Palliative and Supportive Care (2019), **17**, 150–158.

doi:10.1017/S1478951517000190

A qualitative study of the emotional and spiritual needs of Hispanic families in hospice

ALICIA NUÑEZ, M.P.H.,[1] JASON M. HOLLAND, PH,D.,[2] LISA BECKMAN, B.A.,[1]
ABBIE KIRKENDALL, PH.D.,[3] AND NORA LUNA, M.ED.[4]

[1]Department of Psychology, University of Nevada, Las Vegas, Nevada
[2]Department of Clinical Psychology, William James College, Newton, Massachusetts
[3]School of Social Work, University of Nevada, Las Vegas, Nevada
[4]Nathan Adelson Hospice, Las Vegas, Nevada

(RECEIVED June 16, 2016; ACCEPTED March 9, 2017)

ABSTRACT

Background: As the older U.S. population becomes more ethnically diverse, there will be an increased need for culturally sensitive hospice care services. Hispanics often experience multiple barriers to quality end-of-life care services.

Objective: To address the underlying disparities in the cultural, emotional, and spiritual aspects of hospice care, the objective of the present qualitative study was to examine the emotional and spiritual needs of Hispanic patients' families while in hospice.

Method: Semistructured in-person interviews were conducted with 29 Hispanic patients' families regarding their perceived experience of the hospice-based emotional and spiritual support received. Demographic information was collected on both the family member and the patient. Interviews were digitally recorded, transcribed, and analyzed using thematic content analysis.

Results: Participant narratives fell into five main themes: (1) the influence of Hispanic culture in the relationship with hospice care providers; (2) types of social support received from hospice; (3) barriers to receiving support; (4) lack of health literacy regarding hospice care; and (5) cultural preferences for religious/spiritual support in hospice.

Significance of Results: Our results provide insight into the specific emotional and spiritual needs of Hispanic families receiving hospice services. Our findings highlight that cultural values play an important role in the hospice care experiences of Hispanic families.

KEYWORDS: Hispanic, Hospice, End of life, Emotional support, Spirituality

INTRODUCTION

The older (aged 65 and older) Hispanic/Latino population in the United States is projected to experience a fivefold increase from 3.1 million in 2012 to 15.4 million in 2050 (Ortman & Velkoff, 2014). Given this anticipated growth, there is an increased need for hospice care providers to deliver culturally sensitive end-of-life care services. In order to better understand their cultural preferences and expectations, in this study we qualitatively examine Hispanic/Latino (hereinafter the term "Hispanic" is used to refer to people of Latin American or Spanish culture or origin) family members' experiences with emotional and spiritual support services in hospice.

Hospice care usually encompasses a broad range of services that includes palliative care, emotional support, and spiritual resources for terminally ill patients and their families. The provision of tangible and emotional support services to caregivers of hospice patients, typically family members of the patient, has been related to better psychological well-being for caregivers (Empeño et al., 2013; Teno et al., 2004). Despite the need to improve access to high-quality end-of-life services among underserved populations, research shows marked disparities in hospice care

---

Address correspondence and reprint requests to: Jason M. Holland, 1 Wells Avenue, Newton, Massachusetts 02459, USA. E-Mail: jmhollnd@gmail.com.

utilization among Hispanics (Cohen, 2008; Kreling et al., 2010; Colon, 2012; Taxis et al., 2008).

Language barriers and health literacy issues may exacerbate the underutilization of hospice care among Hispanics. It is known that language barriers between providers and patients limit access to health services (Johnson, 2013). Studies have found that many Hispanics have a limited knowledge of hospice and may harbor misconceptions about the type of services provided (Colon, 2012; Quinones-Gonzalez, 2013). Hispanics often also have to confront multiple barriers when accessing hospice care, such as lack of insurance, low physician referral rates to hospice services, family behaviors and beliefs (e.g., that a hospice referral signifies that they have given up on their ailing relative), and absence of culturally competent end-of-life care services (Carrion, 2010; Colon & Lyke, 2003; Colon, 2005; Periyakoil et al., 2015). Although the literature has identified some barriers to the use of hospice by Hispanics, further empirical work is needed to fully understand and address the underlying disparities in the cultural, emotional, and spiritual aspects of hospice care (Evans & Ume, 2012).

Typically, hospice care is delivered at home or in a dedicated facility and relies upon visiting nurses and family caregivers who assist with a patient's care needs. Therefore, effective patient–provider communication in combination with a culturally sensitive approach (i.e., acknowledging the possibility that culture might play a role in the patient's presenting problem [Sue & Sue, 2016]), is essential for the provision of high-quality hospice care (Crawley et al., 2002; Cruz-Oliver et al., 2015; Periyakoil et al., 2015). Previous research has suggested that good end-of-life care may be challenging as a result of cultural differences between the patient and healthcare providers and has emphasized the need for end-of-life practitioners to develop cultural sensitivity and competency (Crawley et al., 2002; Periyakoil et al., 2015). Cultural competency requires healthcare providers to have a set of knowledge and skills in order to effectively deliver care in crosscultural situations. Unfortunately, there is currently a dearth of knowledge about how culture might influence the hospice experience of Hispanics.

A recent study comparing Hispanic and non-Hispanic family members' satisfaction with various aspects of the hospice experience showed that in most domains Hispanic and non-Hispanic caregivers are comparably satisfied with the care that the patient and family receive. However, in this same study, family members of Hispanic patients were found to be more likely to report that hospice was inconsistent with the patient's wishes and that emotional and spiritual forms of support were insufficient (Holland et al., 2015). These findings highlight the need to address deficiencies in the emotional and spiritual aspects of hospice, especially when considering that religiosity/spirituality is generally embedded in Hispanic cultures (Campesino & Schwartz, 2006) and that the spiritual aspects of end-of-life care have been found to be relevant for Hispanic patients' families (Smith et al., 2009). For example, fatalism—a passive life outlook based on the belief that the future is not under personal control or that it is determined by God—may conflict with acceptance and use of hospice services (Cruz-Oliver et al., 2014; Kreling et al., 2010). Recent literature suggests that fatalism intertwined with religiosity/spirituality is a complex phenomenon and that believing the future to be in God's hands may actually serve as a source of emotional and spiritual comfort when confronted with serious or life-threatening illness (Gonzalez et al., 2015).

Understanding such sociocultural barriers as language and resources—e.g., *simpatía* (a pattern of social interaction emphasizing affection, harmony, and courtesy in interpersonal relationships; character that makes a person likeable or agreeable to others); *personalismo* (striving to promote closeness in interpersonal relationships; see Levine & Padilla, 1980); *familismo* (a strong orientation toward the family); and *allocentricism* (collectivist orientation), among others—might help address disparities in end-of-life care. Studies have suggested that familistic views influence expectations about family caregiving (Cruz-Oliver et al., 2014; Del Gaudio et al., 2013). Family-oriented and allocentric views have been found to influence the decision-making experiences of Hispanic hospice patient families but not the experiences of non-Hispanics (Cruz-Oliver et al., 2014; Kreling et al., 2010). Thus, addressing culture in end-of-life care disparities research may elucidate a more comprehensive understanding of the experiences of Hispanic families in hospice.

The present study aimed to examine the emotional and spiritual support needs of Hispanic hospice patients' families. Given the paucity of information on culturally sensitive and competent care in hospice, the present study employed a qualitative approach to provide detailed insights into the specific emotional and spiritual needs of Hispanic patients' families, with the intention of informing the development of effective hospice interventions for this population in the future.

METHODS

Participants and Recruitment

Our study was approved by the institutional review board at the University of Nevada, Las Vegas. All participants provided written informed consent. Eligible participants were family members of former patients at a large and well-established hospice in the Southwestern United States. All participants identified themselves as Hispanic, were at least 18 years of age, and had a family member in hospice for a minimum of two weeks. An interval of at least two months after a participant family member's death was allowed to pass in order to avoid recruitment during the acute stage of grieving. Recruitment was conducted in collaboration with the participating hospice. Potential participants were recruited via telephone by bilingual research assistants. Interested participants were scheduled for an in-person interview about their perceived experience of the hospice-based emotional and spiritual support services they received. All interviews took place in participants' homes.

Overall, 29 participants completed the interview. The sample mean age was 47.5 years ($SD = 14.0$). The average participant was a man (51.7%) with some education beyond a high school diploma (44.9%) who had lost a parent in hospice (62.1%) (see Table 1).

Data Collection

Prior to data collection activities, bilingual research assistants who conducted the interviews completed one-day training on semistructured qualitative interviewing and grief and bereavement reactions. All interviews were held in participants' preferred language (English or Spanish) and ranged from 10 to 50 minutes in duration. The interviews followed a semistructured format in which open-ended questions were utilized to elicit information on family caregivers' perspectives regarding the hospice-based emotional and spiritual support services received. Interview questions are reported in Table 2. Participants were asked to complete a demographic questionnaire and were given $20 in compensation for their participation.

Qualitative Data Analysis

Interviews were audiotaped, transcribed verbatim in their original language, and translated into English by bilingual research assistants. The translations were checked for accuracy by a second bilingual research assistant. The transcripts were then imported into RQDA, an R package for qualitative data analysis (Huang, 2014). Consistent with the principles of grounded theory (Glaser & Strauss, 1967), the qualitative analysis was characterized by an iterative coding process in which emergent themes were refined as the analysis progressed and organized into hierarchical clusters (Bradley et al., 2007; Hsieh & Shannon, 2005). Each transcript was reviewed line-by-line and divided into meaning units, which was operationalized as a set of words or sentences that conveyed a specific idea relevant to the research questions. The meaning units were then assigned codes capturing the thematic ideas expressed by study participants. A codebook describing all the emergent themes was developed. To ensure the accuracy of the coding process and reduce researcher bias, all meaning units were independently coded by two graduate-level researchers, with an interrater reliability of 0.84 as measured by Cohen's kappa (κ). Cohen's κ values ≥ 0.80 are indicative of very good agreement between raters (Cohen, 1960).

Table 1. *Sample characteristics* ($N = 29$)

Demographic characteristic	Family member *n* (%)	Hospice patient *n* (%)
Age, *M* (*SD*)	47.5 (14.0)	59.6 (25.4)
Women	15 (51.7)	17 (58.6)
Marital status		
Single	3 (10.3)	6 (20.7)
Married	19 (65.5)	10 (34.5)
Widowed	2 (6.9)	6 (20.7)
Divorced or separated	4 (13.8)	7 (24.1)
Other	1 (3.4)	–
Education		
< High school/GED	10 (34.5)	14 (48.3)
High school only	5 (17.2)	4 (13.8)
> High school/GED	13 (44.9)	9 (30.9)
Not reported	1 (3.4)	2 (6.9)
Relationship to deceased hospice patient		
Spouse	5 (17.2)	–
Adult child	18 (62.1)	–
Parent	5 (17.2)	–
Other relative	1 (3.4)	–
Religious affiliation		
Christian	5 (17.2)	3 (10.3)
Catholic	17 (58.6)	15 (51.7)
Mormon	3 (10.3)	4 (13.8)
Jehovah's Witness	2 (6.9)	1 (3.4)
Other	–	3 (10.3)
None	2 (6.9)	2 (6.9)
Not reported	–	1 (3.4)
Country of origin		
United States	11 (37.9)	11 (37.9)
Mexico	13 (44.8)	11 (37.9)
Central America	3 (10.3)	3 (10.3)
Other	2 (6.8)	3 (10.3)
Not reported	–	1 (3.4)
English as preferred language interview	17 (58.6)	–
U.S. residence in years, *M* (*SD*)	2.8 (1.1)	3.1 (1.1)

GED = General Education Development; *M* = mean; *SD* = standard deviation.

Table 2. *Summary of interview questions*

	Interview questions
Overarching question:	What are the most helpful and least helpful aspects of hospice-based emotional and spiritual support services for Hispanic families?
Additional questions:	Can you share with me your overall impressions/feelings about your experience here at hospice? How would you describe the emotional support you received from hospice? What is the best way in which hospice staff could make you feel emotionally supported? What does "spiritual support" mean to you? Can you describe the spiritual support that was offered? To what extent was this support helpful? Is there a way that hospice could have been more attentive to your spiritual preferences?

RESULTS

Five overarching themes, as presented in Table 3, emerged from the qualitative data that reflect the different experiences of Hispanic family members when receiving hospice-based emotional and spiritual support services. Subthemes within each of these overarching themes were derived to further illustrate the experiences of these families.

The Influence of Hispanic Cultures in the Relationship with Hospice Care Providers

Patient families' narratives regarding hospice care utilization highlighted how Hispanic cultural norms and values influenced their interaction with hospice care providers. Three subthemes were identified: simpatía, personalismo, and familismo.

Simpatía

Patients' families sought kindness and politeness in their interactions with care providers. They placed strong emphasis on engaging in positive interactions with nurses as opposed to relationships marked by hostility or conflict. Participants reported that having cordial interactions with staff was a source of emotional support:

> They treated me very good, both the social worker and the nurses. I didn't have anything like discrimination, and that was very good support to me.

In contrast, participants expressed discontent when staff did not endorse the attributes of simpatía:

> I wasn't happy with a nurse that was very rude to me. She fought with me in front of my mom.

Personalismo

Patients' families placed value on establishing rapport or building a personal, yet professional, relationship with hospice care providers. Practitioners with personalismo attributes displayed interest in the

Table 3. *Themes and subthemes*

Theme, definition	Subtheme
1. The influence of Hispanic cultures in the hospice care relationship, which included ways in which Hispanic cultural norms and values influenced the interactions between patients' families and hospice care providers.	Simpatía Personalismo Familism
2. Types of social support from hospice, which captured helpful types of social support participants received from hospice care providers.	Instrumental support Informational support
3. Barriers to receiving support, which included both psychological and practical impediments to receiving support.	Perceived psychological barriers Perceived structural barriers
4. Lack of health literacy regarding hospice care, which consisted of participant responses describing difficulties they had in understanding hospice care information.	Desire for education to guide caregivers Desire for education to understand dying process and medical options
5. Cultural preferences for religious/spiritual support in hospice, which included participants' responses that pertained to religious/spiritual support and the extent to which it fit with their cultural values.	Meaning of spiritual support Catholicism The church family Praying together Religious-oriented fatalistic beliefs

personal life of patients' families by: engaging in brief conversations, referring to patients and their family members by their first names, and displaying such socially acceptable physical contact as handshaking or hugging. Participants reported feeling emotionally supported when staff incorporated a personal approach to care delivery:

> [Care providers] would come and sit with us and talk to us. They seemed truly compassionate—they really did. They were supportive. It wasn't like they'd just come in and take her temperature and leave . . . They would hold her hand . . .

In contrast, when an approach lacked personalismo, participants expressed discontent. As one participant put it,

> I wanted [them] to seem like they cared . . . Hospice made me feel like I was just business.

Familismo

Participants placed value on maintaining a strong connection with the family and noted feeling a moral obligation to take care of their ailing relative. They emphasized the active role of extended family members as providers of emotional support: "All my family was here, and everybody was around me." Another feature of familismo was that families described feeling supported when hospice staff acknowledged the presence and importance of extended family.

Types of Social Support Received from Hospice

Patients' families reported receiving various types of support from hospice. Participants' accounts described the significance of receiving tangible assistance and reported feeling comforted emotionally when care providers offered support in ways that addressed their needs. Two subthemes were identified: instrumental and informational support.

Instrumental Support

Participants noted receiving various forms of tangible assistance, such as hands-on patient care, medication administration, provision of medical equipment, cleaning of patients' rooms, and coordination of funerary services. For example, one participant revealed that having a family member in hospice was debilitating and described the tangible help received in terms of assistance with hands-on patient care:

> We put him into hospice care. They immediately started cleaning him off because I didn't have the strength to undress him and wash him, and so they did all of that.

Additionally, participants in financial need recounted how hospice staff referred them to assistance programs or provided them with gift cards.

Informational Support

Families expressed feeling supported when the staff delivered information on patient care procedures, the symptoms associated with the dying process, and what to expect in hospice care. As one participant described,

> They tell you, they give you support in the moment. They talk to you, they tell you what to expect, this and that. They offer help.

Barriers to Receiving Support

Some participants expressed that they did not seek emotional support, even if counseling services or support groups were offered to them by hospice. Two subthemes were identified: psychological and structural barriers.

Perceived Psychological Barriers

Patients' families reported that they sometimes did not accept emotional support from care providers because they did not feel comfortable disclosing emotions in front of others or wanted to keep their feelings private. As one participant stated,

> I didn't take them [referring to emotional support services] because since the beginning I didn't want to share with others how I felt.

Perceived Structural Barriers

Some participants mentioned that they were unable to attend emotional support services due to barriers beyond their personal control. Transportation issues and schedule incompatibility originating from worktime conflict were cited as structural barriers to emotional support. As an example, one participant who had transportation problems (i.e., lack of car ownership and driving skills) noted,

> I wanted to go to this [support] group, but I never went, because I had no one to take me.

Lack of Health Literacy Regarding Hospice Care

Responses that dealt with health literacy referred to one's ability to understand health information in a way that allowed for family caregivers to feel confident in their role and navigate through hospice services. Two subthemes were identified: a desire for education to guide caregiver decisions and a desire for education to understand medical options.

Desire for Education to Guide Caregivers

Families described having little understanding of health information (e.g., about pain medication and side effects) and the difficulties involved in making informed decisions on how to best provide care for their ailing relative. For example, one participant mentioned that she did not know how to provide care for her father and highlighted the need to receive direct guidance from hospice staff:

> I think they should have someone come over to the house and stay for two [or] three hours, or come in the morning and evening to check on the patient, because sometimes we didn't know how to turn him. Since he couldn't move, we tried to move his body in a way that he wouldn't get bed sores and we [wouldn't] know how . . .

Desire for Education to Understand the Dying Process and Medical Options

Some families expressed a desire to receive more information on the dying process and the medical options that might be available for their ailing relative. As one participant put it,

> It would've been ideal to receive information [from staff] about the inevitable, like "Now we're beginning to see the first signs of deterioration, and here's what you can expect about the end."

Another participant who did not understand the options for pain management emphasized the need for health education to take place in order to improve quality of care in hospice:

> I would like [care providers] to give you more explanation of what each prescription does, and mostly morphine, because I have heard some horrible stories about morphine, and they just give you the bottle and say "give it as needed," but I'm not a doctor . . .

Cultural Preferences for Religious/Spiritual Support in Hospice

Patient families' narratives described the importance of receiving culturally sensitive religious/spiritual support services and voiced their preferences for receiving this type of support. Five subthemes were identified: (1) meaning of spiritual support, (2) Catholicism, (3) the church family, (4) praying together, and (5) religious-oriented fatalistic beliefs.

Meaning of Spiritual Support

Patients' families discussed spiritual support as comforting words and actions related to their family members' imminent death that were consistent with their religious/spiritual beliefs. As one participant reported,

> Spiritual support for my grandma was following through what she believed . . . We wanted to bring that one pastor she liked, but that didn't really work out. But it was good enough to have someone come from the church she liked to go to . . . So that's how we defined our spiritual support towards her passing.

Catholicism

Several families expressed the importance of receiving religious/spiritual support services that were consistent with Catholic beliefs and rituals. Participants emphasized the important role of priests as meaningful spiritual figures and discussed the comfort they received from Catholic spiritual practices (e.g., confession, communion, and anointing of the sick). As one participant remarked,

> For my peace of mind, the Catholic father came in and gave him last rites. That was very important because of our beliefs.

Furthermore, participants highlighted the significance of integrating cultural expressions of Catholicism into the hospice experience, such as using prayer candles, having images of the Virgin Mary, and having access to Spanish-speaking priests.

The Church Family

Patients' families described having a strong connection with and loyalty toward their church group or community. They viewed their church group as their spiritual family. Participants emphasized that their church family was an integral piece of the hospice experience by demonstrating solidarity beyond the provision of spiritual support:

> The spiritual support came from all my brothers and sisters [from church] that came to hospice … They'd bring us food every day … they wouldn't leave us without dinner or lunch.

Praying Together

Patients' families placed a strong emphasis on collective prayer. They described feeling spiritually supported when other people offered prayers for their relatives in hospice. Throughout their narratives, families highlighted the perceived healing power of praying together. As one participant indicated,

> My sister, mom, and I used to read a daily [biblical] text. Before I went to work, I used to pray with them. My sister and I talked about what we learned at our [church] meetings, and we would relate it to my mom.

Religious-Oriented Fatalism

This subtheme captured the experiences of families who drew upon their religious and fatalistic views to help them better understand and make sense of the hospice experience. They held the perspective that it was best to trust in God. Participants who endorsed religious-oriented fatalistic views found comfort in handing over the difficulties of the hospice experience to God:

> God is going to pick what is right and wrong for us. Only He knows. He keeps us strong. He never puts more in our plate than we can't [sic] handle. Usually, everything is for the best of us, so I can't interfere with that. Whatever He decides, the fate of my mom is what he decided.

The following narrative illustrates the distress experienced by a patient's family member when her religious-oriented fatalistic beliefs were not fully considered during patient–provider communication:

> A social worker told me that he only had five days left before he died, and there were times when I told her that I didn't believe in her words, because there is only one God, and I believe in God. I didn't pay attention to what she told me. That hurt me a lot.

DISCUSSION

Using a qualitative approach, we aimed to gain insight into the underlying disparities in the cultural, emotional, and spiritual aspects of hospice care by examining the emotional and spiritual needs of Hispanic patients' families while in hospice. Participants' narratives clustered around five themes: (1) the influence of Hispanic cultures in the relationship with hospice care providers; (2) the types of social support received from hospice; (3) barriers to receiving support; (4) lack of health literacy regarding hospice care; and (5) cultural preferences for religious/spiritual support in hospice.

Consistent with research addressing cultural sensitivity in healthcare delivery (Crawley et al., 2002; Periyakoil et al., 2015), our study highlights the need for hospice staff training in culturally sensitive ways of interacting with Hispanic families. Our findings suggest that practitioners who are sensitive to how culture influences patient families' views and perceptions about healthcare (which may or may not differ from their own values) and who incorporate culturally appropriate practices—such as simpatía, personalismo, and familismo—are more likely to be received positively by these families. Specifically, culturally effective end-of-life care practices included knowing what is culturally important and the ability to deliver (verbally and nonverbally) services congruent with patient families' cultural values, such as the use of healthcare management strategies to acknowledge the importance of extended family members.

In addition to training professionals in culturally sensitive and competent hospice care practices, members of the Hispanic community may also have an important role to play in offering health education and social support to these families. In health promotion efforts targeting disparities among Hispanics, the use of *promotoras de salud* (i.e., lay healthcare workers in the Hispanic community, hereinafter referred to as "promotoras") has been shown to be effective in increasing knowledge regarding access to healthcare resources and in providing health education among underserved populations (Balcazar et al., 2006). The integration of promotoras, who are typically knowledgeable about their communities' culture, into hospice care might be a promising approach. Promotoras could then serve as culturally competent liaisons between providers and Hispanic patients' families (Elder, 2003; Poag, 2010).

The participants in our study also indicated that, when appropriate support (e.g., information and tangible assistance) was offered, it had a positive impact on their hospice experience. Despite the helpfulness of these types of support, barriers were noted. Some barriers were psychological in nature (e.g., feeling hesitant to approach staff to get a family's needs met), and others were structural (e.g., transportation difficulties). One possibility for addressing these issues would be to develop psychoeducational materials about hospice that are presented in a familiar format for Hispanics. For instance, information about the benefits of hospice for their family, available resources, and ways of addressing potential barriers could be presented in the context of a *fotonovela* (i.e., an illustrated novel) and could be disseminated by promotoras or other healthcare personnel. Fotonovelas use photographs along with simple, engaging storylines to deliver psychoeducation in a culturally and linguistically appropriate manner (Flora, 1982; Ritter & Hoffman, 2010). Fotonovelas have been successful in reaching Hispanic populations and have served as health literacy tools for an array of physical and mental health problems (Hinojosa et al., 2011; Unger et al., 2013).

Finally, the important role of religion/spirituality in the hospice experience was echoed by many participants. It is notable that more than half of the families in our study identified as Catholic. This finding is congruent with reports indicating high rates of Catholicism among Hispanics (Suro et al., 2007). Thus, hospice staff working with Hispanic families would be well advised to pay careful attention to the religious/spiritual beliefs of patient families and offer care that is consistent with their faith, or at least not contradictory. Our findings show that offering services that are not consistent with religious-oriented fatalistic beliefs may be challenging and that practitioners should strive to communicate in a way that respects the beliefs of patients and their families. Additionally, allocentricism and familismo form part of the religious/spiritual perspectives of these families. They often prioritized collective prayer over individualistic expressions of religion/spirituality. Hospice-based spiritual support services may be enhanced by acknowledging that patients' families may find strength in collective prayer and recognizing the important role of their *church family* in fostering resilience.

LIMITATIONS OF THE STUDY

Our sample was limited to Hispanic patients' families recruited at a single hospice care institution, and no data were collected on type of insurance and income, which restricts the generalizability of our findings. Another limitation was the use of interviewer-administered open-ended questions, which could have introduced self-report and/or social desirability bias from participants. Given our qualitative research design, we recruited a relatively small sample compared to quantitative studies, which limited our ability to examine how responses varied across relevant factors, such as cause of death. However, a smaller sample size allowed for in-depth study of Hispanic families' preferences with regard to spiritual and emotional support services in hospice. In addition, each interview was analyzed independently by two coders to enhance methodological rigor and strengthen the reliability of our results.

CONCLUSIONS

Despite these limitations, the findings of our study highlight the important role of culture in the hospice experience and have implications for the development of culturally sensitive hospice care services for Hispanic families. To improve the quality of care for these families, practitioners would do well to pay particular attention to socioeconomic needs, psychosocial barriers, and cultural preferences in patient care. Although additional research is needed to reduce disparities in hospice care, our study provides an in-depth examination of Hispanic families' preferences for end-of-life care, which may guide the development of culturally competent hospice care models.

ACKNOWLEDGMENTS

This study was supported by a doctoral graduate research award given to Drs. Jason M. Holland and Abbie Kirkendall by the Graduate College at the University of Nevada, Las Vegas.

REFERENCES

Balcazar, H., Alvarado, M., Hollen, M.L., et al. (2006). Salud para su Corazon–NCLR: A comprehensive Promotora outreach program to promote heart-healthy behaviors among Hispanics. *Health Promotion Practice*, *7*(1), 68–77.

Bradley, E.H., Curry, L.A. & Devers, K.J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research*, *42*(4), 1758–1772. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955280/pdf/hesr0042-1758.pdf.

Campesino, M. & Schwartz, G.E. (2006). Spirituality among Latinas/os: Implications of culture in conceptualization and measurement. *Advances in Nursing Science*, *29*(1), 69–81. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2758774/.

Carrion, I.V. (2010). When do Latinos use hospice services? Studying the utilization of hospice services by Hispanics/Latinos. *Social Work in Health Care*, *49*(3), 197–210.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *20*, 37–46. Available from http://www.garfield.library.upenn.edu/classics1986/A1986AXF2600001.pdf.

Cohen, L.L. (2008). Racial/ethnic disparities in hospice care: A systematic review. *Journal of Palliative Medicine*, *11*(5), 763–768.

Colon, M. (2005). Hospice and Latinos: A review of the literature. *Journal of Social Work in End-of-Life & Palliative Care*, *1*(2), 27–43.

Colon, M. (2012). Acculturation and attitudes of Latinos toward hospice. *Journal of Social Work in End-of-Life & Palliative Care*, *8*(3), 229–248.

Colon, M. & Lyke, J. (2003). Comparison of hospice use and demographics among European Americans, African Americans, and Latinos. *The American Journal of Hospice & Palliative Care*, *20*(182), 182–190.

Crawley, L.M., Marshall, P.A., Lo, B., et al. (2002). Strategies for culturally effective end-of-life care. *Annals of Internal Medicine*, *136*(9), 673–679.

Cruz-Oliver, D.M., Talamantes, M. & Sanchez-Reilly, S. (2014). What evidence is available on end-of-life (EoL) care and Latino elders? A literature review. *The American Journal of Hospice & Palliative Care*, *31*(1), 87–97. Epub ahead of print Mar 15, 2013.

Cruz-Oliver, D.M., Malmstrom, T.K., Fernández, N., et al. (2015). Education intervention "Caregivers Like Me" for Latino family caregivers: Improved attitudes toward professional assistance at end-of-life care. *The American Journal of Hospice & Palliative Care*, *33*(6), 527–536. Epub ahead of print May 27.

Del Gaudio, F., Hichenberg, S., Eisenberg, M., et al. (2013). Latino values in the context of palliative care: Illustrative cases from the family focused grief therapy trial. *The American Journal of Hospice & Palliative Care*, *30*(3), 271–278. Epub ahead of print Jun 5, 2012.

Elder, J.P. (2003). Reaching out to America's immigrants: Community health advisors and health communication. *American Journal of Health Behavior*, *27*(Suppl. 3), S196–S205.

Empeño, J., Raming, N.T., Irwin, S.A., et al. (2013). The impact of additional support services on caregivers of hospice patients and hospice social workers. *Omega*, *67*(1–2), 53–61. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4041323/.

Evans, B.C. & Ume, E. (2012). Psychosocial, cultural, and spiritual health disparities in end-of-life and palliative care: Where we are and where we need to go. *Nursing Outlook*, *60*(6), 370–375. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3496155/.

Flora, C. (1982). The fotonovela in America. *Studies in Latin American Popular Culture*, *6*, 15–26.

Glaser, B.G. & Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.

Gonzalez, P., Nuñez, A., Wang-Letzkus, M., et al. (2015). Coping with breast cancer: Reflections from Chinese American, Korean American, and Mexican American women. *Health Psychology*, *35*(1), 19–28. Epub ahead of print Sep 21. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4695243/.

Hinojosa, M.S., Nelson, D., Hinojosa, R., et al. (2011). Using *fotonovelas* to promote healthy eating in a Latino community. *American Journal of Public Health*, *101*(2), 258–259. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3020205/.

Holland, J., Keene, J., Kirkendall, A., et al. (2015). Family evaluation of hospice care: Examining direct and indirect associations with overall satisfaction and caregiver confidence. *Palliative & Supportive Care*, *13*(4), 901–908. Epub ahead of print Jul 3, 2014.

Hsieh, H. & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Huang, R. (2014). *RQDA: R-Based Qualitative Data Analysis*. R Package, Version 0.2–7. Available from http://rqda.r-forge.r-project.org/.

Johnson, K.S. (2013). Racial and ethnic disparities in palliative care. *Journal of Palliative Medicine*, *16*(11), 1329–1334. Epub ahead of print Sep 27. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3822363/.

Kreling, B., Selsky, C., Perret-Gentil, M., et al. (2010). "The worst thing about hospice is that they talk about death": Contrasting hospice decisions and experience among immigrant Central and South American Latinos with U.S.-born white, non-Latino cancer caregivers. *Palliative Medicine*, *24*(4), 427–434. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3570252/.

Levine, E.S. & Padilla, A.M. (1980). *Crossing Cultures in Therapy*. Belmont, CA: Wadsworth.

Ortman, J.M. & Velkoff, V.A. (2014). *An Aging Nation: The Older Population in the United States*. Publication No. P25–1140. Washington, DC: U.S. Census Bureau. Available from https://www.census.gov/prod/2014pubs/p25-1140.pdf.

Periyakoil, V.S., Neri, E. & Kraemer, H. (2015). Patient-reported barriers to high-quality, end-of-life care: A multiethnic, multilingual, mixed-methods study. *Journal of Palliative Medicine*, *19*(4), 373–379. Epub ahead of print Nov 17.

Poag, G.O. (2010). *On the Border: Cultural Competency with Hispanics in Hospice*. Eau Claire, WI: PHC Publishing Group.

Quinones-Gonzalez, S. (2013). Bridging the communication gap in hospice and palliative care for Hispanics and Latinos. *Omega*, *67*(1–2), 193–200.

Ritter, L. & Hoffman, N. (2010). *Multicultural Health*. Burlington, MA: Jones & Bartlett Learning.

Smith, A.K., Sudore, R.L. & Pérez-Stable, E.J. (2009). Palliative care for Latino patients and their families: Whenever we prayed, she wept. *The Journal of the American Medical Association*, *301*(10), 1047–1057. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2782583/.

Sue, D.W. & Sue, D. (2016). *Counseling the Culturally Diverse: Theory and Practice*, 7th ed. New York: John Wiley & Sons.

Suro, R., Escobar, G., Livingston, G., et al. (2007). *Changing Faiths: Latinos and the Transformation of American Religion*. Washington, DC: Pew Research Center. Available from http://www.pewforum.org/2007/04/25/changing-faiths-latinos-and-the-transformation-of-american-religion-2/.

Taxis, J.C., Keller, T. & Cruz, V. (2008). Mexican Americans and hospice care: Culture, control, and communication. *Journal of Hospice & Palliative Nursing*, *10*(3), 133–141.

Teno, J.M., Clarridge, B.R., Casey, V., et al. (2004). Family perspectives on end-of-life care at the last place of care. *The Journal of the American Medical Association*, *291*(1), 88–93. Available from http://jamanetwork.com/journals/jama/fullarticle/197944.

Unger, J.B., Cabassa, L.J., Molina, G.B., et al. (2013). Evaluation of a fotonovela to increase depression knowledge and reduce stigma among Hispanic adults. *Journal of Immigrant and Minority Health*, *15*(2), 398–406. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602405/.