

JAPANESE AMERICAN WOMEN: BEHAVIORS AND ATTITUDES TOWARD BREAST CANCER EDUCATION AND SCREENING

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Moore's University of California, San Diego, Cancer Center's Asian Grocery Store-Based Cancer Education Program trained bilingual, bicultural student health educators to provide breast cancer information to Japanese American women. A subset consented to help evaluate the program by completing baseline and follow-up surveys. Study participants reported high adherence to mammography screening guidelines.

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but lower than optimal adherence to clinical breast examination (CBE) and monthly breast self-examination (BSE) guidelines. While less than half of the women felt they had enough knowledge about breast cancer, nearly all indicated that they would be willing to share any knowledge they gained with loved ones and that their loved ones would be receptive to their information. A limitation of the study is its small sample.

INTRODUCTION

Cultural and language barriers can reduce participation in early detection programs (Moon, 1994). Screening procedures may seem unnecessary, even personally intrusive, to those who are not familiar with Western medicine, thereby increasing the risk of discovering cancer and other life threatening diseases in their later stages (Nebres & Mark, 1996). There is limited information available about the screening attitudes and behaviors of Asian Americans (Moon, 1994). In addition, even less is known about the women in the individual cultural and ethnic subgroups who make up the larger category of Asians and Pacific Islanders (Chen & Hawks, 1995).

Among the cohort of Asian American women, Japanese American women have the highest breast cancer survival rate (Lin et al., 2002; Meng, Maskarinec, & Wilkens, 1997; Pineda, White, Kristal, & Taylor, 2001). Despite their relatively low breast cancer mortality rate, breast cancer is their most commonly occurring form of cancer (American Cancer Society, 1995, 1999a, 1999b, 2002). A study by Lin, Clarke, Prehn, Glaser, West, and O'Malley revealed that 21% of Japanese women age 40 years and older reported never having had a mammogram (Lin et al., 2002). The report of the Third National Cancer Survey of 1969–1971 revealed that the breast cancer risk for Japanese American women in the San Francisco–Oakland metropolitan area closely approximated those for Whites (Buell, 1973). Therefore, finding ways to reach Japanese American women with health information about life threatening illnesses such as breast cancer is critical.

Since 1994, the University of California, San Diego, Cancer Center has been testing culturally tailored cancer education programs at Asian grocery stores to develop a cost-efficient way to educate the Asian Pacific Islander community about cancer prevention and early detection (Sadler et al., 1998; Sadler et al., 2000). The researchers hypothesized that the adherence to screening guidelines for Pacific Asian women would be lower than optimal, and that this would be true for Japanese American women as well.

METHODS

Partnership with more than a dozen Asian grocery stores throughout San Diego County produced promising community outreach study sites. A midpoint review of the sociodemographic characteristics of the sample disclosed relatively low representation of Japanese Americans in the sample. The study's secondary hypothesis thus became that through further refinement of the participant recruitment strategies it would be possible to attract Japanese American women to the study. Through the recruitment of grocery store partners specializing exclusively in Japanese cuisine and culture, 47 Japanese participants were readily recruited to the sample of 1,202 Asian American women (Ko, submitted; Sadler, Dhanjal et al., 2000; Sadler et al., 1998; Sadler, Dong, et al., 2001; Sadler, Ryujin, et al., 2001; Sadler, Ryujin, et al.,

submitted; Sadler, Thomas, et al., 2000; Sadler, Wang, et al., 2000). This article focuses on those Japanese American participants.

The program provided literature and hands-on breast cancer teaching aids along with information about how low income women could access free CBEs and mammograms, as well as treatment in the event that breast cancer was discovered. The program's bilingual, bicultural Japanese American college coeds worked as community health educators at the newly recruited Asian grocery stores. Women were cued to screening via posters with familiar Japanese icons, repeated exposures to the exhibits, and reminders in their native language (Becker, 1974).

When Japanese American women visited the displays they were invited to take part in a baseline and follow-up telephone survey about their breast cancer related attitudes, knowledge, and behaviors and to assess the cultural acceptability of the educational program. The baseline survey consisted of 9 forced choice questions. Researchers initiated a follow-up telephone survey two weeks post baseline using a branching survey composed of either 8 or 13 forced choice and open-ended questions to solicit information about women's adherence to screening guidelines, barriers to screening, and suggestions for improving screening access.

Sample Description

Japanese American women ($N = 47$), ranging in age from 23 to 73 years ($X = 46.7$, $SD = 13.24$), consented to participate in the program's data collection. Japanese was reported as the primary language for 85% (40) of the subjects, while English was reported by 15% (7). Review of the zip codes and telephone exchanges showed that the Asian grocery stores attracted Japanese American women from throughout San Diego county's 5,000-square-mile region.

RESULTS

Baseline Survey

Table 1 shows the sample's adherence to breast cancer screening guidelines by age. When the women were asked about their perception of the adequacy of their knowledge of breast cancer, 43% (20) said they had enough knowledge. Seventy-two

Table 1. Screening reported by age-appropriate adherence to the American Cancer Society Breast Cancer Screening Guidelines*

Screening	20–39 $N = 16$ $N (%)$	40–49 $N = 10$ $N (%)$	50+ $N = 19$ $N (%)$	Age unspecified $N = 2$ $N (%)$
Reported monthly BSE	2 (13)	6 (60)	9 (47)	1 (50)
CBE in past 12 months	6 (38)	5 (50)	12 (63)	0 (0)
Mammogram in past 12 months	0 (0)	7 (70)	14 (74)	1 (50)

*The American Cancer Society recommends that beginning at age 20, women perform monthly breast self-examination and have a clinical breast exam every three years. Clinical breast exam is recommended annually beginning at age 40, plus mammography every one to two years. Annual mammogram is recommended beginning at age 50, along with continuation of monthly breast self-exams and annual clinical breast exams.

percent (34) of the women said they would be interested in receiving in the future free information that might be helpful in keeping their families healthy. Eighty-five percent (40) said they would be willing to share their knowledge of breast cancer with their family and friends, and 74% (35) felt that their loved ones would be receptive to their efforts to share their breast cancer knowledge.

When asked about the barriers they faced to participation in breast cancer education programs, 57% (27) reported lack of time and 15% (7) reported language. Money was a reported as a barrier by 8.5% (4) of the women, 4% (2) preferred not to think about such things, and 2% (1) felt that such things were not important to them. No one reported embarrassment as a barrier to participation in such programs, even though that choice was given as an option and women could select as many options as appropriate.

When the women were asked the preferred ways to reach them with more information, 66% (31) said they would like to receive printed materials by mail, 30% (14) were willing to attend an educational program, and 23% (11) preferred a follow-up phone call to receive additional information. Over half (55% [26]) responded that they would be willing to be contacted if there were any further questions related to the current study. When asked if they would be willing to take part in future studies similar to the present, 28% (13) responded affirmatively.

Follow-Up Survey

Of the 47 women who completed the baseline survey, 81% (38) completed the follow-up survey (29 by phone and 9 by mail after 10 telephone attempts had failed to reach them). Of the 9 lost to follow up, 1 did not respond after being called 10 times, 1 provided a wrong number, 2 had disconnected numbers, and 5 did not furnish a phone number or provide full mailing addresses to which the survey could be sent. There were no significant differences in the age ($X^2 = 19.86$, $p > 0.05$) or language distribution ($X^2 = 1.24$, $p > 0.05$) between the women who completed the baseline survey and the 38 women who completed the follow-up survey.

The follow-up survey focused on whether the women had set up a screening exam in the time since the baseline survey. Of the 19 women ages 40 and over in the follow-up survey, only one woman was in compliance with CBE and mammography guidelines at baseline. None of the women who were not in compliance had attempted to set up an exam during the interval of 2 weeks. Of these 19 women, the one (7%) woman who reported scheduling a breast cancer screening between baseline and follow up had already been adhering to screening guidelines for both mammography and CBE at baseline.

When these 19 women were asked what difficulties they faced in scheduling a screening appointment, 28% (5) reported language as a problem. Cost was reported as a problem by 17% (3) of the women in spite of having received information and having been offered a flyer about how low-income women can access free screening and treatment as part of the post baseline training intervention, and fear was reported by 5% (1).

When the participants were asked whether the screening services could be made easier to use, 17% (5) felt that it would be helpful to have more Japanese speakers in the health care facilities and more information about health care available in their language. In response to the final question, 63% (24) said that it would be acceptable to call them again if there were any further questions.

DISCUSSION

Given the small sample size, the lack of representation of the sample, the single geographic region, and the fact that more acculturated women may have been more comfortable participating in a formal study, conclusions must be drawn with great caution. However, in light of the limited data available on individual ethnic groups within the category “Pacific Asian/Other,” even such limited data may be a valuable contribution to health policy planning.

The study’s secondary hypothesis, that special considerations were required to attract the region’s Japanese American women to the Asian Grocery Store-Based Health Education Program, was proven true. The sample of Japanese American participants quickly grew when Asian grocery stores that specifically catered to the culture and dietary preferences of Japanese Americans were recruited as partners. This confirmed the belief that in order to provide effective breast cancer intervention programs to the Asian American subcommunities, health education programs must be modified according to subcultural differences (Meng et al., 1997). Further, with 83% of the participants reporting Japanese as their preferred language, the linguistic skills of the educators proved essential in assuring that the information the program intended to convey was disseminated correctly. Providing the information in Japanese also helped to provide the women with the important vocabulary and health care resources that would facilitate the transfer of the acquired information to other Japanese-speaking women.

The study’s primary hypothesis was proven false for mammography, but true for CBEs and BSEs. Adherence to mammography guidelines exceeded the National Cancer Institute’s and American Cancer Society’s year 2000 goals that were in place when this study began and begins to approximate the 90% screening adherence goal set for the year 2010 (U.S. Department of Health and Human Services [USDHHS], 2001). This finding is encouraging since mammography helps practitioners detect 90% of breast cancers (American Cancer Society, 1999b).

Although this small sample may not be representative of all Japanese American women, the participants’ screening rates are higher than those observed among the other groups of Asian American women who took part in the same study (Sadler, submitted). Further, when women are given more knowledge and encouraged to share their knowledge with other Japanese women, a tipping point can be reached, with the spread of cancer screening behaviors becoming pervasive (Gladwell, 2000; Rogers, 1995).

Clinical breast examination adherence was below the screening goal, but because 85% of the women reported that their primary language is Japanese, this may have been an artifact of the language barrier with women not associating their doctor’s examination with the term “clinical breast examination” (Nakamura, 2001). The high use of mammography among participants lends support to this hypothesis since CBE is usually offered in tandem with mammography.

In contrast, reported monthly BSE rates for the entire sample, as well as within each of the individual age groups, were considerably lower than optimal. Although the BSE was the most neglected screening practice among these women, it is also the least efficacious (Champion, 1992; Thomas et al., 1997). On the other hand, even though BSE may be the least effective method of early detection, it is the only recommended method for younger women, and it is the only supplemental line of defense between annual exams by health care providers. Hence, it remains an

important tool in the early detection of cancer and one that appears to be underused in this population.

In spite of the relatively high screening rate, the study shows that many women do not feel that they have sufficient breast cancer knowledge. For Japanese women living in America, language and culture may be barriers to obtaining health information and health care. Women's adherence rate to mammograms and CBEs appears to have been encouraged by their health care providers (Kagawa-Singer & Pourat, 2000; Lin et al., 2002). These same providers could help their patients to understand the importance of monthly BSEs and teach them the proper exam techniques.

With 85% of the women in this study reporting Japanese as their native language, health care providers must be more proactive in their communication with their Japanese patients who have limited English language proficiency (Frank et al., 2000). It may be difficult for some women to communicate their questions and concerns to their health care providers and, in turn, understand the explanations provided to them. Even the written educational material that may be available readily in health care settings may overwhelm those women whose medical vocabulary is limited.

Japanese culture also tends to emphasize being submissive rather than being straightforward with one's thoughts. To avoid any type of confrontation, the communication style of the Japanese culture tends to be indirect and away from the point (Clancy, 1986; Lebra, 1987; Tannen, 1994; Tomine, 1991; Wetzel, 1988). The term *omoiyari* in Japanese refers to the cultural concept of empathy and intuition amongst people. This can influence Japanese women's relationship with their health care providers, causing Japanese women to rely upon physician's ability to sense the level of their health understanding intuitively (Lebra, 1987). The doctor of the Japanese patient is expected to infer the patient's preferences and intentions without the patient making explicit requests or asking favors, both of which are considered to be too direct and rude (Fetters, 1998). Doctors in Japanese society are held in high esteem because of their high level of education (Andresen, 2001). As a result, patients often refrain from asking the doctor questions, not just because the doctor is thought to be right always, but also because they expect a specific diagnosis and treatment upon their initial visit (Chung, 2002). Questioning the doctor regarding omissions in care is inconsistent with cultural norms.

Westernized health education intervention programs may appear as unapproachable due to the lack of cultural and linguistic sensitivity (Fukui, Kugaya, et al., 2000). This may result in some women preferring to take the passive approach, believing that seeing a doctor is the best and only thing necessary to detect breast cancer and settling with whatever health care their doctor provides. These circumstances may prevent many Japanese American women from obtaining further knowledge about breast cancer and early detection through give-and-take communication.

Cultural alignment was critical to the success of this program. Having staff who were culturally competent and able to communicate in Japanese were important in reaching a sample of predominantly Japanese-speaking women. Identifying an environment specifically aligned with Japanese culture and cuisine was an equally critical step forward in attracting women to this education program. Japanese icons and posters in Japanese further encouraged women to explore the exhibit.

This study shows that for the majority of the Japanese American women in this sample, the message of mammography screening is being received and followed. Although this cohort may not be representative of all Japanese American women's mammography screening behaviors, it is helpful to know that at least some Japanese

American women are using this optimal screening method. Given that most of these women reported that they are willing to share their health knowledge with others, health care providers and educators can encourage those women who are adhering to screening guidelines to share the importance of these actions with others as a way to amplify the health promotion message. With message amplification, even modest health interventions efforts can lead to long-term improvements in the quality of life among Japanese Americans (Fukui, Kamiya, et al., 2000; Gladwell, 2000).

A deviation worth mentioning between the Japanese American participants in this study and the participants from the other Asian cultural subgroups in this same study was the absence of screening uptake in the time from baseline to follow up among women who were not in adherence with screening guidelines (Ko et al., submitted; Sadler, 2000; Sadler, Dong, et al., 2001; Sadler, Nguyen, et al., 1998; Sadler, Ryujin, et al., 2001; Sadler, Ryujin, et al., submitted; Sadler, Thomas, et al., 2000; Sadler, Wang, et al., 2000). This may have been an artifact of the small sample, a consequence of the women's reluctance to question their doctors' lack of screening recommendations, or a small cohort of subjects that has previously made an affirmative decision not to get screened. On the other hand, since the Asian stores that catered to Japanese American women were recruited as partners later in the program, the Japanese American participants may have had less exposure to information and repeated cueing for screening. The health belief model supports the importance of cueing for screening as a way to increase a women's perceived vulnerability, susceptibility, and the benefits of screening action in order for the health education intervention to be effective (Becker, 1974). In addition, the shibboleth of marketing states that between 7 and 21 messages must be received before awareness of the message is even attained. The lack of uptake of screening behaviors between baseline and follow-up may thus have been the consequence of receiving fewer culturally and linguistically compatible messages cumulatively.

Although Japanese American women in this study showed high adherence with recommended breast cancer screening guidelines, linguistic and cultural barriers still seemed to pose a problem for many of the women in the cohort. Such barriers may explain a considerable portion of women in the study who reported a need for more breast cancer information and the belief that it would be helpful if more health care professionals spoke Japanese and more materials were available in their language.

CONCLUSION

A partnership with Asian grocery stores that cater to the culture and cuisine of Japanese American women appears to be a viable and culturally acceptable way to reach Japanese American women with breast cancer and potentially other health and social welfare information. While a large proportion of the participants were adhering to mammography, it appears that the nonadherent group will require more focused efforts to increase screening behaviors.

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