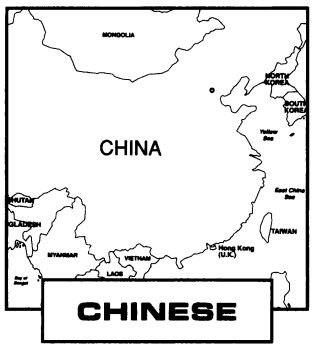
- **1.6 million people of Chinese origin live in the US**
- **Chinese immigrants are heterogeneous in class, occupation, and regional and linguistic backgrounds**
- **Breast cancer rates for Chinese-American women are higher than for women in China but lower than for white women in the US**



Cross-cultural Medicine
A Decade Later

Modesty, Sexuality, and Breast Health in Chinese-American Women

BERTHA MO, PhD, MPH, *San Francisco, California*

Although breast cancer rates among Chinese women are lower than among white women, breast cancers and other breast diseases often go undetected and untreated in Chinese women. Cultural values with respect to modesty and sexuality, especially in unmarried women, partly account for a Chinese lack of attention to breast health. In addition, institutional barriers, such as an unavailability of information in Chinese languages, few female physicians, and an absence of educational campaigns, contribute to Chinese women's neglect of breast health.

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One rainy evening in 1977, I accompanied an old friend (and fellow health professional) on a special errand to a Buddhist shrine in San Francisco's Chinatown. We were to pay respects to the burial tablet of her aunt who had recently died of breast cancer. This is the story she told me.

Ah Ling Ee was born in China in 1905 and emigrated to Singapore in her early 20s. In 1956 at age 51, she emigrated with her married sister and her sister's family to the United States. Ah Ling Ee had a sixth-grade education. In Singapore she had worked alongside her sister as a tailor and as a hairdresser. Never having married, she devoted herself to helping her sister raise six daughters. For three to four years, Ah Ling Ee had complained of pain in her hip and lower back *(ill quit tung)*. This is a common complaint among the Chinese, and the family was sympathetic but did not feel the condition warranted a visit to a doctor. In 1972, in terrible pain and thinking she was dying, she asked to be taken to a hospital. A cursory examination showed extensive bleeding from the left breast and the breast obscured and disfigured by a massive growth. The cancer had metastasized to the bone and the liver. Through surgery, chemotherapy, Chinese medicine to keep her strength up, and the daily ministrations of her niece, Ah Ling Ee survived for four years.

As someone who never married, Ah Ling Ee had never had a pelvic examination or a Papanicolaou smear. Neither had she ever had a breast examination. To do so would be an admission that she was a sexual being capable of reproducing. Because she was not married, the idea of sexual activity was not only immodest but repugnant. My friend also told me that her aunt did not want to say anything because the idea of going to a doctor was totally out of the question—she was too modest for that. Because she was single, she also did not want to draw attention to herself. Having her soul tablet placed outside the home was one last expression of her lack of status. Although beloved by the family, she was in death virtually an outsider.

Over the years, my friend gradually expressed her grief at losing someone who was a second mother to her. There was also guilt at being a health professional who could only stand by helplessly as a loved one wasted away in terrible pain. At last, however, there was also anger—anger at the Chinese social and cultural values that prevented her aunt from getting medical attention earlier.

In this article I hope to illuminate the attitudes and cultural and institutional barriers that must be overcome if Chinese women in America are to achieve optimal health. By focusing on the effects of social roles and cultural beliefs on health and illness, I suggest additional areas of questioning for those interested in researching Chinese women's health care needs. In the interests of time and space, most of the examples and discussion focus on breast health care.

Breast Cancer Epidemiology

In all women, including Chinese women, breast cancer is the most commonly diagnosed cancer. Incidence rates seem to increase after menopause,[1] and the death rate from breast cancer appears to increase slightly among women aged 50 years or older.[2]

Chinese women in the United States have a lower incidence of breast cancer (54.0 per 100,000) than white women (86.5 per 100,000),[3] but survival rates at five years are not better for Chinese women (64%) than for white women (71%).[4] A late stage of diagnosis due to cultural and institutional barriers increases cancer mortality. Racially based differences in estrogen metabolism is the prevailing explanation for the disparity that exists between cancer rates of Asian women generally and of white women.[5]

The incidence of breast cancer in Chinese women in the United States is substantially higher than that in Chinese women in Asia,[6] which ranges from 6.1 per 100,000 in Taipei[7] to 18.2 per 100,000 in Singapore[8] and 21.5 per 100,000 in Hong Kong.[9]

Data from Shanghai confirm what had only been suggested previously—that breast cancer rates among Chinese women are increasing steadily. Factors thought to increase the cancer risk of Chinese women who emigrate to the United States and American-born Chinese women include the westernization of the diet (less fiber, more fat), earlier age of menarche, later age of having a first child, fewer number of children, and fewer women breast-feeding.[10]

Breast Cancer Prevention

Breast cancer prevention is primarily focused on early detection and treatment. With slight variation, since the early 1980s the American Cancer Society's guidelines for asymptomatic women are monthly breast self-examination begin-

From the Consultation, Education, and Information Unit, Division of Mental Health and Substance Abuse, Department of Public Health, San Francisco, California. Reprint requests to Bertha Mo, PhD, MPH, 1380 Howard St, San Francisco, CA 94102.

ning at age 20; clinical breast examination by a health professional every three years between 20 and 40 years and yearly at age 40 and older; and mammography with a baseline examination between age 35 and 39, every one to two years between 40 and 49, and yearly at age 50 and older.[11]

In an important work, Carter and co-workers found that no instrument existed to assess women's attitudes about their breasts.[12] Many investigators have hypothesized that such attitudes play an important role in breast self-examination and in delay in seeking breast cancer treatment. Understanding these attitudes would be useful in any efforts to educate women about breast health. Carter and associates used a 9-item breast attitude scale measuring women's feelings of pride, comfort with self-touch and examination, awareness of changes over the monthly cycle, and experience of sexual pleasure.[12] In working with Chinese women (except the very young, American-born), such direct questioning would be viewed as intrusive and impolite.

Some cultural reasons should be examined to understand why breast health is a problem for Chinese women, looking first at the demographics of Chinese immigration to the United States and then at sociocultural beliefs about sexuality and health.

Chinese Immigration to the United States

Despite anti-Chinese sentiments and discriminatory laws such as the Chinese Exclusion Act of 1882 and the National Origins Quota Act of 1924, Chinese have never stopped coming to North America since the first arrived after the American Revolution.[13] Large numbers of Chinese came in the 1840s and 1850s to work as farm workers and on the railroad. In 1965 when Public Law 89236 abolished the National Origins Quota System, a large number of young immigrant families and the spouses and children of old sojourners came to be reunited. In 1975 after the fall of Saigon, ethnic Chinese fled Vietnam, Laos, and Cambodia to swell the population of Chinatowns all across the United States.

More recently, events like the uprising in Tiananmen Square in 1989 have provoked the continued exodus of refugees from mainland China. The prospect of the return of Hong Kong to mainland China in 1997 has stimulated a unique movement of Chinese families from both Taiwan and Hong Kong. Young Chinese, some as young as 12 years, are being sent to study in the United States and to establish their families' residency rights.

The Chinese comprise the largest Asian population in the United States, with a total of 1,645,472 persons. The largest concentrations are in the states of California (704,850), New York (284,144), Hawaii (68,804), Texas (63,233), New Jersey (59,084), Massachusetts (53,792) Illinois (49,936), Washington (33,962), and Maryland (30,868). In California the largest communities are in Los Angeles County (245,033) and the City and County of San Francisco (127,140).[14]

Gould-Martin and Ngin categorize four major types of Chinese-American households[15]: the single sojourner, the old immigrant couple, the new immigrant family, and the acculturated suburban family. They conclude that although the first three household types require special attention from health care professionals because of poverty, their language problems, and their residence in Chinatowns, the acculturated suburban family merits special concern only in the area of race and disease epidemiology.

In the past decade, increased immigration and economic and educational diversity among Chinese immigrants have made Chinese-American households less homogenous and more difficult to categorize. Well-to-do immigrant families who are bilingual and bicultural are moving into suburban neighborhoods. Combining incomes from members of large extended families is making it possible for immigrant families to move into middle-class, single-family-home neighborhoods.

Cultural beliefs about the body, health and illness, and social norms do not suddenly disappear in immigrants when they move out of Chinatown. Nor are those who are acculturated without "cultural baggage" that may have ramifications on their health or on their ability to obtain health care. Often these cultural themes lie dormant until a person is under stress (being sick or having a sick loved one) or until a situation causes this backdrop to resurge. In addition, the role played by health care institutions in ethnic minority communities in promoting or discouraging health programs is an important consideration.

Social Role of Chinese Women

The subordinate position of women in traditional China and contemporary overseas Chinese societies is well noted. The means for enlisting women in their own subordination is the use of ideology. The cosmologic basis for this elaborate code of subjugation can be found in Chinese beliefs that date back to the first millenium BC. These held that the universe developed from two complementary opposites, "yin" *(ngam)* the female and "yang" *(yeuhng)* the male. The yin represents the dark, cold, wet, passive, weak feminine aspect, and the yang represents the bright, hot, dry, active, strong masculine aspect.

The natural rhythms of day and night and sun and moon corresponded to the balancing roles of male and female. Man represented the "firm nature of heaven" and woman the "yielding" nature of earth.[16(p173)] Originally conceived as equal and complementary, the elements soon developed a hierarchic relationship juxtaposing the yang over the yin. Yin began to manifest all that was evil, negative, and weak. In contrast, yang stood for all that was good, positive, and strong.

Later Confucius and followers incorporated these revised cosmologic beliefs into an elaborate set of rules governing social interaction that became the dominant ideology of China from the second century BC.

Special books elaborating on appropriate behavior for girls and women were written in the first centuries AD for female audiences. The most well known is the *Nu Jie (Precepts for Women)* written by the scholar Pan Chao. She counseled women to be obedient, unassuming, yielding, timid, respectful, reticent, and unselfish. The result of such passivity was a feeling of powerlessness and vulnerability. The accepted formula is that of "thrice obeying" *(sam sing)*, that as a young girl she must answer to her father, as a wife she answers to her husband, and as a mother she answers to her son. The Chinese patriarchal system considers unmarried women outsiders because they will marry and join their husbands' family line. Females who die before they marry, either in childhood or because they remained unmarried as adults, present an awkward situation because there is no provision for them among the family ancestors. Special "soul

houses" are set up to keep the memorial tablets of such female Chinese.[17]

In overseas Chinese communities all over the world, the Confucian classics hold a revered place in Chinese primary and secondary education. For the illiterate, quotations from these texts are repeated by the educated, and concepts of male superiority and strength and of female inferiority and weakness have been embodied in folklore and permeate overseas Chinese society. Many overseas Chinese women have internalized these negative attitudes, and they are usually not conscious of or able to articulate the ideology that is responsible for their predicament. Like a self-fulfilling prophecy, these ideas have serious repercussions for women's health and well-being.

Cultural Beliefs About Health and Cancer

Among the Chinese, cancer is a relatively new disease. The word for cancer in Cantonese is *nham,* which loosely translated means "growth." Breast cancer is called *yee nham.* There is no mention of this disease in the texts on Chinese medicine.

Most practitioners of Chinese traditional medicine (from the literate tradition) or folk medicine say there are no Chinese cures for cancer. There are ample prescriptions, however, to keep the body well nourished during the often debilitating treatment. This type of prescription is called *boh* or *boh bun* and has been well described in many works on Chinese medicine.

A 1981 project on cancer education for Chinese Americans provides some indication of cancer beliefs (B. Mo, "Chinese-American Cancer Education Project Report," National Cancer Institute, 1981). A total of 62 persons, 28 men and 34 women ages 20 to 67 whose primary language was Cantonese, participated in eight focus groups. All participants were born overseas; 46 were from China, 6 from Hong Kong, 5 from Vietnam, 4 from Burma, and 1 came from Indonesia. Half of the participants had been in the United States less than a year. Their average educational level was the 12th grade, which appears to be higher than that of the usual immigrant. They had much general knowledge about cancer, not all of it accurate. Cancer, they thought, could remain undetected in the body forever, and the following could cause cancer: breathing polluted air (coal dust in their homeland), smoking and drinking, using aluminum and lead utensils, and having certain chemicals sprayed on crops. The relationship between diet and cancer was repeatedly stressed. Frozen foods, preserved foods in cans that contain harmful chemicals, instant noodles, raw foods, and foods preserved in the Chinese manner, such as "salted fish," were to be avoided because they cause cancer. Poor or inadequate nutrition was thought to make people susceptible to cancer.

Only 6 of the 62 thought it was important to have regular medical checkups. Only 6 (18%) of the 34 women went for yearly pelvic examinations. This reluctance to seek the care of a physician should not be interpreted as a rejection of preventive care. In fact, there is ample evidence that Chinese are attuned to some preventive strategies such as exercise, diet, and postnatal care.[18] The reluctance to seek care from a physician stems from the inconvenience of having to make and keep appointments and the high cost. In Asia physicians prescribe and dispense medication. There is usually no charge or only a nominal fee for physicians' services, the real cost of the visit being the charge for the medicine. Consequently, the idea of a visit for a checkup without medication does not fit Chinese patients' expectations. This feeling of incompleteness may progress into a lack of confidence in the physician. In my own research, English-educated, foreign-born Chinese have said to me after a visit where medication was not prescribed, "Isn't it strange, we weren't given a prescription. Perhaps we should consult someone else."

Sexuality, Power, and Health

In several of the essays in Wolf and Witke's book, evidence exists for a Chinese conception of women as "weak, timid, and sexually exploitable as well as dangerous, powerful, and sexually insatiable."[18(p2)]

Women's power lies in their contribution to the formation of the fetus and the physical and social danger of contact with birth and menstrual fluids. In women's fertility lies the fate of the patrilineal group. Women are viewed as dangerous socially because their influence over descendants of the family can have repercussions for its survival as a unit.[19]

According to Wolf and Witke, "gestation and childbirth, sources of great good as well as immense unacknowledged female power, have acquired over the centuries an enormous ritual burden of negative sentiment,"[18(p3)] which has had a debilitating effect on Chinese women today.

Ham suup, a Cantonese term that means "salty and wet," is the colloquial term for sexuality. Most frequently used in a derogatory manner, the words describe anyone who is sexually inappropriate. Being overly concerned with another person or talking about or touching one's body is classified as *ham suup.* Expressing curiosity or being knowledgeable about the body is also *ham suup.* Consequently, sex education is not considered an appropriate topic for polite conversation.

In many cases sex education is really birth control information, which is deemed appropriate only just before marriage. To obtain birth control information today usually involves a physician visit, which may also be the first time a Chinese woman receives a complete physical examination with a pelvic examination, a Papanicolaou test, and a clinical breast examination.

Discussions of Chinese women and health invariably mention modesty as the reason women are reluctant to be examined by male physicians. Cultural beliefs continue to be a barrier to health care. Pillsbury notes that in Taiwan, men are never permitted in a delivery room lest they be polluted—made "dirty"—by the blood emitted by women.[20] In China about 90% of obstetricians and gynecologists are women because of the traditional female reluctance to have reproductive problems dealt with by men.[20] This high percentage of women in obstetrics and gynecology may well be due to persisting beliefs in the polluting effects on men of menstruating blood.[15]

Knowledge of Chinese women's attitude toward sexual experiences is limited, but women tend to be "negative and heavily influenced by a fear of the exploitation of their sexuality." Chinese women feel vulnerable not only to illness and natural harm but to exploitation by other people.

Further, according to Ahern,

> during intercourse a man absorbs the female yin essence, which strengthens his vital powers. Ejaculation, however, results in the debilitating loss of vital yang essence. Too frequent intercourse so drains a man's vital essence that he is vulnerable to several serious diseases. For this reason numerous techniques are recommended that enable men to avoid ejaculation; women are in no danger, for their supply of yin essence is inexhaustible.[19(p209)]

Feuerwerker in a discussion of Chinese women's potential for power says that a popular theme used by women writers is of "a man done in by lust for which a woman is to blame."[21(p147)]

Institutional Barriers

Mammography, particularly screening mammography, is a relatively new procedure. In the United States mammography has become common only in the past decade. The American Cancer Society's Breast Cancer Detection Awareness Program became activated between 1986 and 1988. In Ottawa, the capital of Canada, the first government-sponsored breast screening clinic opened only in late 1991. In a 1977 trip to the Peoples' Republic of China, participants noted that they were shown conventional film mammograms, mammography was not done in most hospitals, and it was not used for screening women for breast cancer.[22,23]

Misinformation about breast cancer and mammography is not just a cultural problem; the lack of breast health education is an institutional problem. Too often groups of people are criticized for their lack of awareness of an issue or a problem when the issue is so new that it has only recently emerged in the English-language media. Defining the problem is critical: often health programs are funded without adequate provisions made for outreach and education because these are seen as nonessential.

As an example, for more than five years, a mobile van offering low-cost screening mammography has been available to communities in San Francisco. The van, staffed by female technicians, is parked near a different shopping area each week. Unfortunately, funds for outreach or education were not available. Women who could read and understand English might have received information about breast cancer and mammography through the news media, and the van's schedule was published in a local newspaper. Women whose primary language was not English, however, would have no information about breast cancer, mammography, or the van's purpose or schedule.

The lack of community response to the van's appearance in San Francisco's Chinatown prompted the planning and implementation of a Breast Health Awareness Day for the community. Although the event was successful, planning for the event did point out several institutional problems.

All the Chinese health professionals who helped plan the event worked outside of Chinatown. Some of those who worked in Chinatown were reluctant to participate because they felt that breast cancer was not a critical health issue for the community and that Chinese women would not attend the program either because they did not perceive breast cancer as a problem or out of modesty. The Chinese medical establishment did endorse the program, however. In addition, a Mandarin-speaking oncologist who was a long-time American Cancer Society volunteer agreed to speak during the lunch break. The necessity of providing clinical breast examination by a licensed physician presented two problems. Although many breast health care practitioners are female nurses, male physicians still outnumber female. Consequently, only one female English-speaking physician was available, and the decision was made to have male physicians perform the clinical breast examinations. In retrospect, female nurses could have been used for the clinical breast examination because the program was doing a screening and not a diagnostic mammogram.

With a planning committee composed of both Chinese and non-Chinese community health professionals and extensive education through the use of the Chinese language media, Breast Health Awareness Day, sponsored jointly by the San Francisco Chinatown Young Women's Christian Association and the local chapter of the American Cancer Society, attracted 109 Chinese women to a screening that previously had engendered no community participation. During the program, 97 (89%) were taught breast self-examination and 91 (84%) received a clinical breast examination. Of the 94 women eligible for mammograms, only 55 (59%) received them because the demand exceeded the capacity of the mobile van.[22]

The importance of screening is demonstrated by the following cases.

Case Examples

Case 1. Sadhi, a 32-year-old single woman from Hong Kong, came here to join her fiance, a 35-year-old electrical engineer also from Hong Kong. They had been introduced through mutual friends. She came to our attention because she needed a premarital examination and wanted information about birth control before her impending marriage.

Sadhi informed us that this was her first pelvic examination and Pap smear. She also had never heard about breast self-examination and felt embarrassed even to discuss it. She told us that unmarried women were not supposed to talk about these things. On manual palpation a lump about 1.27 cm (½ in) in diameter was discovered in her left breast. She was sent for an ultrasound examination and aspiration, upon which the lump was diagnosed as a benign cyst.

Case 2. The patient, a 58-year-old wife and mother of four originally from mainland China, had been in the United States six years. She had all of her children in China and could not recall ever having a pelvic examination or a Pap smear, nor had anyone ever examined her breasts. Because she was beyond her childbearing years, she had not felt the need to be concerned about her female parts. Her daughter, a nursing student, brought her to the screening. On manual manipulation a lump was found in her right breast, and she was referred to her health maintenance organization for further evaluation.

These two case histories concern women at the far ends of the reproductive cycle, one at the beginning and the other at the end. Both women think female organs cease to function if they are not used in procreation.

A unique feature of the Breast Health Awareness Day was the outreach to young Chinese women, who were encouraged to talk with and accompany their grandmothers, mothers, and aunts. In immigrant communities, the young are often called on to translate for their older relatives. By drawing on this common practice, the planners hoped to engage and educate several generations of women at once.

The difficulties that these projects had in recruiting female physicians generally and also those who could speak a Chinese language point to the dearth of bilingual, bicultural female physicians in our community. To remedy the situation, institutions of higher learning need to recruit and train more women physicians. In addition, the community must promote the notion of cultural diversity and instill in young people the need to learn and preserve the best of our cultural beliefs, practices, and languages.

Conclusions

Community organizing, outreach, and education are essential if Chinese-American women are to achieve optimal health and obtain necessary health screening and treatment. Health professionals, even those who are Chinese, often make light of the tenacity of cultural beliefs and social constraints. By understanding the social and cultural context of beliefs about health, sexuality, and fertility, health professionals can provide more sensitive health care to Chinese-American women. Information about specific health practices and their traditional rationale can help support those that have a positive effect on health. Only by understanding such cultural ideas in detail can we as a society sensitively discourage practices that are harmful.

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REFERENCES

1. Miller AB: Breast cancer epidemiology, etiology, and prevention, *In* Harris JR, Hellman S, Henderson I, Kinne D (Eds): Breast Diseases. Philadelphia, Pa, JB Lippincott, 1987

2. Howard J: Using mammography for cancer control: An unrealized potential. CA 1987; 37:33-48

3. Baquet CR, Ringen K, Pollack ES, et al: Cancer Among Blacks and Other Minorities: Statistical Profiles—NIH publication No. 86-2785. Bethesda, Md, National Cancer Institute, 1986

4. Young J, Ries L, Pollock E: Cancer patient survival among ethnic groups in the United States. J Natl Cancer Inst 1984; 73:341-352

5. Dickinson LE, MacMahon B, Cole P, et al: Estrogen profiles of Oriental and Caucasian women in Hawaii. N Engl J Med 1974; 291:1211-1213

6. Yu H, Harris RE, Gai YT, Gao R, Wynder EL: Comparative epidemiology of cancers of the colon, rectum, prostate, and breast in Shanghai, China, versus the United States. Int J Epidemiol 1991; 20:76-81

7. Lin TM, Chen KP, MacMahon B: Epidemiologic characteristics of cancer of the breast in Taiwan. Cancer 1971; 27:1497-1504

8. Shanmugaratnam K: Cancer in Singapore—Ethnic and dialect group variations in cancer incidence. Singapore Med J 1973; 14:69-81

9. Ho JC: Current status of the Cancer Registry and population-based studies in Hong Kong, *In* Bailer JC, Weisburger EK, Aoki T, et al (Eds): Epidemiology and Cancer Registries in the Pacific Basin. Natl Cancer Inst Monogr 1978; 47:57-60

10. Yeung KS: Epidemiology of Breast Cancer Among Chinese Women in San Francisco Bay Area—dissertation. Berkeley, Calif, University of California, 1983

11. Fink DJ: Community programs: Breast cancer detection awareness. Cancer 1989; 64:2674-2681

12. Carter AC, Feldman JG, Tiefer L, Hausdorff JK: Methods of motivating the practice of breast self-examination: A randomized trial. Prev Med 1985; 14:555-572

13. Fawcett JT, Carino BV (Eds): Pacific Bridges: The New Immigration From Asia and the Pacific Islands. Staten Island, NY, Center for Migration Studies, 1987

14. Asians in America: 1990 Census. San Francisco, Calif, Asian Week, 1991

15. Gould-Martin K, Ngin C: Chinese Americans, *In* Harwood A (Ed): Ethnicity and Medical Care. Cambridge, Mass, Harvard University Press, 1981

16. Cheng YK: Manual of Chinese Quotations. Hong Kong, 1903

17. Topley M: The Organization and Social Function of Chinese Women's *Chai T'ang* in Singapore—dissertation. London, England, University of London, 1958

18. Wolf M, Witke R (Eds): Women in Chinese Society. Stanford, Calif, Stanford University Press, 1975

19. Ahern EM: The power and pollution of Chinese women, *In* Wolf M, Witke R (Eds): Women in Chinese Society. Stanford, Calif, Stanford University Press, 1975, pp 193-214

20. Pillsbury B: Convalescence of Chinese women after childbirth. Soc Sci Med 1978; 12:111-122

21. Feuerwerker YT: Women as writers in the 1920s and 1930s, *In* Wolf M, Witke R (Eds): Women in Chinese Society. Stanford, Calif, Stanford University Press, 1975, pp 143-168

22. Kaplan HS, Tsuchitani PJ: Cancer in China. New York, NY, Alan R. Liss, 1978

23. Lovejoy N, Jenkins C, Wu T, Shankland S, Wilson C: Developing a breast cancer screening program for Chinese-American women. Oncol Nurs Forum 1989; 16:181-187