Cultural Beliefs and Coping Strategies Related to Childhood Cancer: The Perceptions of South Asian Immigrant Parents in Canada
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Introduction

Childhood cancer remains the most common disease-related cause of death in children and adolescents living in Canada (Public Health Agency, 2009). Each year, on average, 1285 children aged 0 to 19 years are diagnosed with cancer. One of the largest immigrant populations in Canada is South Asian, which includes people from India, Pakistan, Bangladesh, and Sri Lanka (Statistics Canada, 2008). Current data regarding the incidence of childhood cancer among the South Asian population living in Canada are unknown primarily because of cancer registries not collecting data about ethnicity. However, some evidence from the United Kingdom suggests that the overall incidence of childhood cancer is higher for children of South Asian ethnic origin (Cummins et al., 2001; McKinney et al., 2003; Powell, Parkes, Cameron, & Mann, 1994). Statistics Canada (2010) projects that by 2031 the South Asian population will double to 4.1 million from roughly 1.3 million in 2006. Given the rising number of South Asian parents expected to have children with cancer in Canada, it is particularly imperative that we turn our attention to the health care needs of this growing ethnic group as they may have distinct cultural beliefs and coping strategies related to childhood cancer.

South Asians in Canada tend to attach a strong sense of importance to their ethnic culture and traditions, which may influence their perceptions on childhood disease and health (Tran, Kaddatz, & Allard, 2005).

Abstract

The purpose of this study is to describe cultural beliefs and coping strategies related to dealing with childhood cancer identified through a qualitative study of the caregiving experiences of first-generation South Asian immigrant parents of children with cancer. A constructivist grounded theory approach was employed. Families with a child at least 6 months postdiagnosis were recruited from 5 Canadian pediatric oncology centers. In-depth semi-structured interviews were conducted in English, Hindi, Punjabi, or Urdu with a sample of 25 South Asian parents. Analysis of interviews involved line-by-line coding and using the constant comparison method. The following 2 central themes related to culture and coping emerged: (a) cultural beliefs about childhood cancer being incurable, rare, unspeakable, and understood through religion and (b) parental coping strategies included gaining information about the child’s cancer, practicing religious rituals and prayers, trusting the health care professionals, and obtaining mutual support from other South Asian parents. These cultural beliefs and coping strategies have important implications for health care providers to understand the variations in the perceptions of childhood cancer and coping in order to implement culturally sensitive health care services.

Keywords

childhood cancer, South Asian culture, beliefs, coping, qualitative
the context of health and disease has been defined as the “unique shared values, beliefs, and practices that may be associated with the healthcare process and interactions” (Pasick & D’Onofrio, 1996, p. S142). Although Western medicine has improved the survival rate of children with cancer, South Asian parents may struggle with their cultural beliefs and perceptions toward childhood cancer. There have been few studies examining the cultural perceptions of cancer among South Asian adults (Bottorff et al., 1998; Johnson, Bottorff, & Bowneaves, 1999; Randhawa & Owens, 2004). Randhawa and colleagues conducted a qualitative study to gain a better understanding of the knowledge within a South Asian community concerning cancer and cancer services in the United Kingdom. Most South Asians were aware of cancer as some form of illness though they were not able to define exactly what and how cancer occurred (Randhawa & Owens, 2004). Culturally, South Asian communities described cancer as an insidious and deadly disease (Bottorff et al., 1998). Unlike other diseases, such as heart disease and diabetes, they associated cancer with pain and suffering. For many people of South Asian origin, developing a disease such as cancer was viewed as part of one’s destiny and God’s will (Bottorff et al., 1998).

Extensive research has been conducted to describe the coping response of parents who have children with cancer (Grootenhuis & Last, 1997; Klassen et al., 2007). Studies that focus on how parents cope report that most parents of children with cancer cope adequately, even improving their adjustment to the cancer diagnosis in the long term (Hoekstra-Weebers, Jaspers, Kamps, & Klip, 1998; Kazak, 1997; Kupst et al., 1995; Larson, Wittrock, & Sandgren, 1994; Majidi-Ahi, 1996). Cultural practices could play an important role in the coping process of South Asian parents who have a child with cancer. South Asians have been found to use various strategies to cope with childhood illnesses, such as prayer and receiving medical knowledge and support from healthcare professionals (Atkin & Ahmad, 2000).

Cultural beliefs and coping strategies may influence South Asian parent’s attitudes to decision making for cancer management. In a Western medical system that promotes shared decision making (Health Canada, 2010), effects of traditional South Asian cultural and religious perceptions may create challenges for both the parents and health care provider. Especially in oncology, these beliefs might influence parents’ perceptions of diagnosis, symptoms, interventions, and approaches to childhood cancer.

There has been little work examining the cultural understanding and coping strategies related to having a child with cancer among South Asians living in Canada. Most studies that aim to depict the cultural notions of cancer in the South Asian community focus on adulthood cancer. Childhood cancers are different from adult cancers, which is why pediatric oncology is its own field.

The purpose of this qualitative grounded theory study is to describe the cultural beliefs and coping strategies of South Asian parents who have a child diagnosed with cancer in Canada.

**Participants and Method**

**Design**

The findings for this study were drawn from a larger data set that examined the caregiving experiences of first-generation South Asian and Chinese immigrant parents of children with cancer (Klassen et al., 2011) guided by the constructivist grounded theory, as developed by Charmaz (2006). This approach is inductive in nature and involves engaging in simultaneous data collection and analysis. The approach provides guidance in making meaning from the data and rendering the social processes that participants experience.

**Participants**

A theoretical sample of 25 South Asian primary caregivers was recruited from 5 Canadian pediatric oncology centers. Primary caregivers of children with cancer were defined as the parent most responsible for the day-to-day decision-making and care of the child with cancer. Inclusion criteria were the following: self-identified culturally as South Asian, able to participate in an interview in English, Hindi, Punjabi, or Urdu, and having a child that was at least 6 months postdiagnosis and was not considered palliative. This study was approved by all participating research ethics boards and all participants provided written informed consent. Table 1 shows participant characteristics. Caregivers varied in age, marital status, income, education, and religion, which provided a range of demographic backgrounds and experiences of interest to the research area.

**Data Collection**

South Asian parents were approached by a research nurse, clinical research associate, or pediatric oncologist (depending on the centre) to provide details of the study and obtain consent to participate. Study materials were made available in English, Hindi, Urdu, and Punjabi as appropriate. Upon informed consent, parents were contacted by a research assistant to organize a time and location for an interview. Before conducting the interview, informed consent was reconfirmed as was participants’ agreement to the interview being audiorecorded.

Data were collected by multilingual researchers using in-depth semistructured interviews in the language preferred by the parents. In total, 10 interviews were conducted in English, 2 in Hindi, 11 in Punjabi, and 3 in Urdu.
Table 1. Demographics of South Asian Parents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N or Mean (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>41.7 (29-51)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>22</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>&lt;High school</td>
<td>5</td>
</tr>
<tr>
<td>High school</td>
<td>5</td>
</tr>
<tr>
<td>College</td>
<td>2</td>
</tr>
<tr>
<td>University</td>
<td>13</td>
</tr>
<tr>
<td>Annual household income</td>
<td></td>
</tr>
<tr>
<td>$20 000-$39 999</td>
<td>8</td>
</tr>
<tr>
<td>$40 000-$59 999</td>
<td>5</td>
</tr>
<tr>
<td>$60 000-$79 999</td>
<td>7</td>
</tr>
<tr>
<td>$80 000-$99 999</td>
<td>1</td>
</tr>
<tr>
<td>&gt; $100 000</td>
<td>4</td>
</tr>
<tr>
<td>Years living in Canada</td>
<td>16.25 (3 to 35)</td>
</tr>
<tr>
<td>Country of origin</td>
<td></td>
</tr>
<tr>
<td>Fiji</td>
<td>1</td>
</tr>
<tr>
<td>India</td>
<td>16</td>
</tr>
<tr>
<td>Pakistan</td>
<td>5</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>1</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>5</td>
</tr>
<tr>
<td>Muslim</td>
<td>7</td>
</tr>
<tr>
<td>Sikh</td>
<td>10</td>
</tr>
<tr>
<td>Catholic</td>
<td>1</td>
</tr>
<tr>
<td>Christian</td>
<td>1</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>1</td>
</tr>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td>Male gender</td>
<td>14</td>
</tr>
<tr>
<td>Age at diagnosis (years)</td>
<td>6.1 (1-16)</td>
</tr>
<tr>
<td>Cancer type</td>
<td></td>
</tr>
<tr>
<td>Brain</td>
<td>2</td>
</tr>
<tr>
<td>Leukemia</td>
<td>14</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>6</td>
</tr>
<tr>
<td>Neuroblastoma</td>
<td>1</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>1</td>
</tr>
<tr>
<td>Wilms</td>
<td>1</td>
</tr>
<tr>
<td>Treatment status</td>
<td></td>
</tr>
<tr>
<td>Completed</td>
<td>18</td>
</tr>
<tr>
<td>In treatment</td>
<td>7</td>
</tr>
</tbody>
</table>

Interviews lasted an average of 70 minutes, ranging from 30 to 120 minutes, and were guided by an interview guide. Examples of questions in the interview that prompted discussion of cultural beliefs and coping strategies in relation to having a child with cancer included the following: Given your cultural background as a South Asian person, what does cancer mean to you? Can you talk about things that you did that helped you to cope with the stress and worries of having a child with cancer? What kind of problems or challenges did you face as an immigrant parent of a child with cancer? Interviews were digitally recorded. English interviews were transcribed verbatim and non-English interviews were translated and transcribed into English text with the emphasis on retaining the meaning of the words as closely as possible to the original interview. All transcripts and translations were checked by a second person fluent in the language of the interview, who listened to the digital recordings to ensure accuracy.

Analysis

Data collection and analysis occurred concurrently. Interviewing continued until no new themes emerged. QSR NVivo 8 software (Qualitative Solutions Research International, 2008) was used to manage the data.

To ensure the standards of rigor in qualitative research, the data analysis process was informed by the constructivist grounded theory approach (Charmaz, 2006). Analysis involved line-by-line coding by 2 members of the research team who worked independently and met to discuss differences and reach agreement. Data analysis was inductive with codes and categories emerging from participants stories; no predefined codes, categories, patterns, or frameworks were applied to the data. Team meetings were used to review transcripts and to work on the consensus of the interpretation of the data and the discussion of the emerging core concepts. Focused coding was used to sift through large amounts of data and to strengthen initial codes. Theoretical coding was used to conceptualize how codes related to one another. Constant comparison was used to examine relationships within and across codes and categories.

For the purpose of this article on culture, focused and theoretical coding were re-employed to link categories and subcategories together at the level of cultural properties, which led to the development of 2 core cultural themes, labeled beliefs related to childhood cancer and coping strategies. These 2 central themes represented the core cultural concepts in the empirical data.

Results

Cultural perceptions regarding childhood cancer often arose from the South Asian parents. Parents reflected on
how religious and cultural values helped them cope and care for their child with cancer. The resulting findings do not represent beliefs and coping strategies of any one individual nor does every South Asian parent necessarily hold all the beliefs and coping strategies. Instead, the findings describe the multiple beliefs and coping strategies derived from all South Asian parents participating in this study and represent the salient cultural themes that emerged in our analysis. Below we discuss the 2 central cultural themes related to childhood cancer represented in this study.

Beliefs Related to Childhood Cancer

Initial reactions to the children’s diagnosis were a mix of emotions from parents in this study including shock, denial, and worry. This may be because of 4 key cultural beliefs related to childhood cancer South Asian parents discussed,

**Childhood cancer is rare or unheard of.** There was a low level of awareness of childhood cancer among South Asian parents. This was evident by their reaction when the physicians informed them about their child’s diagnosis. Parents were mostly shocked and surprised and did not expect such an illness to come upon children. They questioned and could not understand how a child could get cancer. South Asians generally believed that only adults after a certain age could possibly get such a disease as exemplified by one parent:

> I never thought of a small kid getting cancer. I always thought in my mind that after a certain older age you have a chance of getting cancer. That’s all I had known growing up. (South Asian parent [SAP] 17)

Some parents discussed how cancer among children appeared to be uncommon in South Asia. Most parents discussed how it was rare to hear about a child having cancer. Therefore, many South Asians appeared to see how many children were diagnosed and being treated for cancer at the hospitals in Canada. One mother described,

> I had heard about cancer in India, but I hadn’t heard about it so much that cancer also happens to young children. Whenever we came to the hospital, we would see some other new child patient. Then I said, ‘There is a lot of cancer here.’ (SAP 10)

**Cancer is incurable.** Most South Asians appeared to think that there could be no illness worse than cancer. In comparison with other diseases, parents thought cancer was the worst possible diagnosis. Parents discussed that South Asians tend to think negatively (mara) about cancer, and they described cancer as “dangerous,” “bad,” “fatal,” and “deadly.” Cancer was perceived among our sample of parents to be an incurable disease that was not survivable. On hearing about their child’s diagnosis, parents thought they would inevitably lose their child to cancer. They felt a sense of loss coming to their lives and feared that their child’s life would come to a definite end, as said by one parent:

> I love my daughter and it’s just heartbreaking that we found out about it. So literally I could see her, I could feel her, sense that she was going to die, God forbid. (SAP 14)

A few parents did not believe there were treatments or medications available to cure their child’s cancer. Many parents felt reassured when they learned cancer was curable from the medical team at the hospital but also questioned whether their child would become better despite the treatment options. One South Asian parent explained,

> To tell you the truth, the background and the country that I’m from, cancer is a deadly disease and you die. There is no cure for it and, there is no medication for it. That’s how I knew. (SAP 17)

**Cancer is unspeakable.** Although many South Asians received a lot of emotional support from members of the South Asian community, a few parents discussed the difficulties they encountered in talking about cancer within their South Asian community. The term cancer was not easy for parents to hear or verbalize as one father (SAP 30) stated, “The word cancer itself is bad.”

A few parents feared their child may be discriminated against and were unsure of how other South Asians would react or cope with hearing about their child’s diagnosis. They worried other children would not play with their child because of the cancer. One parent felt their South Asian friends might pity their child or constantly talk about the cancer, which would make them feel further depressed.

> We did fear of him being discriminated against and frowned upon. It will make us more depressed or people will just pity on us and say “Oh sorry too bad your son had the cancer” or something like that. (SAP 09)

A few South Asian caregivers found it difficult to tell their extended family that their child had cancer. They did not want family members, particularly grandparents, to worry or become distressed as described by one father:

> Upon hearing the word cancer, every person becomes mentally upset—and I didn’t want that mine or my wife’s family becomes disturbed or that they stay disturbed. (SAP 16)
Cancer is understood through religion. Some South Asian parents questioned whether their child’s cancer was a consequence of their own or their child’s mistakes in their past or present lifetime. A few of the parents felt that perhaps they did not do something right at some point in their life and that God was not happy with them. One parent believed the cancer was a form of punishment and that God was sending him a message:

As soon as the doctor told me, I began to tear up. I was thinking to myself, who knows what mistake I made for which God is punishing me. (SAP 04)

Other South Asian parents felt their child’s cancer was part of their fate and that their family must endure the child’s illness despite the difficulties that would be placed on the child with cancer. These families expressed it was important to have faith and believe that everything would work out because God was ultimately in control of the cancer situation and their lives.

The body has to endure whatever has happened, right? With some time, it will be okay. Whatever is in our luck, whatever is written in our fate, right? (SAP 28)

Coping Strategies

South Asian parents discussed 4 key strategies that helped them cope positively with having a child with cancer and potentially could have changed their prior perceptions about the disease:

Learning about their child’s survival rate. As discussed, most South Asians in our study perceived childhood cancer as fatal and incurable. Therefore, it was helpful for parents to learn from health care professionals that their child’s cancer was treatable and that most children survive cancer with treatment. Learning this information and believing that it was true helped parents overcome their fears and negative perceptions of cancer.

We got to talk to the oncologist over there. She said that whatever you have heard about leukemia just forget about it. Basically she was trying to give us hope and support us in that actually it’s not the same leukemia anymore and that it’s curable for this kind of a disease especially for the kids. (SAP 15)

Also helpful to parents was learning about the survival rate of their child’s cancer. Coming to learn that most children survive cancer encouraged many parents to be optimistic and remain hopeful that their child would indeed survive following treatment. Interesting, parents gained courage regardless of whether their child had a 20% or a 90% chance of surviving their cancer. Just learning that there is a chance that their child would survive seemed to enable parents to move on from the devastating news of the diagnosis to focus on their child becoming better and cured from cancer.

We are always focusing on the positive side. So it was a good thing when she (doctor) said that 20% kids survive. So that was all and we say, “Yeah, that means 20% kids survive.” So I hope she’s one of the 20%. (SAP 27)

Trusting the doctors. South Asian parents tended to have high respect and regard for doctors and discussed how this view is held culturally among South Asians. Most parents abided and trusted the doctors in their treatment plans and did not question or disagree with the doctors. They felt the health care professionals were doing the best for their child and seemed overall grateful for all their medical efforts.

The doctor always considered like you know—they get the highest respect in the Indian culture. Usually, ok. People don’t argue with them. I took doctor’s “word.” (SAP 42)

Some parents expressed how they believed in doctors taking care of their child’s cancer was similar to how they believed in God taking care of their child. One parent explained the feeling that God was residing within the doctors:

I kept a lot of faith in God, that, no, God is with us, and there are the doctors, God is growing in them also. I believed in them, the doctors too. (SAP 28)

Engaging in religious practices. Most participants described themselves as “religious” before the diagnosis and remained religious after the diagnosis. Parents talked about how increased faith in God and prayer and other practices helped them cope with their child’s cancer diagnosis, treatment, and recovery. Some Muslim families described how they would recite verses from the Quran (holy text) and blow on water for drinking to the child to help alleviate any side effects (eg, fevers) from the treatment. Parents of Sikh faith often engaged in parth (a religious program) or read the Shabad (religious text) with other followers at the Gurudwara (place of worship) for their child recovering from cancer. One Hindu mother fasted once a week for 5 years and took an oath in front of God that she would bring her son to a temple in India after he fully recovered from the cancer.
So I flew all the way down from here to India and I took him to the temple and everything and I told the God I said here is your son. He’s well and you listen to my prayers and everything and I promise you that I will, if he gets well I’ll bring him to your doorstep and here he is and he’s well and everything. (SAP 17)

Parents of religious faith believed it was ultimately God who gave their child health and would also take care of him or her. For most parents, it was important to keep strong in their faith and to trust God and trust that whatever God did for their child was for his or her good.

Look, the one to grant life is God and the one to take away life is also God. So you have faith on this and then if God willing . . . if our child’s life is destined, then God willing . . . she will be fine. If not, then you can’t do anything. (SAP 44)

Parents also found attending places of worship (eg, church or temple) as a form of community support. Friends from the places of worship provided a means of support and strength by praying for their child.

Most of our families and friends are all praying. One of my uncles is a priest in the United States so in his church they were praying. After she was cured, we went there and in front of everybody we told them that she’s cancer-free now. (SAP 11)

Parents often had to spend much time at the hospital during their child’s inpatient stays. Some parents described how they would pray in the child’s hospital room and how they appreciated the hospital staff respected their religious practices as described by one parent:

We would keep a prayer mat in our daughter’s hospital room when she was there. If the hospital staff came in the room and we were praying, they just kind of quietly leave and come back in five minutes or so. (SAP 15)

Talking with other South Asian parents who have a child with cancer. South Asian parents wished to communicate with other South Asian parents with similar experiences in caring for a child with cancer. Parents who were not able to speak English found it extremely helpful to connect with other parents and talk about their experiences in their South Asian language. Parents exchanged details about their child’s cancer and sought advice on difficult caregiving tasks, such as how to manage side effects from the treatments and how to give medications orally.

Connecting to one another in a social way also helped parents realize there were other parents and children going through the same medical situation as their child and this helped reduce their isolation.

We used to come across other families or other children who were going through treatment. If somebody would be sitting next to us, we would ask them what their child’s problem was and they would tell us, “Our kid has this problem.” We used to feel that we are not the only ones who are going through this problem. (SAP 50)

South Asian parents gave each other support and encouragement when talking to one another. They felt encouraged and hopeful in hearing the stories of other children who were cured from having cancer or going through a similar treatment as their child and becoming better.

It was nice. We would talk amongst one another. Then I would find out that many people got better and he too is better [referring to other kids]. They [family] would talk about someone else that the child is well and he grew up now. Then, I would feel a bit better that my kid can also get better. (SAP 39)

Discussion

Cultural norms include unwritten definitions that influence how individuals react to cancer and how they cope with having a family member with cancer (Dien, 2004). Our study considered how culture influences the way South Asian parents perceive childhood cancer and how it plays a role in determining how they cope with caring for a child with cancer. It is evident that cultural beliefs and coping strategies described by the parents are intertwined. The strategies South Asian parents used to help them cope positively with their child’s cancer appeared to ease their negative beliefs of cancer.

Prior research shows that South Asians tend to believe that cancer is one of the most life-threatening diseases with limited treatment options available (Bottorff et al., 1998; Randhawa & Owens, 2004). These perceptions are in line with our findings that South Asian parents describe childhood cancer as rare and unheard of and demonstrate the need for current knowledge about childhood cancer and cancer treatment in this ethnic community. They discussed how they benefited from learning about their child’s survival rate. Therefore, clearly informing and explaining childhood cancer and treatment procedures on diagnosis is of value to ethnic parents to help them overcome their fears and misconceptions of cancer.
A small number of parents were reluctant to let members of the South Asian community know about their child’s cancer for fear of discrimination or becoming further depressed by other people’s reactions to the news. Though not related to cancer specifically, prior qualitative and quantitative studies report South Asians are often unwilling to disclose the nature of a child’s chronic illness because of a concern that it would reflect negatively on the child and their family (Bottorff et al., 1999; Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002; Smeeton, Roberto, Gregory, White, & Morgan, 2007).

However, parents were willing to discuss their situation with other parents of children with cancer and, more specifically, mentioned frequently how much they felt supported from other parents of children with cancer they met who were from their own community. Earlier studies indicate that immigrant parents, including South Asians, prefer communicating with other parents who have similar circumstances in caring for a family member with a chronic illness (Liang, 2002; Neufeld et al., 2002; Randhawa & Owens, 2004; Wong & Chan, 2006). Research on social support does show higher levels of social support were associated with better adjustment in ethnic parents of children with cancer (Leavitt et al., 1999). Parent-to-parent programs could be an effective intervention for South Asian parents consisting of parent volunteers who are trained and are matched to parents requesting help with challenges similar to those the volunteer has experienced. A study by Singer et al. (1999) indicates that this type of connection is a valuable source of assistance to make adaptations to having a child with an illness, making progress on dealing with specific problems, and helping parents to become more effective at coping with the demands of parenting a child with an illness.

Majority of our participants (24 out of 25) reported affiliation with a religious faith primarily Hinduism, Sikhism, and Islam. Religion exerts an important influence on South Asian communities and plays a role in shaping their perceptions of disease as well as how they cope during a life crisis (Hussain & Cochrane, 2002). A few parents attributed their child’s cancer to a religious cause. They tended to believe cancer was part of their fate or a punishment from God based on their previous or present life’s sins. Studies report that South Asian parents accept their child’s illness as predetermined and endure their child’s illness with courage and faith in God (Fatimilehin & Nardishaw, 1994). The majority of the South Asian parents in this study, regardless of their religious affiliation, spoke about the significance of prayer and other religious practices in helping them cope with their child’s diagnosis, treatment, and recovery. A growing body of literature has shown South Asians often read verses from holy texts (eg, the Quran and Gita) relating specifically to asking for recovery from disease and pain, which in itself was viewed as part of managing the health situation (Hussain & Cochrane, 2002). Thus, it is key for health care environments to be respectful and sensitive to South Asian families in practicing their religion or spirituality to help them cope with the experience of having a child with cancer.

South Asian parents in this study not only emphasized their faith in God but exhibited a strong sense of trust in the health care professionals taking care of their child. Some parents reported having faith in their oncologist taking care of their child’s cancer to the same extent they had faith in God. South Asians generally hold high respect for health care professionals. Previous qualitative studies have shown that South Asians view physicians as authorities who rarely make mistakes and have full knowledge of the conditions they treat (Ali, Atkin, & Neal, 2006; Bottorff et al., 1999; Greenhalgh, Helman, & Chowdhury, 1998). Physician-training models in South Asian countries are more traditional, with a marked power hierarchy between the doctor and patient, and the attribution of positive social skills to physicians reflect the importance of physician–patient communication style among South Asians (Ahmad, Hansa, Rawlins, & Stewart, 2002). Therefore, good doctor–patient communication is essential for South Asian parents to obtain the most benefit and trust in the health care needs of their child. Furthermore, it may be important for these parents to be informed and understand the concept of family-centered care (FCC) within the Canadian health care system (Health Canada, 2010). Particularly in pediatrics, family-centered care is a process of health-care delivery that emphasizes sharing of information, supporting parents in the decision-making process, and respecting the choices made by families (Dix et al., 2009).

The cultural findings in this article should be interpreted with caution. There may be differences specific to the parent’s country of origin (eg, India vs Pakistan) that were not identified. Although much of the information collected for this study was centralized, the term South Asian refers to people of those countries that constituted Old India. These countries included India, Pakistan, Bangladesh, and Sri Lanka. Since the ancestors of each of these countries were once part of a united nation, similar traditions and beliefs have developed despite the geographical borders. Another limitation is that this study includes only participants living in Canada. These findings may not be applicable to South Asians living in the United States, United Kingdom, or other developed nations. Finally, those who chose to participate may be different from those who did not choose to participate.
A strength of this study is that the sample was recruited from 5 Canadian pediatric oncology centers in which a very broad range of South Asian parents of diverse demographic characteristics exists; they include some individuals with low income and no English-speaking ability and some individuals with high income and English fluency. Therefore, we believe that our findings have reasonable theoretical transferability to South Asian immigrants living in Canada.

Health Care Implications

This study suggests that South Asian parents could value additional support and information from their health care professionals. Information that is culturally sensitive could be useful for South Asian parents who have children undergoing cancer treatment. Several ways health care providers can facilitate coping in South Asian parents are as follows:

1. Ensure staff receives cultural awareness training that begins with an understanding of what South Asian families believe and ensuring they understand that cancer is curable with modern medications and those findings from their home nation are not transferrable to here.
2. Launch childhood cancer awareness campaigns that disseminate information about the prognosis and treatment of childhood cancer in South Asian communities to eliminate the stigma attached with cancer and allow families to talk about cancer.
3. Establish a peer-to-peer support program that connects immigrant parents with volunteers who most closely resemble their ethno-cultural background, child’s cancer diagnosis, and personal experiences so that they can speak with someone who has gone through the process to share ideas, information, and support with each other.
4. Support and be sensitive to the religious needs of immigrant parents in hospital settings by ensuring that they are aware of the facilities (e.g., chapel) on-site. Parents should be encouraged and feel comfortable to pray in the room with their child, and health care professionals should respect their privacy.

Conclusion

Working with culturally diverse families requires understanding how parents’ beliefs about childhood cancer and their coping strategies might be influenced by their cultural background. Perceptions toward cancer vary with each culture, and negative beliefs could exacerbate the distress already created by a newly diagnosed cancer for parents. Understanding how culture influences perceptions, communication, and support needs is critical to providing effective care to ethnically diverse parents.

Declaration of Conflicting Interests

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