Cross-Cultural Aspects of Cancer Care

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Life and death, emotion and social support, stress and disease are universal human concerns. The diagnosis of cancer induces a human dread that is grounded in our biological being. Nonetheless, the experience of cancer and its treatment is inevitably influenced by cultural, ethnic, economic, and religious differences. In some cultures, the diagnosis of cancer conveys a greater sense of shame than others. Only recently have Japanese cancer patients been willing to make public declarations of their disease status, forming heretofore unheard of support groups such as “Akai Bono Kai.” Cultural concerns about modesty and sexuality, or cultural acceptance of a fatalistic approach to life may inhibit screening activities in certain cultures, such as among Chinese and Latina women.1-3 Direct talk about the future that might make an American cancer patient feel respected and involved in treatment could seem to a Chinese cancer patient a self-fulfilling prophesy of doom. De Toqueville described Americans as a “nation of joiners.” We tend to be relatively direct and open, inclined to discuss problems and try to solve them. At the same time, we do not like to admit to having problems, and often lose ourselves in work and other activities when confronted with threats to health. Our desire for openness and shared decision-making in medical care is not entirely consistent with our belief in success, in
transcending any obstacle and our reluctance to “give in” to illness or failure. Thus, while the problems associated with cancer are universal: fear of death, loss of social roles and physical abilities, and treatments that can cause mutilation, fatigue, cognitive impairment, nausea, menopause, and weight changes, the ramifications of these problems are magnified or mitigated by cultural and social context. The treatments that have been developed to provide social and emotional support in one cultural context cannot automatically be assumed to work in a different cultural context. In some cases, the differences are primarily in the process of engaging the patient in treatment. For example, Latina women with cancer are reluctant to enter a program of treatment without initial review and approval of their husbands, while European and American women would resent such a process of initiation. In other cultural situations, elements of intervention must be added or deleted to respect feelings or redress specific cultural problems.

Our approach in this chapter is to examine one intensive and well-studied program of psychosocial support for cancer patients, Supportive/Expressive group therapy, and contrast and compare its utilization in two rather different cultures: China and France. The supportive/expressive approach to helping cancer patients has been tested in a number of different cultures: France, Canada, Australia, and Hong Kong, China among others. While there are important differences in these cultures in the propensity to openly discuss problems, or even admit to having cancer, this approach has been found to work in reducing distress and pain. The fundamental human need to surround oneself with support, express the strong emotions associated with illness, confront existential concerns, reorder priorities in life, improve family support, clarify communication with physicians, and control symptoms such as pain and anxiety transcends cultural differences. Nonetheless, important cultural differences in how to introduce, conduct, and evaluate the effects of supportive/expressive group therapy require further research. We first present the model as developed in the United States over the past 25 years, and then place it in cultural context by exploring differences in the model in contrasting cultures. This approach is designed to construct a dialectic between the synchronic, or relatively invariant components of intervention, and the diachronic, or relatively culturally specific elements, analogous to the approach of Levi-Strauss.

**ESSENTIALS OF SUPPORTIVE-EXPRESSIVE PSYCHOTHERAPEUTIC INTERVENTION DEVELOPED IN THE UNITED STATES**

Our supportive/expressive intervention model has been extensively tested among women with breast cancer and women and men with HIV infection,