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Initial Evaluation of the Validity and Reliability of the Culturally Adapted Spanish CaSUN (S-CaSUN)

Dinorah Martinez Tyson
University of South Florida, dmtyson@usf.edu

Patricia Medina-Ramirez
Moffitt Cancer Center and Research Institute

Coralia Vázquez-Otero
University of South Florida, coralia@usf.edu

Clement K. Gwede
University of South Florida, gwede@usf.edu

Margarita Bobonis Babilonia
Moffitt Cancer Center and Research Institute, mbobonis@health.usf.edu

See next page for additional authors

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Authors

Dinorah Martinez Tyson, Patricia Medina-Ramirez, Coralia Vázquez-Otero, Clement K. Gwede, Margarita Bobonis Babilonia, and Susan C. McMillan

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Dinorah Martinez Tyson,
Department of Community and Family Health, University of South Florida, Tampa, FL

Patricia Medina-Ramirez,
Department of Health Outcomes & Behavior, Moffitt Cancer Center & Research Institute, Tampa FL

Coralia Vázquez-Otero,
Department of Community and Family Health, University of South Florida, Tampa, FL

Clement K. Gwede,
Department of Health Outcomes & Behavior, Moffitt Cancer Center & Research Institute, Tampa, FL and Morsani College of Medicine, Department of Oncologic Sciences, Tampa, FL

Margarita Bobonis Babilonia, and
Psychiatry, Moffitt Cancer Center & Research Institute, Tampa, FL

Susan C. McMillan
College of Nursing, University of South Florida, Tampa, FL

Abstract

Purpose—There is a dearth of knowledge and limited research on the needs of Hispanic male cancer survivors (HMCSs). There is a clear need for the development of culturally and linguistically adapted needs assessment tools that are valid and reliable for use among the growing HMCS population. Thus, the purpose of this paper is to describe the field testing and psychometric evaluation of the translated and culturally adapted Spanish Cancer Survivor Unmet Needs Measure (S-CaSUN).

Methods—Hispanic male cancer survivors (n=84) completed the Spanish CaSUN (S-CaSUN), the Hospital Anxiety and Depression Scale (HADS), and the Functional Assessment of Cancer Therapy-General Population (FACT-GP). Construct validity of the S-CaSUN was assessed by correlation analysis among aforesaid measures. A test-retest procedure with two-week delay was used to examine reproducibility with a participant subsample (n=50). Cronbach's alpha was computed to assess internal consistency of the S-CaSUN.

Results—Construct validity of the S-CaSUN was estimated by moderate correlation with the HADS anxiety (r = 0.55, P<0.001) and depression scales (r = 0.60, P<0.001) and the FACT-GP (r = −0.62, P<0.001). The test-retest correlation coefficient for the S-CaSUN was 0.78. Cronbach's

Correspondence concerning this article should be addressed to Dinorah Martinez Tyson, Department of Community and Family Health, University of South Florida, 13201 Bruce B. Downs Blvd, MDC56, Tampa, FL, 33612-3805. dmarti20@health.usf.edu. Fax: 813-974-5172.

alpha was 0.96. Field-testing yielded a mean S-CaSUN score of 38.3 (SD=26.2); all needs and positive change items were endorsed.

Conclusion—Findings from field-testing and preliminary psychometric evaluation of the S-CaSUN provide initial evidence of validity and reliability of the measure and highlight the importance of going beyond translation when adapting measures to take culture, literacy, and language into consideration.

Implications for Cancer Survivors—Reliable, culturally and linguistically valid instruments facilitate identification of unique unmet needs of Hispanic cancer survivors that, in turn, can be addressed with evidence-based interventions. As cancer centers continue to develop survivorship programs, the S-CaSUN may be useful for a growing group of cancer survivors.

Keywords

Supportive Care; Hispanic/Latino; Psychosocial Oncology; Unmet Needs; CaSUN; Men

Introduction

Advances in cancer detection and treatment have led to an increase in the population of cancer survivors [1–9], thus augmenting the need for effective support services [1, 5, 10–18]. This has resulted in attempts to more broadly identify individual needs, in order to improve supportive care services [1, 12, 19–24]. While numerous quality of life (QOL) measures currently exist, they do not directly assess supportive care needs. Typically, needs are inferred from identified deficits in functioning, obtained by patients rating the presence and/or severity of an item but not whether it is a problem for which they need help [1, 25, 26]. In contrast, needs assessments directly identify and evaluate patients' specific needs, as well as the perceived magnitude of those needs. In this context, "needs" can be defined as the requirement of some action or resource that is necessary, desirable, or useful to attain optimal well-being [5, 27].

Needs assessments offer an enriching opportunity to obtain more insightful and accurate comprehension of the experiences of cancer survivors [14, 28] and play a critical role in the process of resource allocation with regards to prioritizing services for the most at-risk groups. Most cancer-related needs assessment measures were developed for cancer patients irrespective of treatment or disease status (e.g., the Supportive Care Needs Survey [5]) but do not specifically focus on the survivorship phase, as many of the items used assess medical care needs and may be more relevant to those in treatment [14, 20, 29–39]. The Cancer Survivor Unmet Needs Measure (CaSUN) was specifically developed to assess the supportive care needs of cancer survivors [12] and is more appropriate for addressing the demands of the survivorship phase of the disease trajectory [20]. However, this assessment tool has not been culturally adapted for, or validated among, Spanish-speaking Hispanic cancer survivors (herein defined as those who have completed initial treatment).

There is a dearth of knowledge and limited research on the needs of Hispanic male cancer survivors (HMCSs). HMCSs are part of the largest minority group and the second fastest-growing racial/ethnic group in the United States [31]. Hispanic and Latino/a are terms that

may be used interchangeably [40]. Among Hispanics with cancer, men carry a greater burden of disease morbidity and mortality. Health disparities pertaining to cancer emerge from structural, psychosocial, and cultural contexts in which Hispanic men are diagnosed and treated [32–35]. While Hispanics have lower incidence rates for all cancers combined, as well as from the four most common cancers (prostate, lung and bronchus, colon, and rectum), they are more likely to have larger tumors or metastatic disease or both at the time of diagnosis [36–39]. Hispanic men with cancer, compared to non-Hispanics, report significantly worse sexual and physical function, bowel bother, bowel function [32, 35], QOL [41, 42], emotional well-being [43], and mental health [44]. Resulting emotional problems can be exacerbated by lack of support, information, and skills to manage illness [44, 45]. Also, men with cancer are less likely than women to use health and psychological support care services [46–50] and have significant unmet psychosocial and health system/ information needs [51, 52].

Thus, there is a clear need for the development of culturally and linguistically adapted needs assessment tools that are valid and reliable for use among the growing HMCS population. A systematic approach was used to culturally adapt the CaSUN, drawing from the Cultural Equivalency Model for Translating and Adapting Instruments [53]. This model was selected because 1) it incorporates both the emic (e.g., understanding and meaning of concepts from within the culture) and etic (e.g., evaluation of the constructs through a more culturally neutral objective lens) perspectives [54, 55], and 2) it has successfully been used in other studies to culturally adapt instruments for Latinos/Hispanics [56–58]. We used consensus-building approaches and iterative processes that facilitated ongoing feedback and input from HMCSs, cancer care providers, and the project's Cultural Adaptation Community Advisory Board (CA-CAB). Our combined methodologies offered a rigorous and contextual approach to translation alone and supported the cultural adaptation of this measure in a purposeful and relevant manner. Details regarding the translation and cultural adaptation process are reported elsewhere [59]. The purpose of this paper is to describe the field testing and preliminary psychometric evaluation of the Spanish Cancer Survivor Unmet Needs Measure (S-CaSUN), which includes initial evidence of validity and reliability of the translated and culturally adapted S-CaSUN measure for HMCSs.

Methods

Design

This study used a cross-sectional survey design. Construct validity was assessed using the hypotheses approach [60, 61]. It was anticipated that unmet needs would be positively associated with anxiety, depression, and poorer QOL. Reliability was assessed using test-retest procedures [61, 62]. Internal consistency was evaluated using Cronbach's alpha and a review of item-to-total correlations. In addition to analyzing psychometric properties, preliminary analyses of the needs of HMCSs were conducted since the adapted CaSUN was found to be initially valid and reliable. The data adds to the sparse literature on Hispanic male cancer survivors. The University of South Florida Institutional Review Board approved the study.

Sample and Recruitment Procedures

Participants were recruited using the cancer registry of a local cancer center. A sample size of 84 participants was determined using the G*Power 3 program [63] to provide 80% power to detect medium effect size at the two-tailed 0.05 significance level. To be elegible, participants must speak Spanish and self-identify as Hispanic, be older than 18 years of age, and have been diagnosed with cancer within the last five years. Studies show that the first five years are a particularly crucial adaptation period [64] wherein a patient might experience the most need in their survivorship trajectory. We elected to use the term Hispanic in our study; the term is inclusive of people from Spain, as well as those who speak Spanish/are from Spanish-speaking countries in Latin American/Caribbean. Over 600 recruitment packages were mailed to individuals who were classified as male, Hispanic, and within 5 years of diagnosis. The recruitment packages included a letter of invitation with a description of the study, a response card to indicate study interest (agree or decline to participate), and a stamped, pre-addressed envelope to return the response card. Other mailed information included a study information sheet and information about community resources. Non-respondents were contacted via telephone approximately four weeks after mailing out recruitment packages.

Participants who were interested, met the study criteria, and provided verbal consent were administered the questionnaire over the telephone (Time 1) by one of two bilingual co-authors (PMR or CVO). The Time 1 survey included all the items/measures described below, including the S-CaSUN. A sub-sample of 50 participants completed the S-CaSUN a second time (Time 2) over the phone two weeks after the baseline interview [65].

Measures

S-CaSUN—The S-CaSUN includes 43 items: 37 needs items and 6 positive change items. During the translation and cultural adaptation process, five items were removed from the original CaSUN and seven items were added, which resulted in a total of 43 items [59]. In addition, the format was also simplified. The four response alternatives of the S-CaSUN were scored as either no need (= 0) or on the self-perceived importance of the existing need: a little (= 1), somewhat (= 2), or a lot (= 4). A total score for the S-CaSUN was computed by summation of the ratings of all 37 need items, with a higher score indicating greater needs. Similar to the original CaSUN, the information assessed by the six positive change items was not included in the calculation of the total score.

Anxiety and Depression Assessment—The Hospital Anxiety and Depression Scale (HADS) is a 14-item measure widely used as a screening tool with cancer populations ranging from recently diagnosed patients to long term cancer survivors [66] in a variety of oncology settings [67–69]. HADS scores below 8 are designated as "normal," scores 8–10 are "borderline," while people scoring above 10 are considered "clinical" cases. The Spanish version has good validity, a test-retest reliability of r > 0.85, and high internal consistency (Cronbach's alpha = 0.86 for anxiety; 0.86 for depression) [70].

Quality of Life Assessment—Adapted from the Functional Assessment of Cancer Therapy-General (FACT-G) [71], the FACT-GP is a 21-item instrument for the assessment of

non-cancer specific quality of life (QOL). The 5 Point-Likert scale (with response categories ranging from 0 to 4) assesses physical well-being (PWB), social/family well-being (SWB), emotional well-being (EWB), and functional well-being (FWB). The overall summary score for the FACT-GP ranges from 0 to 104, with higher scores indicating better QOL. The FACT-GP was adapted from the FACT-G by removing 6 cancer-specific items and prorating the subscale scores to obtain comparable overall summary scores. Assessments of the psychometric properties of the Spanish of the version FACT-G report good validity and reliability across all subscales, equivalent to the original English version [72, 73].

Demographic Questionnaire—Questions elicited basic socio-demographic data, including marital status, Hispanic origin, English/Spanish language proficiency, length of time in the United States, education level, household income, as well as cancer and treatment related information, such as type of cancer, date of diagnosis, and treatment received.

S-CaSUN Qualitative Evaluation of Feasibility and Comprehension— Respondents were asked four questions at the end of the interview to assess the culturally adapted S-CaSUN in terms of relevance, comprehensiveness, and acceptability, and to identify additional areas of need. To assess the flow of the questionnaire and evaluate general issues during administration, the interviewers kept detailed field notes regarding the interview, including the duration of the interview and comments from the participants.

Statistical analysis

Survey data was scanned directly into Microsoft Excel via scannable response sheets. Ten percent of the data entered was checked for unusual or out of range values. Missing data were minimal given the structure of the questionnaires and training of the team. Statistical analysis was performed using SPSS version 22. Statistical significance was defined as p-value <0.05. Mean and standard deviation were reported for continuous data, as well as counts and percentages for categorical data. Once data collection and analyses were completed, study participants received an executive summary of the findings and were invited to a presentation where study results were shared.

Construct Validity—of the S-CaSUN was assessed by the hypotheses approach [60, 61]. It was anticipated that higher levels of needs would be positively associated with anxiety, depression, and poorer QOL. Computing the Pearson and point bi-serial correlation coefficient to assess the relationship between the S-CaSUN score and the variables of interest tested each hypothesis.

Reliability—was assessed by using test-retest procedures [61, 62]. A sub-sample of 50 participants, which is in line with the number of participants needed to assess adequate levels of test-retest reliability, were selected consecutively [74]. They were administered the S-CaSUN a second time after a two-week delay. The two-week time period was chosen to reduce both recall bias and the likelihood of change in the participant's reported needs. Reliability was estimated by means of correlation analysis (Pearson's coefficient) between the within-subject pair of repeated total scores.

Internal Consistency—was evaluated by calculating Cronbach's alpha values using the scores from the baseline interview, as well as the retest. In early stages of tool development, reliability of 0.70 is considered acceptable [75].

Results

Participant characteristics

Participants were, on average, 59.6 (SD=11.3) years old and had been diagnosed with cancer an average of 2.8 years prior to participating in the study (SD= 1.8). The demographic characteristics of the study sample are shown in Table 1. The sample was diverse with regard to Hispanic origin; the largest percentages were Puerto Ricans (33.3%) and Cubans (27.4%). A large proportion of the sample (82%) was also comprised of monolingual Spanish speakers. Seventeen survivors (20.2%) showed symptoms of probable or certain depression, and 19 survivors (22.8%) presented symptomology of probable or certain anxiety. The HADS subscales mean total score were 5.08 (SD= 4.17) and 4.15 (SD= 3.88) for anxiety and depression, respectively. The mean FACT-GP summary score was 60.9 (SD=15.8). The mean scores for the subscales were 19.5 for physical well-being (SD = 4.4), 11.3 for social/ family well-being (SD = 3.8), 12.7 for emotional well-being (SD = 3.9), and 15.2 for functional well-being (SD = 6.1).

Construct validity

Table 2 displays the correlations between the S-CaSUN total scores and previously validated scales for assessment of anxiety and depression symptomology (HADS) and QOL (FACT-GP). Pearson product moment correlations indicate statistically significant correlations between the S-CaSUN and the aforesaid questionnaires and their subscales. Higher anxiety and depression scores, as well as poorer QOLscores, were positively associated with higher levels of needs. The total FACT-GP, as well as all four of its subscales, showed inverse and significant correlation with the S-CaSUN. The social/family well-being subscale had the strongest correlation with the S-CaSUN. Both HADS subscales were directly and significantly correlated with the S-CaSUN, but correlations were stronger for anxiety than for depression.

Reliability

Internal Consistency—Cronbach's alpha for the S-CaSUN was 0.96. None of the items, if removed, has a significant impact on the scale alpha. Cronbach's alpha value remained unchanged from Time1 to Time2.

Test-Retest Reliability—The Spanish CaSUN was orally administered to 50 out of the total 84 participants, approximately 2 weeks after completing the baseline interview. The correlation between Time 1 and Time 2 assessment was $r = 0.80$ ($p< 0.05$).

Feasibility and Comprehension

The S-CaSUN showed good feasibility for use as an assessment instrument among HMCSs. On average, it took approximately 15 minutes to complete the Spanish CaSUN. Qualitative and quantitative data from the evaluation sheet indicates high acceptability and

comprehensibility of the S-CaSUN. Comments included "very good, straight to the point;" "very good, all very concrete questions;" and "comprehensive, formal, good." A participant from the formative phase of this study (focus groups), who saw the translated CaSUN prior to and after cultural adaptation commented that the S-CaSUN was "…worded better than the original; the goal has been achieved." In addition, participants believed that other HMCSs would feel comfortable answering the S-CaSUN questions and that most people would take the time to complete the questionnaire. Furthermore, feedback and comments from respondents show a perceived necessity for the S-CaSUN as a tool to assess the needs of HMCSs who are non-English speakers. Participants described the items in the S-CaSUN as "important" and "valuable." Comments included "excellent questions that need to be asked;" "very suited to my needs;" and "very interesting. No one asked [me] those questions; it would had helped a lot [if they had]." Several participants also stated that some of the items presented more of an issue at the time of diagnosis or during treatment but presented less of an issue now.

Supportive Care Needs of HMCS

All of the needs items in the S-CaSUN were endorsed by at least one participant (See Table 3). The most highly endorsed items included needs related to comprehensive care/provider communication (items 6, 7, and 8), information (items 1, 19, and 21), existential survivorship (items 18, 23, 24, 29 and 33), knowledge-related (items 10 and 11), and interpersonal/partner-related (items 25 and 26). The mean total S-CaSUN score (needs) was 25.76 (SD = 26.65, Range 1–107). All positive change items were endorsed by at least 77 participants.

Discussion

The current study examined the preliminary psychometric properties of the S-CaSUN with a sample of Hispanic male cancer survivors living in the Southeastern United States. The results from the validity and reliability assessment of the S-CaSUN indicate psychometric properties that are similar to or better than those of the original CaSUN [19].

The hypotheses related to construct validity were supported. A moderate relationship between the HADS and the S-CaSUN was hypothesized because patients with more needs were more likely to feel some level of depression. This hypothesis was confirmed in this study, providing one piece of evidence regarding construct validity. Similarly, there was a significant moderate relationship between the S-CaSUN and the FACT-GP scales, as expected. Again, it seemed logical that survivors with more needs would have lower quality of life; this relationship also was confirmed, providing further evidence of construct validity. Similarly, other studies have also reported that higher levels of needs were associated with higher psychosocial distress and poorer quality of life [76, 77]. Cancer survivors face fears of cancer recurrence, as well as the challenges of being a long-term cancer survivor [24]. Depression can increase even after an individual has been given a cancer free diagnosis [78]. This study has provided strong support for the construct validity of the newly translated S-CaSUN.

Two approaches to estimating reliability were used; both had good outcomes. The test-retest reliability coefficient was strong. This is especially important given that the S-CaSUN was translated for adaptation above the 0.7 threshold for use in a population other than the one originally intended [79]. Reliability using an internal consistency method was even stronger at .96. Both estimates of reliability strongly support use of this translated tool with HCMS.

Similar to what has been reported in the literature, Hispanic male cancer survivors expressed several existential survivorship-related needs, such as the need for emotional support and concerns about cancer recurrence [12, 21, 80]. However, the needs that were endorsed most frequently centered around patient/provider communications and the need to have one's opinions and worries addressed and taken into consideration. Furthermore, these findings are in line with our previous work with Hispanic male cancer survivors, which centers on the participant's ability to communicate about and understand cancer-related information and suggests the need for more culturally sensitive cancer care and better communication with providers. Such needs could be addressed, in part, by actively engaging patients in the management of their care, which may provide patients with a greater sense of control [21] and agency [81]. Sociocultural factors, such as limited English proficiency, uncertainty about using interpreters, and lack of trust, were intimately connected to issues of nondisclosure and limited communication with providers [49]. Information needs related to follow-up care and health could be met with a cancer survivor care plan and referral to services providing psychosocial support and assistance [21]. Consistent with the literature, financial-related needs were also reported [81].

The total S-CaSUN scores were lower than expected, considering the majority of the sample were monolingual Spanish speakers [82–84]. While higher needs may be expected, due to the potential language barrier between the patient and their English speaking health care providers, lower scores may be attributed to the high percentage of study participants with insurance who received cancer care at a comprehensive cancer center providing language assistance, psychosocial services, and an existing survivorship program. Burg et al. [81] reports that the provision of psychosocial services (e.g., social workers) for cancer patients and their families improved psychosocial health outcomes and addressed patient needs. We also attribute the lower than expected needs scores to the time that had passed since diagnosis [85]. Psychological distress may fade as time increases from the initial cancer diagnosis and treatment [81, 86]. As noted in the field notes taken during the administration of the S-CaSUN, several participants identified the needs listed in the S-CaSUN as a bigger concern during diagnosis and treatment than now.

However, there was a slight increase in reported needs over time. The subsample of participants who were administered the S-CaSUN a second time (as part of the test-retest procedures) reported slightly more needs after completing the S-CaSUN for the second time. This is in contrast to Hodgkinson et al., who reported a drop in needs over time [12]. It is possible that the first administration of the S-CaSUN prompted participants to reflect on their needs and thus contributed to the slight increase in scores. This phenomenon is reported in studies of this nature [1, 79].

Strengths and Limitations

We followed systematic and rigorous processes to culturally adapt and psychometrically evaluate the S-CaSUN [59]. Our findings provide initial support for the S-CaSUN as a suitable measure of the needs of HMCS. Statistical analysis illustrated strong psychometric properties with regard to the initial evidence of validity and reliability of the S-CaSUN, which can be exported and used in clinical trials with a much larger sample. Due to the sample size, we are not able to do more advanced psychometric evaluations of the S-CaSUN, such as factor analysis to assess multi-dimensionality of the instrument in this context. Research with a larger sample will accommodate psychometric tests, like confirmatory factor analysis, that are valuable for confirming factor structure and further evaluating the validity of the S-CaSUN. While we were able to successfully recruit HMCSs, participants were primarily recruited from a cancer center in west central Florida, an area that has a large concentration of Puerto Ricans and Cubans. Thus, a larger study with a more representative sample of Hispanics in the US (e.g., Mexicans) is warranted. Although initial validity and reliability assessments of the S-CaSUN indicate psychometric properties that are similar or better than those of the original CaSUN, the changes and modifications made to S-CaSUN [59] preclude the ability to make direct comparison between the S-CaSUN and the original CaSUN. Future research should also examine if needs such as those captured by the S-CaSUN predict future outcomes [20].

As the number of Hispanic cancer survivors increase, instruments with good psychometric characteristics are required to capture the needs of this growing population. Tools like the S-CaSUN can be used in the field of psycho-oncology to assess the supportive care needs of Hispanic cancer survivors and to identify the types of interventions and programs that could be most beneficial. In summary, our findings add to the sparse literature on cancer survivorship among Hispanic males and inform an evidence-based approach for the validation of cross-cultural measures.

Acknowledgments

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Table 1

Demographic characteristics of participants (N = 84)

	Mean (SD)
Age	59.6 (11.3)
Age at Diagnosis	56.3 (10.8)
Years from Diagnosis	2.82 (1.8)
S-CaSUN	25.76 (26.6)
FACT-GP	60.9 (15.8)
HADS-D	4.15 (3.9)
HADS-A	5.08 (4.2)

	Number of participants (N = 84)	%
Cancer Diagnosis		
Prostate	27	32.1
Lymphoid/Hematopoietic	15	17.9
Colorectal	10	11.9
Digestive	8	9.5
Head and Neck	7	8.3
Kidney	5	6.0
Other	12	14.3
Marital Status		
Married/Living with Partner	65	77.4
Single/Never Married	9	10.7
Divorced/Separated	8	9.5
Widowed	2	2.4
Highest Level of Education		
Less than High School	19	22.6
High School/Vocational School	38	45.2
College	17	20.2
Graduate Degree	10	11.9
Language Spoken		
Spanish Only	69	82
Bilingual (English/Spanish)	15	18
Language Received Cancer and Treatment Info		
English	36	43
Spanish	17	17
Both English and Spanish	31	31

	Mean (SD)	
Employment Status		
Employed	31	37.0
Retired	23	27.4
Unemployed	4	4.8
Other	5	6.0
Income		
Less than $10,000	13	15.5
$10,000 – $39,999	40	47.6
$40,000 – $79,999	9	10.7
Greater than $80,000	13	15.5
Prefer Not to Answer	6	7.1
Unknown	3	3.6
Insurance Status		
Had insurance	74	88.1
Length of Time in the US		
1–10 years	9	11
11–20 years	23	27
21+ years	20	24
Missing	32	38
Hispanic Origin		
Puerto Rico	28	33.3
Cuba	23	27.4
South and Central America	17	20.2
Mexico	7	8.3
Dominican Republic	5	6.0
Spain	4	4.8

Table 2

Correlations between Scores on the Spanish CaSUN and the HADS, FACT-GP Subscales, and Selected Demographic Variables

Scale/Subscale	Total Score Spanish CaSUN	P-value
HADS-Depression	0.55[a]	<0.001
HADS-Anxiety	0.60[a]	<0.001
QoL (FACT-GP)	−0.61[a]	<0.001
Physical QoL (FACT-GP)	−0.58[a]	<0.001
Social/Family QoL (FACT-GP)	−0.39[a]	<0.001
Emotional QoL (FACT-GP)	−0.48[a]	<0.001
Functional QoL (FACT-GP)	−0.56[a]	<0.001
English Proficiency	−0.14[b]	0.22
Length of Time in the US	−0.21[a]	0.18
Marital Status (Yes/No)	0.09[c]	0.28

[a] Pearson's (r),

[b] Spearman's (r_S),

[c] Point-biserial (r_{pb})

Table 3

Percentage of Participant Endorsement of Needs Items on the S-CaSUN (N = 84)

During the last month I have needed,	No	Yes, a little	Yes, Somewhat	Yes, a lot
1. Up to date information about my health. *Información actualizada sobre mi salud.*	63.1	4.8	14.3	17.9
2. Information relevant to my disease for my family/partner. *Información relevante a mi enfermedad para mi familia y/o pareja.*	76.2	4.8	9.5	9.5
3. Information presented in a way that I can understand. *Información en una forma que yo pueda entender.*	70.2	4.8	9.5	15.5
4. Better medical care. *Una mejor atención médica.*	87.5	3.6	6.0	4.8
5. Health care services available nearby. *Atención médica cercana disponible.*	75.0	8.3	11.9	4.8
6. To feel that my opinion is important to my doctor. *Sentir que mi opinión es importante para mi médico.*	54.8	9.5	16.7	19.0
7. To know that all my doctors talk to each other to coordinate my care. *Saber que todos mis médicos se comunican entre ellos para coordinar mi cuidado médico.*	54.8	8.3	3.6	33.3
8. To know that my worries regarding about my health are adequately addressed. *Que mis preocupaciones de salud sean tratadas adecuadamente.*	53.6	9.5	13.1	23.8
9. More information about the follow up care that I need and how often I should see the doctor. *Más información sobre el tipo de seguimiento que necesito y cuando debo ver al doctor.*	58.3	7.1	19.0	15.5
10. Help to know how to eat healthy *Ayuda para saber cómo comer saludablemente.*	64.3	4.8	14.3	16.7
11. Help to improve my physical condition, for example to know which types of exercise I can do. *Ayuda para mejorar mi condición física, por ejemplo cuales ejercicios puedo hacer.*	63.1	4.8	15.5	16.7
12. Access to alternative treatments such as yoga, massages, acupuncture, etc. *Acceso a tratamientos alternativos, como yoga, masajes, acupuntura, etc.*	66.7	9.5	11.9	11.9
13. Access to psychotherapy or other program that would help my mood. *Acceso a psicoterapia u otro programa para mejorar mi estado de ánimo.*	70.2	4.8	14.3	10.7
14. Help to stop smoking and/or drinking alcohol *Ayuda para dejar de fumar y/o tomar alcohol.*	94.0	0.0	6.0	0.0
15. Doctors and/or nurses to treat me in a warmer and/or friendlier way. *Que el trato de los médicos y/o las enfermeras sea más cálido y humano.*	84.3	3.6	6.0	6.0
16. Help to reduce stress.	66.7	8.3	13.1	11.9

During the last month I have needed,	No	Yes, a little	Yes, Somewhat	Yes, a lot
Ayuda para reducir el estrés.				
17. Help to manage the side effects and/or treatment complications.	69.0	4.8	10.7	15.5
Ayuda para controlar los efectos secundarios y/o complicaciones del tratamiento.				
18. Help to adjust to the changes in the quality of my life as a result of cancer.	61.9	7.1	10.7	20.2
Ayuda para adaptarme a los cambios en mi calidad de vida como resultado del cáncer.				
19. Help with having a family due to fertility problems.	90.5	0.0	4.8	4.8
Ayuda para procrear una familia debido a problemas de fertilidad.				
20. Help with getting and/or maintaining employment.	84.5	1.2	7.1	7.1
Ayuda para conseguir y/o mantener un empleo.				
21. Help to obtain information about financial support and/or government benefits.	59.5	4.8	7.1	28.6
Ayuda para obtener información sobre apoyo financiero y/o beneficios del gobierno.				
22. Help to get health insurance and/or to pay for treatment.	66.7	1.2	14.3	17.9
Ayuda para conseguir seguro de salud y/o para pagar mi tratamiento.				
23. Help with my concerns about the cancer coming back.	65.1	6.0	15.7	13.3
Ayuda con mis preocupaciones de que el cáncer regrese.				
24. Emotional support.	56.6	7.2	16.9	19.3
Apoyo emocional.				
25. Help to know how to support my partner and/or family.	63.1	6.0	17.9	13.1
Ayuda para saber cómo apoyar a mi pareja y/o familia.				
26. Help to deal with the impact that cancer has had on my relationship with my partner.	65.5	10.7	9.5	14.3
Ayuda para enfrentar el impacto que el cáncer ha tenido en mi relación de pareja.				
27. Help to adapt to the new role I play in my family.	67.9	7.1	11.9	13.1
Ayuda para adaptarme al nuevo rol que juego en mi familia.				
28. Help to develop new relationships with others after my cancer.	78.6	6.0	11.9	3.6
Ayuda para relacionarme con otras personas después del cáncer.				
29. To talk to others who have experienced cancer.	63.1	11.9	14.3	10.7
Hablar con otras personas que han tenido cáncer.				
30. Help to handle the topic of cancer in social and/or work situations.	78.6	7.1	9.5	4.8
Ayuda para tratar el tema del cáncer en situaciones sociales y/o en el trabajo.				
31. Help to adjust to how I feel about changes in my body.	66.7	6.0	10.7	16.7
Ayuda para adaptarme a como me siento sobre los cambios en mi cuerpo.				
32. Help to address problems with my/our sex life.	66.7	7.1	6.0	20.2
Ayuda con los problemas en mi vida sexual.				

During the last month I have needed,	No	Yes, a little	Yes, Somewhat	Yes, a lot
33. A counselor or social worker to whom I can go when needed. *Un consejero o trabajador social a quien pueda acudir cuando sea necesario.*	63.1	7.1	15.5	14.3
34. Help to move forward. *Ayuda para seguir adelante.*	71.4	8.3	9.5	10.7
35. Help to make decisions in times of uncertainty. *Ayuda para tomar decisiones en momentos de incertidumbre.*	71.4	6.0	14.3	8.3
36. Help to explore my spiritual beliefs. *Ayuda para fortalecer mis creencias espirituales.*	65.5	8.3	17.9	8.3
37. Help to make my life meaningful. *Ayuda para hacer que mi vida tenga sentido.*	68.7	7.2	15.7	8.4