmly invite participants into the experience of family support. An emphasis is placed on warm and inviting communication due to potential negative effects of a perceived sense of “coldness” from the facilitator. The Latino family needs to feel that the facilitator is a caring and understanding person. For this reason, mild self-disclosure related to feeling tense or
nervous might welcome the family to make similar disclosures to break the ice. It is essential to continuously revisit the understanding that this session might be the first time that the Latino patient or family member has accepted or requested any form of psychosocial support. Therefore, it is advised that the facilitator create an open, judgement-free and healing space in which the family feels welcomed and at ease. The facilitator should shake hands with each family member, preferably beginning with the elder/patriarch, and then make introductions (state their role within the team and explore the reason for referral). Next steps include inviting the family to share their names, nicknames, their cancer story and experience, and what they would like support and guidance with. Allowing the family to share their unique story with the facilitator and clearly state what they would like to focus on, likely will decrease the power dynamic between clinician and client. This will set the stage for a more collaborative therapeutic alliance moving forward. The facilitator should engage in formal greetings (while maintaining a sense of warmth at the same time). Examples of this include: referring to the elders as Mr. and Mrs./Ms. followed by their last name until it has been made clear by these individual that it is okay to use first names and/or nicknames.

• Latino and Mexican-American clients might be predisposed to believe that clinicians and mental health workers are authority figures, which might create a sense of tension and apprehension. This is a factor related to the core construct of respeto, which places value on deference to authority figures. Given this tension, it is critical to ensure that the family feels comfortable enough to share personal experiences. This can be done in several ways; by creating an inviting physical space with warm colors
and culturally-appropriate pictures and objects (candles); by determining where the facilitator should set up their position in the room in relation to the family; and by being aware of how to greet the elders and the rest of the family. It will also benefit the level of engagement by encouraging a sense of openness regarding discussions. Some Latino families might adhere to the notion of only sharing and speaking when asked a direct question. If this is the case for the family in your session, share that open participation is highly encouraged by all family members at any and all times. If this appears to be uncomfortable to the family, the facilitator will need to work to allow each member in the family an opportunity to speak by calling upon them and validating their shared experience until the individual feels comfortable speaking up on their own.

- In an effort to reduce tension between the facilitator and the individual and/or family, the facilitator is encouraged to avoid intense and prolonged eye contact with clients during initial interactions as this may be seen as a sign of disrespect and provocation. Additionally, it might be seen as bad luck to maintain prolonged eye contact due to “mal ojo” (evil eye) which has been associated with illnesses and evil spirits. The facilitator could bring this topic up and even highlight that eye contact within the context of these sessions will not be seen as evil or disrespectful, but rather as a form of communication among all family members as well as the treatment team. Ultimately, it is up to the individual to decide what they are comfortable with.

- The initial session is a good place to discuss potential barriers to therapy in order to create successful outcomes going forward. If applicable, express to the family that sharing close familial issues and concerns may feel uncomfortable at first, but it is
important to remember that open expression will promote healthy outcomes for each member of the family. Let the family know that it is normal to feel uncomfortable with verbalizing feelings during the initial stages of support. In order to join with the family and show an interest to support successful outcomes, the facilitator may share a few hopeful outcomes in order to guide the sessions. Additionally, encourage the family to feel free to let the facilitator know whether there are any changes that could be made in each session order to allow for more openness. In addition to asking questions such as: “can you tell me what caused the illness?”, “how does this illness impact the family?”, “how do your religious and/or spiritual beliefs support you?” or “how are you presently feeling about what is going on?” the facilitator should inquire into primary language, language preference, and whether there is a need for an interpreter. By asking the patient and each individual family member to describe what they are presently experiencing in terms of symptoms (physical and emotional) related to the illness, you are opening the way for cultural descriptions and expressions of pain and suffering to come to light. These terms can then be utilized in subsequent sessions with the family to continue to build rapport. One way of phrasing this could be, “I would like to learn more about how each of you feel. I am wondering whether we could start by describing for me how you feel about what has recently happened to your family?” Additionally, due to the manner in which the family might be set up, it might be beneficial to encourage the eldest family member to begin first. This will highlight the importance of the elder participating in the group and bring to the forefront that respect within the family context begins with this family member. By highlighting that the cancer occurrence has happened to the
family, you are relaying to the family that there is a shared understanding of fatalism. If the family is having difficulties with describing their symptoms (physically and emotionally), the facilitator may provide examples.

- The facilitator should make reference to and provide examples of *dichos* - proverbs and sayings - in an effort to address and reframe emotional struggles. Some examples of *dichos* related to the present experience of cancer include: “Esto pasará” (“this will happen”) – which can promote conversation related to why this cancer diagnosis is occurring to this family at this time; “a quien dios ama le llama” (whom God loves (is) called) - this may promote the idea of fatalism and learning to understand why this situation is happening, rather than trying to reverse the situation, “a grandes males, grandes remedios” (desperate diseases must have desperate remedies) - this might encourage a conversation surrounding the “desperate remedy” being therapy. Additionally, to promote a sense of strength, the facilitator might provide this *dicho*: “a mal nudo, mal cuno” (you must meet roughness with roughness) - this could lead to a conversation related to strength of resilience in times of strife. Other helpful proverbs include: "No hay mal que por bien no venga." (there is no bad from which good does not come or every cloud has a silver lining), and “despues de la lluvia, sale el sol" (after a rainstorm, the sun will shine). *Dichos* offer the family a means of pulling from their language and cultural framework to make a connection with what is happening presently. Beginning with a *dicho* might make it easier to then flow into a conversation about the present experience of cancer. Psychological and emotional processes within the Latino and Mexican-American culture are viewed as a sign of weakness, thus, sharing *dichos* may make it easier to share an emotional experience.
because it is almost as though sharing a proverb that is related to one’s life creates a sense of distance from reality as well as a shared connection with others who have faced similar circumstances before. The goal is to have the family collaboratively share and discuss proverbs and ways in which they are relevant to their present situation. This will allow for the facilitator to get a clear picture of the emotional framework as well as what the client is experiencing in order to create something similar to an individualized treatment plan. The facilitator will only be able to provide support if the family is willing to share, in a culturally-sensitive manner, what is currently causing a sense of distress.

- In some cases, the child with cancer may not be present due to medical observance, treatment, or other such situations. However, if the child is present, it is the facilitators role to make their experience come to life through appropriate questions. Staff should emphasize that children’s experiences are often discounted and ask whether this is something that they have observed. Questions appropriate to ask children might include: “do you feel heard by the medical team?” Or “tell us what types of treatment you are receiving and why you are receiving them.” The responses to these questions might invoke a response related to how much they feel a part of their own treatment. Follow up questions can then be asked related to how this feeling of being excluded feels and what can be done to reframe the experience with the inclusion of practical steps to follow in order to take more of an ownership role in the current experience. During these portions of the sessions, facilitators should stress the importance of the child learning how to feel empowered through active verbalization related to how they feel and what they are experiencing in order to
create recognition that the cancer experience is occurring in their life. This will allow the child to create meaning from their experience and to feel as though they have a voice and hold a sense of empowerment over their experience.

• The first session should end with the facilitator thanking the family for attending the session, asking them whether they felt a sense of support, and highlighting important components that arose from the session.

**Week Two**

**Focus on the “Values”**

**Goal:** The second component of this ACT model focuses on the freely chosen personally constructed and culturally meaningful values that act as a motivation for change to work towards accepting the distressing thoughts and feelings and finding appropriate means of coping.

• The psychosocial facilitator might begin this session by referring to several common feelings, which have been listed by the National Cancer Institute (2018), as prominent feelings and emotions that many caregivers experience when taking care of a child. It is useful to start by listing the following symptoms: feeling overwhelmed, being in denial, angry, fearful and worried, hopeful, stressed and anxious, sad and depressed, guilty, lonely, and/or grateful. Express to the family that these are common symptoms that many other families and communities have experienced at one point or another during a similar process. This speaks to a similar construct related to *familismo*, in which there is a tight-knit community of individuals who lean on and seek out each other for support. It might be helpful to verbalize this link out loud so as to showcase that the family is not alone, although they might feel as though they
are. Furthermore, facilitators should ask questions related to what supportive figures exist for each individual or for the family as a whole. This will identify a potential need for re-engagement with family and might invoke a family desire for heightened connectedness, if there has been a disruption in the family dynamic. Highlight the role and amount of power that family togetherness will play in determining how psychologically strong this family will turn be after the cancer experience.

• The next step would be to ask whether anyone in the room has experienced similar feeling to the ones listed, per the NCI. If one or more people positively identify with any of these feelings, it might benefit the client if the staff member provides a validating statement before asking them to explain how this symptom uniquely presents itself to them. For instance: “I hear you say that you have felt fear and worry about the cancer. What exactly are you afraid might happen?” or “What is it that worries you the most about what is happening to you and your family?”

• A core value embedded within Latino and Mexican-American culture is spirituality and religion. It is encouraged to ask the family what their level of religiosity and spirituality is (“What is your faith?”, “How often do you pray/attend church?”, “Do you talk to God about what is happening to your child and family? If so, what are some things that you say?”). These questions will give the facilitator an enhanced sense of how strong this value is and whether to incorporate healing practices into the sessions. It is important to ask caregivers questions related to passages of life and what it means to them that their child is currently staying and sleeping in a hospital bed. It is encouraged to ask the family what religious and spiritual practices they engage in to provide them with appropriate suggestions. For instance, PEW (2017)
states that 48% of Latino families identify as Catholic and 20% identify as Evangelical protestant. This is important to be aware of when suggesting whether they would or would not benefit from having a priest or other religious leader visit during these sessions as well as knowing whether it is culturally appropriate to suggest bringing rosary beads and religious medallions to the hospital to keep at the bedside. Ask the family questions such as, “What home remedies do you use?”, “Does the child seek care from a curandero?”, or “What herbs or vitamins does the child take?” This is done to facilitate a discussion regarding what interventions the family values and what culturally-attuned language is appropriate for use when speaking of the cancer, illness, or ailment.

- Some families from this culture might also have difficulty approaching people who are seen as authority figures, so the staff could coach parents through a potential dialogue with nurses or doctors. Families may consult an elder or an influential person from the community when deciding treatment and making end-of-life decisions.

- Additionally, facilitators should be educated on the various patron saints that are essential pieces of support and guidance in the lives of this population. Some powerful healing figures include: God, Jesus, the Virgin Mary, and the Virgin of Guadalupe. If it is possible to do so, facilitators should try to bring figurines or pictures of healing saints to each session.

- The value of food might play an especially essential role in the context of psychosocial support. Staff should inquire into what a traditional meal may include and encourage the family to bring these items to the next session and/or eat this with
family members in the hospital. This is done to bring a deep sense of comfort, nurturance, and a sense of connectedness to family and traditions. This will help to ease anxieties. Some traditional meals include: soups, meat, some vegetables, corn tortillas, rice, and pinto beans. If it is possible to provide these food items within the treatment intervention and family support group, it is encouraged to do so. This will help to build the therapeutic alliance and allow for a sense of overall comfort to exist within the intervention.

Week Three

Focus on the “Committed Action”

Goal: The third component of this ACT model focuses on values-guided committed action.

- This session involves providing psychoeducation to the family. Topics include: how to ask for help and how to speak to healthcare providers. It is important to remember that in some traditional Latino families, the mother determines when a child needs healthcare, while it is the father’s role to allow the child access to going outside of the home and into a hospital. This can be used to empower both caregivers and providing education to both of them regarding the imperative nature of receiving consistent healthcare after a cancer diagnosis.

- Share with the family findings from The National Cancer Institute regarding advocating for families to be prepared and keep a “passport” of all factors related to diagnosis and treatment. This is a helpful skill to encourage and teach during the intervention as it will help to alleviate some of the nervousness and feelings of
uncertainty. Some considerations to the passport might include: the type and stage of cancer; date of diagnosis and dates of any relapses; types and dates of imaging tests; contact information for the hospitals and doctors who provided treatment; names and total doses of all chemotherapy drugs used in treatment; the parts of the body that were treated with radiation and the total doses of radiation that were given; types and dates of all surgeries; any other cancer treatments received; any serious complications that occurred during treatment and how those complications were treated; and the date that cancer treatment was completed.

Week Four

Focus on the “Self as Context”

Goal: The fourth component of this ACT model focuses on flexible perspective taking that will work to enable an awareness of one’s own experiences without attachment to the event or experience.

• The facilitator may once again highlight the importance linked to the construct of familismo. This concept is greatly embedded within most members of the Latino and Mexican-American culture and therefore it is relevant and culturally-inclusive to propose that the family share a family narrative relevant to the cancer experience.

• Begin by asking the family to write a letter or poem reflective of their journey and experience through cancer. The letter may be as long, detailed, and transparent as the client would like it to be. Once the letters are completed, each family member will read their letter out loud (in their language of choice). In most cases, an emotion felt by a caregiver or cancer patient has consequences that might negatively or positively
impact other members of the family. The goal of this activity is to allow for a family narrative to be shared among those closest to the cancer experience. Feelings of acceptance and a shared concept of grief might be persistent among many of the family members. This might bring up feelings of heightened connectedness and propel family members to share what they are going through and feeling more often.

**Week Five**

**Focus on “Defusion”**

**Goal:** The fifth component of this ACT model focuses on observing distressing thoughts rather than letting the experience and/or event (cancer diagnosis, medical treatments, physical changes due to treatments) distress the individual.

- The focus of this session is to build upon the former components of ACT and continue to work towards the final stage of accepting that cancer has become a part of the family narrative.

- The facilitator during this session may ask the family to describe their understanding of the “concept of cancer” in a culturally-appropriate manner. This will allow for the group to break down exactly what is internally occurring to them and allow for an expression of feeling, rather than blaming the disease for drastically changing areas of life. Questions might include: “What does cancer mean to you and your family?” It is expected that negative cognitions linked to the child having cancer will be shared, it is only then that the facilitator begins to explore the distressing feelings and emotions with the family, rather than how “bad” cancer is. This is because neither the facilitator nor the family has the medical knowledge to make the cancer disappear.
However, the facilitator is able to work with the family to identify distressing thoughts and feelings and support the client in changing their negative relationship with these cognitions.

- A next step could include highlighting the belief of fatalism by inquiring into “mal de ojo” (magic spell). Some Latino beliefs contend that cancer is a spell that has been cast onto them. This is similar to the belief of fatalism. An open dialogue related to this aspect might implore the family to address why they believe the cancer experience is occurring to them. This is an opportunity for the facilitator to engage in conversation beginning with questions such as: “If the cancer is a spell or has been predetermined, how can we learn to accept the cancer for what it is and start to move on and feel more at ease with what is happening?” By simply stating this out loud, anxieties and worries might start to diminish and a slow acceptance of fate might begin to set it.

Week Six

Focus on “Acceptance”

Goal: The final goal of acceptance and commitment therapy, when combined with constructs consistent with cultural inclusiveness, involves the act of placing acceptance onto the situation at hand. In this case, it includes the family learning how to face, deal with, and emotionally accept the cancer diagnosis and what this means for the trajectory of the child’s life moving into the future. Additionally, it includes learning to accept that distressing thoughts are temporary and will come and go throughout the family’s journey with cancer. What is imperative is that the family hold onto this notion and resist the
urge to displace blame onto the disease. All this will do is project internal negative emotions onto the cancer or onto other family members. Through the use of ACT, imbedded with core cultural constructs consistent with Latino and Mexican-American families, a sense of acceptance will be reached at the end of the intervention. Projections such as: having to live with cancer; having to take care of a child with cancer; and experiencing even more hardships than minority individuals already have to deal with will be addressed head on. The emotions derived from these cognitions will be thoughtfully heard, embraced, and accepted in order to allow for the patient and family to begin to heal.

- The facilitator will need to remind the child/teen and family that acceptance involves an active and aware embrace of internal experiences without changing their frequency or form. Coach the family on how to lean on sources of support throughout the upcoming weeks, months, and years. Remind family members of their strength and resilience. Encourage them to openly communicate with immediate and extended family members, especially because of the special and meaningful interdependent nature of the family.

- Ask questions pertaining to how the family feels at the end of the six weeks and offer them words of encouragement relevant to unique growth opportunities that came to fruition and that were directly witnessed. This will allow for a sense of personal connection between facilitator and family and might possibly motivate the family to seek further psychosocial support at the end of these sessions. It is hoped that each family member will walk away feeling fewer PTSS symptoms than they did when they walked in during the first week.
Limitations

Although this is a treatment intervention proposal, there are various noteworthy limitations found within this study that perhaps future researchers could further address. One such limitation involves the fact that this proposal has never been executed as a trial or study with a representative population. There were insufficient participants and the weekly sessions were only tested hypothetically and in theory based on best practices gathered from an extensive literature review as well as from the needs and desires expressed by parents directly impacted by situations like the ones discussed in this paper. Further, the proposed manual is based on a small population of affected families in the Santa Barbara, California, community, who may not be representative of other Latino populations. Most of the issues raised within this paper derive from suggestions and disparities observed and found within this small population. Thus, it would be difficult to generalize these suggestions and interventions to the larger population sample in the United States. The age of the child or teenager diagnosed with cancer has potential to be a third limitation in terms of impact of the intervention. For instance, due to their age and inability to verbally express their feelings, toddlers and infants are unable to participate in family and group process and dialogue. This could be dealt with by providing on-site childcare so that the child is still present in the room during the intervention. After all, the affected child is the reason for the psychosocial service and it might benefit the caregiver/s to see the child in their presence while participating in each weekly session. Furthermore, teenagers might find it difficult to engage in family and group processes during such a sensitive time in their lives. They also might not know what is appropriate to say in front of their caregiver. It will be beneficial for the facilitator to have a
conversation with the teenager at the beginning of the intervention in an attempt to meet them where they are by inquiring about their specific needs and wants. This way, the weekly interventions might be tailored to their interests - such as introducing art therapy into each session in order to facilitate engagement. The focus of this dissertation was specific to the Latino and Mexican-American population. A limitation within this fine scope includes the fact that the term “Latino” is a pan-ethnic classification that incorporates a diverse group of people with distinct racial, social, cultural, and historical backgrounds (Espinosa de los Monteros and Gallo, 2011). Thus, due to the fact that Latino populations include such a diverse array of sub-ethnic groups such as: Dominican, Puerto-Rican, Cuban, etc.; the cultural concepts described in this uniquely created treatment intervention might be misleading due to some constructs that do not allow for a sense of cohesive coming together with other subgroups. In relation to acculturation levels among participants, the facilitator could host a collaborative discussion related to level of assimilation and acculturation in order to allow room for unique cultural adaptations consistent with where the family currently is on the spectrum of level of acculturation. The level of acculturation found to exist among an individual or family may be determined by observation and by asking questions relative to the following factors: language preference, social and community affiliation, daily living habits and activities, how the person culturally identifies, asking what their cultural values are, what their perceived prejudice/discrimination factors include, length of stay in their current residence, generational status, how they dress, and various other factors (Cuellar, Arnold & Maldonado, 1995; Zane & Mak, 2003). Furthermore, this treatment proposal utilizes the literature and primary sources including families that have been directly impacted by
psychosocial hardships linked to the childhood cancer experience. However, it is imperative that the reader understands that each family is unique and a core value or construct found to be important and beneficial to one or a few families does not mean that every Latino and Mexican-American patient and family finds this value useful within the context of their family. Staff are encouraged to utilize this modality as a guide to providing psychosocial support to families in need. If one aspect does not apply to the family sitting in front of the clinician, it is encouraged that a clear and honest conversation occur between staff and family members in order to provide appropriate cultural substitutions for the approach. This manual is merely a guide highlighting the importance of cultural inclusion and insight into the unique each cancer experience of each individual family.

**Conclusion**

Childhood cancer is an all-encompassing family disease. Each member of the family is deeply affected by the experience of a loved one being diagnosed with such a potentially life-threatening illness. Latino individuals have been found to have the highest cancer mortality rate among races and ethnicities across the U.S. (Ward et al., 2014). Cultural values, traditions, and customs when integrated into the weekly ACT psychosocial treatment intervention will support families in helping their children through the traumatic and frightening journey that is childhood cancer. This intervention will assist in bringing the family together and creating a space and feeling of healing and nurturance that is especially needed during this time. There is a dire need for efficacious psychosocial support for all children and members of the family, and such support should be provided with appropriate care and cultural inclusion. It is essential for professionals
to be aware of cultural dynamics within the Latino and Mexican-American cultures in order to provide a form of support that will be well received by the individual, family and the culture to which they belong. Most psychological interventions utilized in American society place a strong emphasis on uniquely Western ideals such as individualization, independence, assertiveness, and rational thoughts, feelings, and behaviors. However, it is imperative to consider the identified culture of each client and simultaneously adapt an intervention to fit the unique needs of the family. The mainstream therapeutic approaches previously identified within this paper may come in direct conflict with the values, morals, and beliefs held by many cultural groups belonging to a collectivistic worldview in which interdependence, religion and spirituality, and family connectedness may take precedence (Woidneck et al. 2012). Children may present with medical-related illnesses that may consequently have an impact on psychological distress. Due to the fact that families typically exist within a system of complex networks, it is advantageous that clinicians be well trained in the best practices prevalent to psychological and psychosocial practices for individuals from various cultural backgrounds.

It is therefore essential for practitioners to have complete awareness of the available culturally-conscious treatments and interventions that may be beneficial to an individual and a family affected by childhood cancer. It is this writer’s hope that this culturally-adaptive form of ACT intended for use with families affected by childhood cancers will be piloted in the near future, potentially at a university-level hospital training facility due to the population sample and demographic backgrounds required.
References


http://www.cancer.org/acs/groups/content/@research/documents/document/acsp
c-046405.pdffind actual page/link


https://doi.org/10.1177/07399863950173001
https://doi:10.1525/aeq.1994.25.3.04x0146p

https://doi.org/10.1017/S0021963098002583

https://doi:10.1007/s12529-010-9119-4


Fuchs, C., Lee, J. K., Roemer, L., & Orsillo, S. M. (2013). Using mindfulness- and acceptance-based treatments with clients from nondominant cultural and/or marginalized backgrounds: Clinical considerations, meta-analysis findings, and introduction to the special series: Clinical considerations in using acceptance- and


and validity across age subgroups using the Pediatric QL 4.0 Generic Core Scales.


Zane, N. & Mak, W. (2003). Major approaches to the measurement of acculturation among ethnic minority populations: a content analysis and an alternative
empirical strategy. In: K.M. Chun, P. Balls Organista & G. Marin (Eds.),
Acculturation: advances in theory, measurement and applied research (pp. 39–60).


https://doi.org/10.1111/j.1540-4560.1952.tb01860.x