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# Perceptions of Food and Eating Among Chinese Patients With Cancer

## Findings of an Ethnographic Study

### KEY WORDS

Chinese patients

Diet

Eating

Ethnography

Food

Support groups

This article explores the ways that participants in a Chinese cancer support group talk about food, diet, and eating. An ethnographic research design was used, including participant observation at a Chinese cancer support group over an 8-month period and key informant interviews with 7 members of the group. Food, eating, and diet were a recurrent focus of discussion at support group meetings throughout the fieldwork period. The ways in which support group participants talked about food centered on 3 distinct but interconnected themes: the prevalence of eating issues as an adverse effect of cancer and its treatment, the importance of eating ability, and questions and concerns connected with the differing and often contradictory cultural models of diet that they were exposed to. Culturally specific understandings of the relationship between food and health informed Chinese patients' experience of eating issues during cancer treatments and their ongoing concern with food and nutrition after the completion of treatment. Health professionals need to pay more attention to the meanings and attributes of food and eating beyond their physiological properties, and further research needs to be conducted with other immigrant populations with culturally distinct understandings of food.

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## Cancer and the Social Meanings of Food and Eating

The direct consequences of food consumption are biological; food is consumed to meet the energy and nutrient needs of the body. However, food plays many other roles—food rituals and dietary practices are shaped by numerous social, cultural, economic, lifestyle, and other factors.<sup>1</sup> Although anthropologists and sociologists have studied the symbolic and cultural meanings of food and eating,<sup>2-5</sup> there has been little investigation on the role of food in the context of illness.<sup>6</sup> As Hughes and Neal note, “[t]he nature and purpose of food in human societies is not often imported into health care practice, where eating is seen from a medical rather than anthropological perspective.”<sup>7(p1101)</sup>

Oncology is one health setting wherein food and eating difficulties are particularly salient. Cancer treatments such as radiation and chemotherapy may affect patients’ ability to eat and their interest in food. However, although eating difficulties and appetite loss are well-documented adverse effects of cancer treatments, they are generally not deemed to be particularly distressing for patients (as a generalized category), and studies of quality of life (QOL) in chemotherapy patients have suggested that adverse effects such as nausea, fatigue, and loss of hair have a far more substantial impact on patients.<sup>8-11</sup> Thus, little available research explores patient perceptions and experiences of food and eating issues, although 2 recent studies do highlight the impact of radiation<sup>12</sup> and chemotherapy<sup>13</sup> on patients’ ability to partake in meals and the negative social consequences that this entails.

An area of oncology where there has been more widespread recognition of the meanings of food and eating is palliative care because of the high prevalence of weight loss (cachexia) and appetite loss (anorexia) among patients with advanced cancer.<sup>6,14</sup> Studies have shown that caregivers often experience more distress than patients do, and appetite loss may be a substantial cause of conflict between patients and caregivers.<sup>6,14-19</sup> As Hughes and Neal note, “[i]f the seeking of food is a biological imperative, the giving of food also takes on a social imperative, food becoming symbolic of the relationship between the giver and the receiver.”<sup>7(p1103)</sup> Thus, when people with advanced cancer are unable to consume food, caregivers cannot express love and support through the preparation of meals.<sup>7,16</sup>

In light of this evidence regarding the social and cultural meanings of food, it is likely that cancer patients from different cultural backgrounds will have culturally specific understandings of the eating issues connected with cancer and may experience heightened levels of distress as a result. Unfortunately, cultural differences in people’s reaction to eating difficulties have been given little consideration in the fields of oncology nutrition and psychosocial oncology despite the existence of large immigrant populations in North America that have culturally distinctive views of food—such as the Chinese.

### Food and Eating in the Chinese Culture

According to Chang,<sup>20</sup> few other cultures are as food oriented as the Chinese, and food is at the center of social life. As Liu

notes, “[e]ating is not just meant to fill the stomach; having food at one’s disposal, being able to consume a good amount of food, and knowing what to eat and how to eat are all viewed as good ‘fortune.’”<sup>21(p1)</sup> There are frequent references to food in conversations among Chinese of all dialect groups; “have you eaten?” is a common greeting.<sup>22</sup> The Cantonese folk expression “to be able to eat is a blessing” (*sik dug hai fook*) clearly spells out the view that eating transcends physiological needs and encompasses psychological, spiritual, and social dimensions.

Food is also seen to be intimately related to health, and many foods are considered to have curative value,<sup>20,21</sup> especially among Cantonese speakers in the South.<sup>23,24</sup> In the Chinese system, the notion of balance between the forces of yin and yang guides the classification and use of food for medicinal purposes; thus, hot-cold, wet-dry, and tonic-poisonous are categories ascribed to different foodstuffs on the basis of the effects they have on the human body.<sup>25-30</sup> In the case of cancer, certain foods are seen to “cause” the disease, whereas other foods are beneficial in helping to “fight” it.<sup>31-33</sup>

Chinese beliefs emphasizing the role of food in maintaining health have been found to be dominant among migrant communities in countries such as Australia,<sup>30</sup> United States,<sup>34</sup> and United Kingdom.<sup>27,35</sup> However, despite the centrality of food and eating to Chinese life and perceptions of well-being, there have been few studies in the field of oncology that have explored the impact of eating difficulties on Chinese patients with cancer. Nevertheless, several studies of Chinese patients with cancer have highlighted the importance of eating to QOL,<sup>36,37</sup> and one recent study has focused on the relationship between eating ability and QOL among Chinese patients with cancer. Wong and Fielding<sup>38</sup> assessed longitudinal changes in eating function and QOL in 1,079 Chinese patients with cancer in Hong Kong who were diagnosed with breast, liver, lung, and nasopharyngeal carcinomas. They found eating and appetite to be significant predictors of QOL among patients enrolled in the study. This association was found for all cancer sites, and results remained significant after adjusting for major clinical variables such as pain and depression. Their research findings highlight the importance of conducting further research into perceptions of food and eating among Chinese patients with cancer.

This article will explore the ways that participants in a Chinese cancer support group talk about food, diet and eating and will highlight the cultural meanings of food and eating. It forms part of a larger comparative ethnographic study on cancer support groups that seeks to understand more about the dynamics of such groups and how they differ based on the gender, cultural background, cancer stage, and cancer site of the participants. Four cancer support groups were included in the study: the Chinese group, a prostate group, a colorectal group, and a group of women with metastatic cancer. However, early in the analysis, it was apparent that participants in the Chinese cancer support group expressed specific ideas and issues regarding food and eating that were not present in the accounts of participants in the other groups included in the study. Therefore, the data on food and eating from the

Chinese cancer support group were extracted and analyzed and formed the basis of this article.

## ■ Methods


### Participants

The research setting was a professionally facilitated support group for Cantonese-speaking patients with cancer and their families held at a cancer treatment center in western Canada. The purpose of the support group, which met monthly for 2 hours, was to provide psychoeducation and emotional support. Meetings were generally divided into an information/lecture component, which included presentation of topics such as cancer care resources, pain and symptom management, community home care, and meditation techniques. The support component was for open discussion about topics and concerns that emerged from the participants. During the 8-month fieldwork period (September 2007 to April 2008), 7 meetings were held, with an average attendance of 21 participants at each meeting. Of the 96 participants who attended the group during the fieldwork period, 36% (n = 35) were males and 64% (n = 61) were females (see Table 1). The group consisted of 59 (61%) patients and 37 (39%) family members (including spouses, children, siblings, parents, and parents-in-law), and often, more than one member of the family would accompany patients to meetings.

### Research Design

An ethnographic research design was used for this research. Ethnographic research entails the study of groups and people as they go about their everyday lives. "The ethnographer participates in the daily routines of this setting, develops ongoing relations with the people in it, and observes all the while what is going on."<sup>39(p1)</sup> This emphasis on the context of attitudes and behaviors provided by ethnographic methods has demonstrated substantial value in the field of health research. As Oliffe and Bottorff note, "using a cultural lens, ethnographers have been able to interpret and describe lay health and illness beliefs, explain disparities between patient and medical perspectives, and create new understanding that offer ways to bridge, negotiate, and translate between popular, folk, and professional sectors."<sup>40(p104)</sup> Indeed, previous ethnographic research on cancer support groups has provided an important window into patients' understanding of cancer<sup>41,42</sup> and the meanings, functions, and operation of such groups.<sup>43-46</sup>

Another key benefit of ethnographic methods is the way that research questions and findings are driven by the fieldwork itself. As Kapferer notes, "[p]erhaps the single most important dimension of the anthropological ethnographic emphasis is the primacy given to the ethnographic over the conceptual, interpretational or the abstract-theoretical."<sup>47(p81)</sup> This "method of statistic documentation by concrete evidence"<sup>48(p17)</sup> allows ethnographers to "maximise the validity of our research in ways that questions generated in offices or

 **Table 1 • Characteristics of Chinese Support Group Participants**

Characteristic	N	% <sup>a</sup>
First language		
Cantonese	84	87.5
Mandarin	12	12.5
Sex		
Male	35	36.5
Female	61	63.5
Role		
Patient	59	61.5
Caregiver	37	38.5
Attendance		
Regular <sup>b</sup>	5	5.2
Once	57	59.4
Sporadic	34	35.4
Cancer type <sup>c</sup>		
Lung	9	17.3
Breast	16	30.8
Prostate	5	9.6
Stomach	1	3.7
Nasopharyngeal	8	15.4
Pancreatic	1	3.7
Colorectal	6	11.5
Gynecological (cervix, uterus)	2	3.8
Liver	1	3.7
Lymphoma	2	3.8
Leukemia	1	3.7
Treatment stage <sup>d</sup>		
Pretreatment	5	10
In treatment	30	60
Posttreatment	15	30
Prognosis <sup>e</sup>		
Palliative	10	22.2
Nonpalliative	35	77.8

<sup>a</sup>All calculation based on N = 96, unless otherwise stated.

<sup>b</sup>Present at each meeting, missing no more than 2 consecutive meetings.

<sup>c</sup>Percentage per cancer type based on N = 52.

<sup>d</sup>Percentage per treatment stage based on N = 50.

<sup>e</sup>Percentage per prognosis based on N = 45.

laboratories, or by persons unfamiliar with cultural realities, simply cannot."<sup>49(p281)</sup>

### Data Collection and Analysis

A cancer treatment agency research ethics board provided approval for this study. Before conducting the fieldwork, approval was obtained from the Chinese support group facilitator (an oncology social worker in the cancer treatment center), and K. B. and J. L. attended a support group meeting to explain the goals of the project to the group members and ascertain their level of interest in taking part in the study. The group members present at the meeting were very enthusiastic about the project and provided verbal consent for the research; based on this positive response, fieldwork was initiated. K. B., a medical anthropologist, provided J. L. with training in ethnographic methods, and J. L. conducted the fieldwork and

interviews under K. B.'s supervision. J. L. is of Chinese origin and is proficient in English, Cantonese, and Mandarin.

As the support group has a drop-in format, obtaining informed consent from the group participants was an ongoing challenge. To facilitate the consent process, a number of measures were undertaken. First, before each scheduled meeting, the facilitator attached an addendum to her e-mailed reminder notice that provided information regarding the project and requested members to contact her if they were uncomfortable with J. L.'s presence at the meetings. Second, J. L. approached new members at the beginning of meetings to explain the project and give them written information (in Chinese) about the study. Third, during each meeting, J. L. introduced herself and reminded participants of her presence in the group. Immersion in the research setting involved participation in and observation of the monthly cancer support group meetings (n = 7) held over the fieldwork period. Because of the group's drop-in format, the researchers and the facilitator decided that it would not be appropriate to audiotape the meetings. Rather, observational data were recorded in a notebook during the group meetings and written up into full field notes after the meetings.

Aside from participant observation at the support group meetings, key informant interviews ranging from 1 to 2 hours were conducted with 7 group members to seek further "clarification, explanation and validation"<sup>43(p473)</sup> of the fieldwork data. Key informants received a nominal honorarium (a \$20 gift card) to acknowledge their time and contribution to the study. With the written consent of the informants, written notes of all interviews were taken; only 4 of the 7 interviews were recorded, in keeping with the stated preferences of interviewees. All interviews were conducted in Cantonese and covered basic questions including demographic information, personal experience of cancer, cultural issues for Chinese patients with cancer, and patients' views on the support group itself. Information pertaining to food, eating, and dietary practices was not explicitly elicited in the interviews, as this was not the focus of the research. However, a number of informants voluntarily raised this topic—which provides further evidence of the importance of this issue to members of the group.

The data analysis software program Nvivo 8 (QSR International) was used in the initial stages of analysis to facilitate coding of the data. All coded material dealing with food, diet, and eating was then extracted and subjected to thematic analysis.<sup>50</sup> Each member of the research team separately read the coded material and classified it into key themes to triangulate the findings and increase the validity of the analysis. The final themes represent areas that all 3 authors identified as primary.

## ■ Results

Food, eating, and diet were a recurrent focus of discussion at support group meetings throughout the fieldwork period and were also spontaneously raised in several key informant interviews. The ways in which support group participants

talked about food centered on 3 distinct but interconnected themes: the prevalence of eating issues as an adverse effect of cancer and its treatment, the importance of eating ability, and questions and concerns connected with the differing and often contradictory cultural models of diet that they were exposed to.

## Prevalence of Eating Issues Among Cancer Patients

Chinese patients with cancer, posttreatment survivors (*hong fook jie*), and family members in the support group consistently raised eating difficulties as a key issue throughout the fieldwork period, as the following selection of quotes demonstrate.

In response to a question about the side effects of radiation Ling [all names are pseudonyms] explains that she experienced tiredness, loss of appetite, and difficulty in swallowing (colorectal cancer survivor, 70s).

Victoria says that while she did not experience any discomfort in the first two days after treatment, her ability to eat was substantially affected after the treatment, when she had severe sores in her mouth area. She adds that she is very thankful to her family, who carefully prepared food in such a way (mixing in small portions) that would allow her to eat without aggravating the pain (colorectal cancer survivor, 50s).

Roger, a prostate cancer patient (70s), asks Sam, another prostate cancer patient (50s), about his appetite following treatment. Sam says he has been able to eat but this is not the case for people with nasal cancer undergoing radiation, which interferes with food intake. Sara (nasopharyngeal cancer survivor, 40s) says that she was not able to eat at all, after 10 rounds of radiation.

Li says he has been diagnosed with nasal cancer and is in treatment. He tells the group that he is unable to swallow and has not been eating well, after receiving 21 rounds of treatment (nasopharyngeal cancer patient, 60s).

Paul talks about the fact that he has undergone over 70 bouts of radiation and he has not been able to eat properly for the past seven years (prostate and nasopharyngeal cancer survivor, 70s).

Wei says that she is not able to sleep and has problems eating. She begins to weep, looking very distressed. She adds that she wants to receive help in addressing these two concerns (stomach cancer patient, 60s).

June (caregiver of spouse with lung cancer), looking distressed, asks what food she can prepare for her husband, who is not eating well at all. Ling and Bobby (fellow patients) both urge June not to be concerned with her husband's loss of appetite. They recall that they completely lost their sense of taste following treatment (likening all food to tasting "like water") [*ho qi sui*]. They further advise June that patients should be free to not eat when they do not feel like eating.



Overall, many participants (men and women and patients and family members) expressed difficulties relating to food intake, which they associated with the adverse effects of the cancer treatments. Importantly, participants with a variety of cancers highlighted eating issues, not merely those patients with cancers wherein eating difficulties are a well-documented adverse effect of treatment (such as radiation therapy for nasopharyngeal cancer patients).

## Importance of Eating Ability

Although eating was frequently raised as a troublesome adverse effect of treatment among individual cancer patients, group members collectively emphasized the importance of eating ability to well-being. Thus, in one meeting,

Sam speaks of his initial fear of dying, adding that it is very important that one could sleep well, as well as eating well (prostate cancer patient, 50s).

In another meeting where an oncology nurse had been invited to speak about palliative care, the importance of eating was highlighted on several occasions, as this extended fieldwork excerpt shows:

*Chinese cancer support group meeting 3.* When the oncology nurse asks the group to brainstorm ideas associated with a “good death,” the phrases mentioned include “no pain,” “breathing,” “family/friends,” “not to be a burden to others,” “able to sleep/rest well,” “able to eat...” When she [the oncology nurse] asks the group what they believe to be the most frequent complaint of cancer patients, suggestions brainstormed include “pain, can’t eat, time stop, worry about family.” The nurse then clarifies that the most common complaint is “fatigue,” and she expounds on the idea of “conserving energy.” The conversation then turns to a discussion of pain when the nurse provides an explanation of “total pain,” including its “physical, emotional, existential/spiritual” dimensions.

The importance of eating well and the distress caused by the loss of this ability were also poignantly highlighted at the following meeting where an extended discussion took place about food, diet, and eating.

*Chinese cancer support group meeting 4.* Jennifer shares about her lack of appetite and her interest to hear from others the ways she can improve her food intake. The ten remaining group participants each give suggestions to Jennifer, including specific Chinese food, ways of preparing it, and Chinese herbs noted to be helpful for cancer patients. Jennifer comments that she has already explored the different options outlined, but her condition has not improved. She adds that she has “given up” [*fong hei*] on Chinese herbs and adheres to her doctor’s prescription, given that the two methods of treatment often “conflict” [*chong dug*] with each other. Jennifer continues that she has tried practicing qigong in the past, which she has found helpful. However, her current condition is too weak for her to continue with the exercise.... She comments that she “can’t do much

now” [*zhou hm dou mug*], smiling wryly and staring at the floor as she speaks. She reiterates quietly that she would still want to be able to eat, which she believes to be most important to her health.

More suggestions are offered to Jennifer on ways to facilitate her food consumption, including taking medication to prevent vomiting and ways of eating. A few participants highlight the importance of having rice in her diet, narrating stories of how individuals during the severe acute respiratory syndrome outbreak survived solely on the consumption of rice. The participants then give advice on ways to prepare rice to facilitate consumption. Jennifer comments that having nutritious food is equally important, and the other participants agree on the importance of a balanced diet.

Overall, many group members associated food and eating with health and well-being, and the ability to eat was often seen to be primary to QOL. Thus, when participants raised such concerns, they were often greeted with a litany of suggestions, advice, and guidance on how they could improve food intake.

## Conflict Between Chinese and Western Dietary Practices

As the previous field note excerpt highlights, group members also frequently expressed dietary concerns and were acutely aware of the “conflict” between Chinese and Western practices. Interestingly, this perceived conflict was often seen to revolve particularly around food—as became apparent when a dietitian from the cancer treatment agency attended a meeting to ask group participants to fill out a survey relating to their dietary needs.

*Chinese cancer support group meeting 5.* Towards the close of the meeting a woman who is clearly from the agency staff enters the room and the facilitator introduces her as a dietitian, and that she is here to seek the input from the group members concerning the dietary needs of Chinese patients through a survey. The dietitian briefly explains the study in English (with the facilitator interpreting), adding that she will provide the survey to those who are interested in participating. As the dietitian asks about the interest of the members in participating in the survey, three hands are raised promptly. Roger says “yes” loudly, as he raises his hand. The group laugh and the dietitian comments on the group’s enthusiasm in participating—noting that she is already familiar with some members.

In English, Roger then asks the dietitian what food should cancer patients avoid. She acknowledges the importance of the question, adding that the facilitator will be making arrangements for a talk on the subject for the group.... Li then approaches the dietitian and comments in English on the confusion in dietary needs often found across cultures.

The conflict between Chinese and Western dietary practices was also highlighted in the context of individual interviews—particularly when informants were asked to identify challenges

facing Chinese patients with cancer. Although 2 of the 3 informants interviewed were uncomfortable with being recorded, excerpts from their interview notes indicate the salience of dietary issues.

Mary says that one of her key concerns is her dietary needs, explaining that her daughter is not able to prepare meals that are suitable for her consumption. She has also sought help from “Meals on Wheels” but has found the food to be unsuitable for her current needs. Later on in the interview, when asked to comment on issues facing Chinese cancer patients, Mary identifies food and nutrition to be a key factor. She notes that the different dietary practices in the Chinese and Western cultures are particularly problematic for individuals having special nutrition needs. She also notes that the availability of Chinese produce in her area of residence is limited, adding to these dietary problems. Mary adds that the different practices would pose a problem for a non-Chinese dietician to understand her needs. On this matter, she believes that it would be most helpful if she could interact with Chinese dieticians, who would be able to converse with her with cultural understanding (metastatic lung cancer patient, 60s).

Similarly,

Lucy observes that Chinese cancer patients often face great pressure in making informed decisions on food consumption when conflict between Chinese and Western dietary practices arise. She adds that the approach to treating illness tends to be more direct in Western medicine, which differs from the less linear treatments offered through Chinese medicine (breast cancer survivor, 60s).

Betty, who allowed her interview to be recorded, responded in a similar vein:

Chinese are very concerned with what one eats. Chinese are concerned with what one can eat that will be helpful, to be able to provide nutrients to one's body—what kind of food is not good. Some people say it is not good to be eating chicken, it has lots of hormones and a lot of friends have said beef is not good; even pork is not good. Bird nest [an expensive Chinese tonic food] is not good. Everything is said to be not good to eat. Then in the end if the patient believes it all, he/she will not eat anything at all!

My attitude is that the cancer agency has given me many booklets about what I should eat at each stage that will be helpful to me. Actually, that will be very sufficient. I do not have boiled chicken soup at all. Instead, I would eat more yoghurt, milk that will give me more protein, going out less often to reduce contact with people [outside the home] to reduce my chances of contracting a virus, allowing myself to recover faster.

My focus is on recovery. Everything I do is for recovery and not to eat anything that will be worse for my health. Chinese will not always listen to Western practices. They

tend to believe their Chinese tradition... So it's hard to change. When one is well, it's okay. But when one is sick and fearful, he/she will believe in anything' (breast cancer survivor, 60s).

Overall, many support group members highlighted a perceived conflict between Western and Chinese dietary advice and practices—a perception that was further validated in the key informant interviews. Participants emphasized their confusion regarding the foods that they should be eating to improve their health and minimize their chances of cancer recurrence—concerns that appeared to be exacerbated by the special relationship between food and health in Chinese medicine.

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## ■ Discussion

Clearly, food, eating, and diet were of central concern to the Chinese patients with cancer and family members in the support group. Patients consistently highlighted the prevalence of eating issues, the critical importance of the ability to eat, and the conflict they experienced between Chinese and biomedical models of diet. Importantly, these research findings were generated unexpectedly in the context of a comparative ethnographic study on cancer support groups. The comparative focus of this larger study revealed food and eating to be a particular concern and preoccupation for Chinese patients with cancer, as this issue was rarely (if ever) raised in other cancer support groups—where treatment adverse effects such as hair loss and neuropathy were a far more substantial focus of concern. Overall, the findings provide qualitative support for Wong and Fielding's<sup>38</sup> quantitative study on the relationship between eating ability and QOL among Chinese patients with cancer and help explain why eating ability and QOL are connected in this population.

The social and symbolic dimensions of eating are strongly evident in the accounts of group members, particularly the ways in which food becomes an instrumental expression of love and support for the patient—such as when Victoria discussed her family carefully preparing food in order that she might eat without aggravating her pain. From her comments, it is clear that she perceived her family's care in food preparation as an expression of their care and love for her—an aspect of food that has also been highlighted in previous studies on Chinese patients with cancer in Hong Kong.<sup>36,51</sup> Clearly, the use of food as an expression of love is not restricted to Chinese patients with cancer. As previously noted, this aspect of food is also present in the accounts of Western patients with advanced cancer.<sup>7,16</sup> Thus, the concerns that June raised about her husband's inability to eat have much in common with the caregiver's distress noted in studies of anorexia and cachexia conducted with Western patients.<sup>7,16–18</sup> However, it is possible that such concerns may become particularly acute for many Chinese caregivers.

As Chan et al.<sup>51(p391)</sup> point out, given the cultural value placed on controlling emotional expression, “[Chinese] people may find it easier to express their care and concern through

actions, such as food preparation or physical presence, rather than verbal communication.” Similarly, in their study of Asian American survivors of breast cancer, Kagawa-Singer and Wellisch<sup>52</sup> note the emphasis that women placed on tangible, instrumental support rather than emotional sharing. Thus, when family members are denied the opportunity to express support instrumentally, the resultant distress may be felt even more acutely than in cultural contexts where other forms of support are also strongly valued. Yet, despite the centrality of food and eating issues to both patients’ and families’ experience of cancer, as previously noted, such concerns are not generally seen to be problematic for cancer patients before the onset of advanced disease.

Another facet of support group members’ experience of cancer and survivorship was a strong sense of confusion about the food that they should be eating. Similar concerns about food have also been noted among Chinese patients with cancer in Hong Kong.<sup>31,32</sup> For example, in Simpson’s<sup>32</sup> study of patients with breast cancer in Hong Kong, patients and their families expressed considerable confusion about what they could and could not eat. These concerns would seem to highlight Betty’s point that “everything is said to be not good to eat. Then in the end, if the patient believes it all, he/she will not eat anything at all!”

However, these culturally specific concerns about food and diet are clearly exacerbated because of group members’ simultaneous exposure to a biomedical model of diet and nutrition. Thus, participants commonly expressed a sense of conflict (*chong dug*) between the 2 models (and between Western and Chinese medicine more generally). It is clear that a number of members of the group dealt with this conflict by integrating elements of both systems—much along the lines of the “mosaic” of ideas that Prior et al<sup>35</sup> report based on their research regarding health beliefs among Cantonese-speaking immigrants in the United Kingdom. Thus, when group members offered Jennifer ways to facilitate her food consumption, they highlight the importance of rice, but they also draw on Western concepts regarding the importance of “nutritious food” and a “balanced diet.”

Other research on health beliefs among Chinese immigrants has highlighted similar processes of integration. In the study of Liang et al<sup>34</sup> of Mandarin-speaking female immigrants to the United States, women often spoke of the need to limit fat and cholesterol intake, along with the importance of choosing the right food to keep the hot-cold balance in the body. Similarly, Papadopolous et al<sup>33</sup> note the ways in which Chinese immigrants in London moved between dietary models, simultaneously highlighting culturally specific views on cancer-causing foods (eg, peanuts, fermented bean curd) along with more generalized biomedical ideas about the dangers of foods high in salt, sugar, and fat. Jovchelovitch and Gervais also note the ease with which the Chinese Britons whom they interviewed sustained both biomedical knowledge and Chinese health beliefs without any apparent conflict—which they attribute to a world view that “accommodates opposites which, in the Western world, would appear as unresolvable contradictions.”<sup>27(p256)</sup>

Although it appears that most support group participants integrated both models to varying degrees, there was some evidence that not all group members viewed the models equally. Biomedically trained health professionals, regardless of their ethnic and cultural background, were often seen as the legitimate voice of authority from which people should seek advice and guidance about their dietary practices. Indeed, the literature shows that health professionals (physicians, nutritionists) consistently rank as one of the key sources of information on whom people turn to with dietary questions.<sup>53,54</sup>

In the case of Jennifer and Betty, perceived conflict between the 2 systems could only be resolved by “giving up” (*fong hei*) Chinese dietary rules. In light of the integral relationship between food and cultural identity,<sup>55–58</sup> such decisions should not be taken lightly, as they require a fundamental shift in values. Thus, Betty implicitly suggested that Chinese food “traditions” are irrational and that, when Chinese patients are sick, they will “believe in anything.” In this respect, she clearly perceived the 2 systems to be in hierarchical opposition, with “traditional Chinese” dietary prescriptions inferior to “modern” biomedical dietary guidelines.

Strict allegiance to a biomedical approach to diet often entails a rejection of previously held beliefs about food, as biomedical dietary advice focuses on a few limited Western dietary practices, disregards traditional food culture, and may not acknowledge the specific issues of migration that relate to food decisions. As Mary notes, those people who are not willing to “give up” culturally specific dietary guidelines are left with very few expectations that health professionals will understand much about their culture. They learn that different health strategies are to be chosen according to whether the problem is seen to relate to Western or traditional food culture.<sup>59</sup> Indeed, the existing health literature demonstrates that communication problems exist between ethnic majority health workers and ethnic minority patients. This is precisely what we see in the case of the nurse who visited the group, who asked participants what they believed to be the most frequent complaint of cancer patients and then corrected them when their responses did not fit the prevailing biomedical knowledge about the treatment adverse effects that are generally considered to be most distressing.

The preliminary research findings of this study indicate that healthcare professionals should pay more attention to how patients talk about the adverse effects of cancer treatments rather than assume that all patients who suffer from treatment adverse effects understand and experience them in a similar way. For Chinese patients with cancer and their families, in light of the distinct cultural meanings of food as a means to fight the disease and improve health, the distress that eating difficulties cause may substantially outweigh other seemingly more “troublesome” adverse effects, as the loss of the ability to eat is connected to a loss in ability to “fight” the cancer (S. Kwong, personal communication, June 26, 2008). This finding illustrates the limitations in attempting to describe patients’ perceptions of cancer treatments in physiological and psychological terms without considering the broader social and cultural contexts in which they are experienced. It

also highlights the need for the development of more culturally sensitive screening tools for assessing eating difficulties, treatment adverse effects, and patient distress.

Furthermore, although Chinese patients' concerns regarding diet and nutrition may seem similar to concerns that many cancer patients express during and after treatment, the dietary information that Chinese patients seek may be substantively different because of culturally specific ideas about cancer-causing and cancer-destroying foods. Chinese patients therefore often want very specific advice and information about which particular foods to consume and avoid, and general assurances from healthcare professionals about the value of reducing red meat intake, increasing consumption of fruits and vegetables, and so forth are likely to be met with frustration (S. Kwong, personal communication, June 26, 2008). A greater understanding of Chinese dietary beliefs among health professionals and attempts to integrate Chinese medical knowledge into dietary advice and guidelines aimed at Chinese patients with cancer are therefore likely to lead to improved communication around diet and eating. Providing Chinese patients with cancer with culturally appropriate food examples in dietary and nutrition guides would also be beneficial, as the standard dietary guides available for cancer patients focus on foods that are more suitable to a Western diet.

Clearly, this study has limitations, and the findings of this research require "ethnographic testing"<sup>49</sup> elsewhere, as it is based only on the depictions of food, diet, and eating elucidated at a single cancer support group. In light of the fact that only a small percentage of patients attend support groups,<sup>60</sup> the findings may be biased toward certain categories of patient. However, as outlined above, there is evidence to suggest that a similar understanding is present in the accounts of many Chinese patients with cancer both in Hong Kong and in countries such as the United Kingdom, Australia, and the United States. Nevertheless, it is important to note that as the support group caters to Cantonese-speaking Chinese, it is unclear how broadly research findings can be generalized to Chinese of other linguistic and ethnic groups—especially in light of the regional differences that anthropologists have highlighted in Chinese conceptions and uses of food.<sup>20,24,26</sup> Further research therefore needs to be conducted for other Chinese groups such as Mandarin speakers and for other immigrant populations with distinct relationships with and understandings of food (eg, South Asians).

In conclusion, it is clear that issues with food and eating take on particular salience for Chinese patients with cancer and their families. Culturally specific understandings of the relationship between food and health inform people's experience of the eating difficulties connected with cancer treatments and their ongoing concern with food and diet after treatment has ended. Yet, to date, there has been little acknowledgment in the oncological literature of the meanings and attributes of food and eating beyond their physiological properties and the complex relationship between food and health, which cannot be explained solely through nutrition.

Importantly, although it is necessary to consider the meanings of food for Chinese patients with cancer and other

immigrant populations, it is important that the social and cultural context of eating difficulties—and indeed all treatment adverse effects—is recognized for all cancer patients. The anthropological and sociological literature has demonstrated the social and symbolic meanings that food entails for all human beings—none of us experience the consumption of food as a purely biochemical act. However, the physiologically and psychologically deterministic view of food and eating that prevails among health professionals leads clinicians and researchers to overlook the cultural dimensions of these central human activities.

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## References

1. Furst T, Connors M, Bisogni CA, Sobal J, Falk LW. Food choice: a conceptual model of the process. *Appetite*. 1996;26:247–266.
2. Harris M. *Good to Eat: Riddles of Food and Culture*. Long Grove, IL: Waveland Press; 1998.
3. Lupton D. *Food, the Body and the Self*. London, England: Sage; 1996.
4. Counihan C. *The Anthropology of Food and Body*. London, England: Routledge; 1999.
5. Weismantel MJ. *Food, Gender and Poverty in the Ecuadorian Andes*. Long Grove, IL: Waveland Press; 1998.
6. Poole K, Froggatt K. Loss of weight and loss of appetite in advanced cancer: a problem for the patient, the carer, or the health professional? *Palliat Med*. 2002;16:499–506.
7. Hughes N, Neal RD. Adults with terminal illness: a literature review of their needs and wishes for food. *J Adv Nurs*. 2000;32(5):1101–1107.
8. Nerenz DR, Leventhal H, Love RR. Emotional distress during chemotherapy. *Cancer*. 1982;50:1020–1027.
9. Coates AS, Abraham S, Kaye SB, et al. On the receiving end—patient perception of the side effects of cancer chemotherapy. *Eur J Cancer Clin Oncol*. 1983;19:203–208.
10. Griffin AM, Butow PN, Coates AS, et al. On the receiving end V: patient perceptions of the side effects of cancer chemotherapy in 1993. *Ann Oncol*. 1996;7:189–195.
11. Lindley C, McCune JS, Thomason TE, et al. Perception of chemotherapy side effects: cancer versus noncancer patients. *Cancer Pract*. 1999;7(2):59–65.
12. Larsson M, Hedelin B, Athlin E. Lived experiences of eating problems for patients with head and neck cancer during radiotherapy. *J Clin Nurs*. 2003;12:562–570.
13. Bernhardson B-M, Tishelman C, Rutqvist LE. Chemosensory changes experienced by patients undergoing cancer chemotherapy: a qualitative interview study. *J Pain Symptom Manage*. 2007;34(4):403–412.
14. Hopkinson JB, Wright DNM, McDonald JW, Corner JL. The prevalence of concern about weight loss and change in eating habits in people with advanced cancer. *J Pain Symptom Manage*. 2006;32(4):322–331.
15. Shragge JE, Wismer WV, Olson KL, Baracos VE. The management of anorexia by patients with advanced cancer: a critical review of the literature. *Palliat Med*. 2006;20:623–629.
16. Strausser F, Binswanger J, Cerny T, Kesselring A. Fighting a losing battle: eating-related distress of men with advanced cancer and their female partners. A mixed-methods study. *Palliat Med*. 2007;21:129–137.
17. Holden CM. Anorexia in the terminally ill cancer patient: the emotional impact on the patient and family. *Hosp J*. 1991;7:73–84.
18. Meares CJ. Primary caregiver perceptions of intake cessation in patients who are terminally ill. *Oncol Nurs Forum*. 1997;24(10):1751–1757.



19. Hopkinson J, Corner J. Helping patients with advanced cancer live with concerns about eating: a challenge for palliative care professionals. *J Pain Symptom Manage.* 2006;31(4):293–303.
20. Chang KC. Introduction. In: Chang KC, ed. *Food in Chinese Culture: Anthropological and Historical Perspectives.* New Haven, CT: Yale University Press; 1977:1–15.
21. Liu J. *Chinese foods.* Translated by William W Wang. Hong Kong: Chinese Intercontinental Press; 2004.
22. I-Ling K-H. *Symbolism in Chinese Food.* Singapore: Graham Brash; 1991.
23. Lai TC. *Chinese Food for Thought.* Hong Kong: Kong Kong Book Centre; 1978.
24. Anderson EN, Anderson ML. Modern China: South. In: Chang KC, ed. *Food in Chinese Culture: Anthropological and Historical Perspectives.* New Haven, CT: Yale University Press; 1977:319–382.
25. Koo LC. The use of food to treat and prevent disease in Chinese culture. *Soc Sci Med.* 1984;18(9):757–766.
26. Anderson EN. *The Food of China.* New Haven, CT: Yale University Press; 1988.
27. Jovchelovitch S, Gervais M-C. Social representations of health and illness: the case of the Chinese community in England. *J Community Appl Soc Psychol.* 1999;9:247–260.
28. Satia-Abouta J, Patterson RE, Kristal AR, Teh C, Tu S-P. Psychosocial predictors of diet and acculturation in Chinese American and Chinese Canadian women. *Ethn Health.* 2002;7(1):21–39.
29. Holroyd E. Health-seeking behaviors and social change: the experience of the Hong Kong Chinese elderly. *Qual Health Res.* 2002;12:731–750.
30. Chui Y-Y, Donoghue J, Chenoweth L. Responses to advanced cancer: Chinese Australians. *J Adv Nurs.* 2005;52(5):498–507.
31. Mok E, Martinson I. Empowerment of Chinese patients with cancer through self-help groups in Hong Kong. *Cancer Nurs.* 2000;23(3):206–213.
32. Simpson P. Hong Kong families and breast cancer: beliefs and adaptation strategies. *Psychooncology.* 2005;14:671–683.
33. Papadopoulos I, Guo F, Lees S, Ridge M. An exploration of the meanings and experiences of cancer of Chinese people living in London. *Eur J Cancer Care.* 2007;16:424–432.
34. Liang W, Yuan E, Mandelblatt JS, Pasick RJ. How do older Chinese women view health and cancer screening? Results from focus groups and implications for interventions. *Ethn Health.* 2004;9(3):283–304.
35. Prior L, Chun PL, Huat SB. Beliefs and accounts of illness: views from two Cantonese-speaking communities in England. *Sociol Health Illn.* 2000;22(6):815–839.
36. Chan CWH, Molassiotis A. The impact of fatigue on Chinese cancer patients in Hong Kong. *Support Care Cancer.* 2000;9:18–24.
37. Molassiotis A, Chan CWH, Yam BMC, Chan SJ. Quality of life in Chinese women with gynecological cancers. *Support Care Cancer.* 2000; 8:414–422.
38. Wong WS, Fielding R. Eating ability predicts subsequent quality of life in Chinese patients with breast, liver, lung, or nasopharyngeal carcinoma: a longitudinal analysis. *Acta Oncol.* 2008;47:71–80.
39. Emerson RM, Fretz RI, Shaw LL. *Writing Ethnographic Fieldnotes.* Chicago, IL: University of Chicago Press; 1995.
40. Oliffe J, Bottorff J. Innovative practice: ethnography and men's health research. *J Mens Health Gend.* 2006;3(1):104–108.
41. Mathews HF. Negotiating cultural consensus in a breast cancer self-help group. *Med Anthropol Q.* 2000;14(3):394–413.
42. Coreil J, Wilke J, Pintado I. Cultural models of illness and recovery in breast cancer support groups. *Qual Health Res.* 2004;14(7):905–923.
43. Cope DG. Functions of a breast cancer support group as perceived by the participants: an ethnographic study. *Cancer Nurs.* 1995;18(6):472–478.
44. Arrington MI, Grant CH, Vanderford ML. Man to man and side by side, they cope with prostate cancer: self-help and social support. *J Psychosoc Oncol.* 2005;23(4):81–102.
45. Ussher J, Kirsten L, Butow P, Sandoval M. What do cancer support groups provide which other supportive relationships do not? The experience of peer support groups for people with cancer. *Soc Sci Med.* 2006;62:2565–2576.
46. Oliffe J, Halpin M, Bottorff JL, Hislop TG, McKenzie M, Mroz L. How prostate cancer support groups do and do not survive: British Columbian perspectives. *AJMH.* 2008;2(2):143–155.
47. Kapferer B. Anthropology and the dialectic of the enlightenment: a discourse on the definition and ideals of a threatened discipline. *TAJA.* 2007;20(1):72–96.
48. Malinowski B. *Argonauts of the Western Pacific.* Long Grove, IL: Waveland Press; 1922.
49. Sanjek R. Keeping ethnography alive in an urbanizing world. *Hum Organ.* 2000;59(3):280–288.
50. Aronson J. A pragmatic view of thematic analysis. *TQR.* 1994;2(1). <http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html>. Accessed February 26, 2008.
51. Chan CWH, Molassiotis A, Yam BMC, Chan SJ, Lam CSW. Traveling through the cancer trajectory: social support perceived by women with gynecologic cancer in Hong Kong. *Cancer Nurs.* 2001;24(5):387–394.
52. Kagawa-Singer M, Wellisch DK. Breast cancer patients' perceptions of their husbands' support in a cross-cultural context. *Psychooncology.* 2003;12:24–37.
53. Hiddink GJ, Hautvast GAJ, van Woerkum CMJ, Fieren CJ. Consumers' expectations about nutrition guidance: the importance of primary care physicians. *Am J Clin Nutr.* 1997;65:1974S–1979S.
54. Holgado B, Martinez-Gonzalez MA, De Irala-Estevez J, Gibney M, Kearney J, Martinez A. Sources of information about diet and health in a Mediterranean country: comparison with other European member states. *Eur J Public Health.* 2000;10:185–191.
55. Bell D, Valentine G. *Consuming Geographies: We Are Where We Eat.* London, England: Routledge; 1997.
56. Lupton D. Food, memory and meaning: the symbolic and social nature of food events. *Sociol Rev.* 1994;42:664–686.
57. Valentine G. Eating in: home, consumption, and identity. *Sociol Rev.* 1999;47(3):491–524.
58. Caplan P, ed. *Food, Health and Identity.* London, England: Routledge; 1997.
59. Fagerli RA, Lien ME, Wandel M. Experience of dietary advice among Pakistani-born persons with type 2 diabetes in Oslo. *Appetite.* 2005;45: 295–304.
60. Herron L-M. *Building Effective Cancer Support Groups: Report to the Department of Health and Ageing.* Sydney, Australia: Cancer Council Australia; 2005.