

An Online Forum Exploring Needs for Help of Patients With Cancer: Gender and Ethnic Differences

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Purpose/Objectives: To explore gender and ethnic differences in needs for help among patients with cancer.

Research Approach: Qualitative.

Setting: Internet and community settings.

Participants: 16 self-identified patients with cancer aged at least 18 years who could read and write English.

Methodologic Approach: Using six discussion topics on needs for help, an online forum was administered for one month. Data were analyzed with thematic analysis.

Main Research Variables: Need for help.

Findings: Four major themes emerged: (a) from side effects to racism, (b) same or double stress, (c) cultural hesitance and God, and (d) a family disease with mistrust. Depending on gender and ethnicity, the participants' concerns were various and ranged from a simple physical need to a social need for elimination of racism in United States society. Women tended to report double burden and stress as patients with cancer resulting from their gender. Ethnic minorities tended to be hesitant to talk about cancer or seek help because of the stigmatized nature of cancer. Ethnic minority patients perceived cancer as a family disease that they needed to go through as a family, and they tended to mistrust healthcare providers.

Conclusions: The overriding theme was a marginalized experience for ethnic minority patients with cancer.

Interpretation: Researchers should include cultural needs as a separate category of needs and consider contextual factors influencing the needs of patients with cancer in their daily lives.

Gender differences in needs for help of patients with cancer have not been explicitly explored. Rather, most studies have implicitly supported gender differences in diverse aspects of cancer-related needs (Sanson-Fisher et al., 2000; Thome & Hallberg, 2004). In a recent study examining concerns of patients with lung cancer, women tended to report a significantly larger number of concerns than men (Hill, Amir, Muers, Connolly, & Round, 2003). The instruments measuring needs for help of patients with cancer were developed separately for breast cancer and prostate cancer (Dale, Jatsch, Hughes, Pearce, & Meystre, 2004; Templeton & Coates, 2001). Gender differences in help-seeking behaviors also imply gender differences in perceived needs for help: Men are more likely to seek information, whereas women are more likely to seek encouragement and support (Dale et al.;

Key Points . . .

- ▶ Patients with cancer have various types of needs for help, ranging from a simple physical need to a social need for elimination of racism in U.S. society.
- ▶ The Confucian culture of Asian populations prescribes that women should be wise mothers and good wives, meaning that Asian women can suffer from the additional burden of household work while struggling with cancer.
- ▶ A cultural attitudes stigmatizing cancer of sexual organs and emphasizing “macho men,” causes some Hispanics to not seek help because of embarrassment.
- ▶ Ethnic minority patients might not disclose their diagnoses or openly seek help for their needs because of the stigmatized nature of cancer.

Klemm, Hurst, Dearholt, & Trone, 1999; Sharf, 1997). Also, studies on pain and symptoms of patients with cancer imply gender differences in physical needs. In a systematic review of the literature on gender differences in pain, fatigue, and depression, Miaskowski (2004) reported that research studies yielded inconsistent results. Some recent studies reported no differences (Edrington et al., 2004; Turk & Okifuji, 1999),

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whereas others reported certain differences (Feine, Bushnell, Miron, & Duncan, 1991; Vallerand, 1995).

Ethnic differences in patients' needs have been reported as well. White patients with cancer tend to place the highest priority on their own individual experiences and interests and want to have control of their own bodies and lives, whereas patients in some cultures (e.g., Asian, Hispanic) tend to emphasize the welfare of family (familism) (Pinquart & Sorensen, 2005). According to Arraras et al. (2004), in the United Kingdom and Scandinavian countries, all information is disclosed frequently; in Japan, open disclosure is less frequent. African American women have been reported to depend more on God for support rather than family, friends, or healthcare professionals, and Internet use was reported less often as a source of support (Henderson & Fogel, 2003). Cleeland, Baez, and Pandya (1997) found that patients treated in settings serving ethnic minorities were three times more likely to be undermedicated than patients treated in nonminority settings. Bernabei et al. (1998) reported that ethnic minority patients with cancer were more likely to receive no analgesia.

Despite the findings, very little is known about gender and ethnic differences in needs for help among patients with cancer. A MEDLINE® search of the years 1990–2005 using search terms including *ethnicity*, *gender*, *cancer*, and *needs* retrieved only 17 articles; another search for *ethnic difference*, *cancer*, and *needs* retrieved only 7 articles; and a search for *gender difference*, *cancer*, and *needs* retrieved only 11 articles. However, even the retrieved articles were not actually about gender and ethnic differences in patients' needs for help. The purpose of this study was to explore gender and ethnic differences in needs for help of patients with cancer; the study used a qualitative online forum.

The study used a feminist perspective as its theoretical basis. No unitary feminist perspective exists; rather, literature shows diverse perspectives within feminism, including liberal, essentialist, radical, Marxist, socialist, and postmodern. Yet distinctions among diverse feminist perspectives become blurred in contemporary feminism, which can be summarized by several principles that all feminist perspectives have in common: (a) it is important to center and make problematic women's diverse situations and the contexts that influence those situations; (b) all feminists refer to the examination of contexts in the interest of realizing social justice for women; (c) all feminist theory posits gender as a significant characteristic that interacts with other factors, such as race and class, to structure relationships among individuals; (d) with the exception of liberal feminism, most feminist theories do not believe the neutral objective observer for a social construction of scientific research; (e) most feminist theories reject dualism (e.g., good, evil); (f) women's experience is important; (g) the distance between observer and object of study is shortened; and (h) uncausal, hierarchical approaches are rejected (Im, 2007).

Methods

This was a qualitative study among 16 patients with cancer conducted in an online forum. Subjects were recruited through Internet and community settings. Approval was obtained from the review board of the institution where the authors are affiliated.

Sample and Settings

Subjects were recruited through a convenience sampling method. The Internet settings were Internet cancer support groups that were identified through MSN.com searches; the community settings included a cancer clinic in central Texas and a cancer support group in New York. Six to 12 participants are regarded as ideal for focus group discussion, including online forum discussion (Hall & Stevens, 1991). Therefore, a sample of 16 was considered an adequate number for the online forum discussion. The inclusion criteria for research participants were self-identified patients with cancer at least 18 years of age who could read and write English.

The online forum discussion was conducted for one month. The researchers used an online forum to reach out to patients in dispersed geographic areas and hear diverse experiences. One to two topics per week were posted on the forum site, and the participants were asked to visit the forum site and post their messages when new topics were posted. Multiple strategies were used to retain the participants. First, bonds between the participants and researchers were established via respectful and trustworthy interactions through online forums, and one research staff member was assigned to follow the online forums consistently. Also, a monetary incentive of a \$50 gift card was provided to each participant at the completion of the online forum.

Discussion Topics

The online forum discussion topics included: (a) patients' attitudes and responses to cancer; (b) schedules, hardships, and sufferings in daily life; (c) needs for help (culturally universal and ethnic specific); (d) gender and ethnic differences in needs for help; (e) things and life events influencing needs for help in their daily lives; and (f) currently available supports and preferences for supports. Several prompts related to each topic were provided to help the participants understand the topics. The topics and prompts were developed by the authors and reviewed by an expert panel of oncology nurses.

Data Collection Procedures

When a potential participant agreed by e-mail or in person to join the online forum, he or she was asked to visit the online forum site. Each participant received a username and password, which were randomly assigned by the researchers, and was asked to use them when logging onto the forum site. A participant could change his or her username and password at any time during the online forum discussion. Each participant also was asked to choose and use a pseudonym for the online forum discussion to ensure anonymity. In addition, visits to the online forum site were recorded and monitored; only those who registered were allowed to enter the online forum.

When 24 participants were recruited, the online forum was initiated, but only 16 participants still were posting at the end of the online forum. One of the researchers e-mailed the registered participants and informed them about the initiation of the online forum discussion. On the opening page of the online forum, introductory questions were posted so that the participants could introduce themselves when they visited the site for the first time. Then the topics were posted serially on the forum site for the one-month period. The participants could post their messages at their convenience in any form (e.g., stories, conversations, responses to other's

messages), and limits were not placed on the number and length of messages. Contact information for the research staff was provided so that participants could contact the staff members directly.

Data Analysis

The transcripts were printed directly from the online forum site and analyzed with thematic analysis (Boyatzis, 1998). First, the printed transcripts were read thoroughly, then re-read for line-by-line coding, and the codes from the line-by-line coding process were summarized as a coding book. Based on the coding book, the researchers performed categorization through internal cognitive processing and reflexive thinking by analyzing content and context. Then, while formulating the associations between categories, the researchers sought gender and ethnic differences in patients' needs for help by reviewing and reformulating the relationships. Also, the researchers examined influences of variable contextual factors (e.g., health status, socioeconomic circumstances, families' responses and roles, stability of daily lives, social support networks) on the participants' needs for help. Additionally, to get more abstract and refined ideas about gender and ethnic differences in needs for help, the researchers read and re-read the texts and identified themes representing gender and ethnic differences.

Participants' views were prioritized during the research process (Hall & Stevens, 1991). Hall and Stevens' criteria for feminist research were used to ensure rigor of the study. For example, to ensure the dependability of the study, the research team met regularly during data collection and analysis and created and discussed the methodologic and analytic decision trails created throughout the process. Also, to ensure the reflexivity of the study, the research team wrote chronologic research memos and notes and held regular group meetings to discuss any issues related to the study.

Findings

Table 1 summarizes sociodemographic characteristics of the participants, and Table 2 reviews their health and disease characteristics. The participants included 12 whites, 1 Hispanic, 1 African American, and 2 Asians. The mean age of the participants was 51.19 years (SD = 10.20), and 81% were women. More than 80% of the participants were college graduates or had graduate degrees, and 44% were not employed. Seventy-six percent reported that their family incomes were sufficient or more than sufficient, and 25% were Catholic. About 75% were born in the United States. Among those who were born outside the United States, the length of stay in the United States varied from 4.5–43.5 years (\bar{X} = 26.05 years, SD = 19.79 years). More than 60% perceived that they were healthy or very healthy.

Four themes related to gender and ethnic differences in needs for help emerged through the analysis process: (a) from side effects to racism, (b) same or double stress, (c) cultural hesitance and God, and (d) a family disease with mistrust.

From Side Effects to Racism

Depending on gender and ethnicity, the participants' concerns varied and ranged from a simple physical need to a social need for elimination of racism in United States society. Most of the white patients were concerned about side effects

Table 1. Sociodemographic Characteristics of the Participants

Characteristic	\bar{X}	SD
Age (years)	51.19	10.20
Annual family income (\$)	48,603.33	35,300.08
Number of children	2.13	0.96
Number of friends	3.06	0.68
Length of stay in the United States (years)	26.05	19.79
Characteristic	n	%
Ethnicity		
White	12	75
Hispanic	1	6
African American	1	6
Asian	2	13
Gender		
Female	13	81
Male	3	19
Marital status		
Married	11	69
Divorced	3	19
Single, never partnered	2	13
Religion		
Protestant	3	19
Catholic	4	25
Other	6	38
No religion	3	19
Education		
High school	1	6
Partial college	2	13
College graduate	9	56
Graduate degree	4	25
Employment		
Not employed	7	44
Employed	9	56
Income satisfaction		
Totally insufficient	3	19
Somewhat insufficient	1	6
Sufficient	9	56
More than sufficient	3	20
Support from family, relatives, or friends		
None of the time	1	6
A little of the time	3	19
Some of the time	4	25
Most of the time	8	50
Born in the United States		
Yes	12	75
No	4	25

N = 16

Note. Because of rounding, percentages may not total 100.

from cancer, medication, and chemotherapy; subsequent physical limitations; lack of socialization; and low energy. Among ethnic minority groups, financial and insurance issues were the biggest concerns reported. In addition, Asian women were concerned about bone density, insomnia, work performance, help cooking, and difficulties finding a support group. A Hispanic woman was concerned about emotional issues (e.g., how to deal with crying, how to talk about emotional issues). An African American woman was concerned about low energy, loss of friendship, personality change, and

Table 2. Health and Disease Characteristics of the Participants at the Time of the Study

Characteristic	n	%
Health status		
Unhealthy	3	19
I don't know	3	19
Healthy	9	56
Very healthy	1	6
Cancer type		
Breast	5	31
Thyroid	1	6
Lung	1	6
Colon	1	6
Brain	1	6
Skin	1	6
Ovarian	3	19
Nasopharyngeal	1	6
Combined	2	13
Pain medication		
Yes	7	44
No	9	56
Regular place for health care		
Clinic or health center	14	88
Other	1	6
Missing	1	6
Cancer stage		
I	3	19
II	8	50
III	2	13
IV	3	19
Treatments received		
Only radiation therapy	1	6
Only chemotherapy	5	31
Only surgery	2	13
Combined	8	50
Regular access to health care		
Yes	15	94
No	1	6
Having difficulties getting health care		
Yes	4	25
No	11	69

N = 16

Note. Not all respondents answered all questions. Because of rounding, percentages may not total 100.

changes in the meaning of life. One of the Asian women talked about her concerns.

I decided not to have chemotherapy and radiation, so I didn't have as many side effects as others. However, I still have to deal with the sudden menopause after my hysterectomy. The worst part is insomnia. I have had constant fatigue due to the lack of sleep. Sometimes, my job can be demanding too. I am very lucky to have some of the best coworkers you can imagine . . . not my boss though. Osteoporosis runs in my family and I feel it's not to my benefit to have to take Aramasin® [Pfizer Inc.], which will increase the bone density loss. I have tried hard to exercise, take calcium, and check my bone density to ensure I don't lose more than the average.

An African American woman also mentioned her concerns.

I am a black female. . . . I think that my race has experienced many challenges over the years. Racial, political, cultural, etc. In regard to cancer, I feel that a number of blacks have been unable to receive the proper treatment that they need because of economic hardship. Then again, there is miseducation about the illness, myths, and lack of proper resources. I think, in our culture, a lot of the older people ignore going for proper checkups, and so do the younger ones.

Same or Double Stress

Men tended to perceive no gender differences in needs for help. On the contrary, women reported certain gender differences in the cancer experience in general and in subsequent needs for help. One man briefly described his opinion on gender differences: "I don't think that there are any differences or similarities between men or women because it affects us all the same way." A woman described her experience.

When I was confirmed with breast cancer, a general surgeon wanted me to go into the operating room and he would "open me up and then decide what he was going to do." I asked for and got a second opinion from strictly a breast surgeon and feel that was the best thing I ever did. The first surgeon was upset that I wanted a second opinion and just left the room. I doubt this was due to my gender, more to his godlike attitude. . . . When I was having chemotherapy, it was in a large room with up to 10 others. There were men and women there with all types of cancer, many much worse than breast cancer. I found that men seemed to like to chat or watch TV, while the women tended to sleep or read. I did notice that there were far fewer men than women who attended our local cancer service's educational support group.

White women posited that women tended to have more difficulties getting adequate health care than men, although women were more likely to seek help than men. Some white women even mentioned that men were not as serious about cancer as women were. Asian women reported that women usually have tougher lives than men because men have some privileges in their particular culture. One Asian woman wrote that women in her culture were suffering from "double stress," and getting cancer usually added another dimension of stress. A Hispanic woman mentioned that Hispanic men would have more difficulties in their lives (related to cancer) compared with Hispanic women because Hispanic culture emphasizes "macho men." One of the Asian women said

As a woman, I think that we have a tougher life than men. In today's world, women have to work just as hard, if not harder, than men on the job. However, you have more responsibilities at home as a mom and/or as a wife. My husband will help, as he always reminds me, but I still feel tired because I am the one who makes sure laundry is done, coffee is on, dinner is ready, and the house is presentable. He will help as long as you tell him what to do. The same comes to parenting. I was the one to make sure teacher conference days were marked on the calendar and doctors' appointments were set, and the list goes on. Now both my kids are grown up and I am again the one to make sure we arrange the family gatherings.

Cultural Hesitance and God

Another prominent ethnic difference was that whites tended to be more willing to talk about cancer and seek help, whereas ethnic minorities tended to be hesitant to talk about cancer or seek help. One explanation might be the stigmatized nature of cancer in some cultures. The Hispanic participant viewed cancer in sexual organs as a loss of sexuality and a cause for public embarrassment. Consequently, the participant was hesitant to ask for help for her needs related to cancer. The African American participant specifically talked about racism, lack of insurance, and financial issues that prevented her from having adequate support for her needs and from having appropriate and adequate healthcare service in the U.S. healthcare system. The African American woman talked about her experience with cancer in general and about having her needs for help met by current resources and support systems.

I was very fortunate that my medical team was very quick and responsive in dealing with my diagnosis and treatment. I'm 43 and they were quite surprised to find someone at my age with lung cancer. My treatment was aggressive. However, I think that blacks do not also receive the best treatment, due to lack of insurance, economics, racism, etc.

Religious beliefs embedded in some cultures also influenced the participants' experiences and their needs for help. An African American woman stated that Christianity was a major factor influencing her needs for help. She also talked about "keeping in the faith" and expressed her belief that God would be with her throughout the course of the disease. Among Asian women, Confucian cultural beliefs influenced their needs for help. For example, one of the Asian women believed that (a) women should be wise mothers and good wives, (b) women should place their own needs behind the needs of their family members, and (c) women should shoulder the burdens of household tasks and child-rearing responsibilities even when they are sick. A Hispanic woman talked about a cultural taboo that inhibited Hispanics from talking openly about cancer and their concerns. She also mentioned their cultural tradition of not letting patients with cancer know about their own disease, therefore, she chose to talk with God.

So there you can see that in the Cuban and Hispanic background they are not used to letting the patients directly know of their illness, and since we live in Miami, which is multiethnic and most of it is Hispanic, they still follow it up to a point. I have made sure that all of my doctors talk to me and not my family members. . . . My Cuban oncologist . . . doesn't want to talk much about it. . . . I said "damn, why did I have to ask" . . . then I searched the Internet and had a little talk with God and I realized that God sent it that way to get me to have more faith in him.

A Family Disease With Mistrust

All of the participants in the ethnic groups mentioned the importance of family support in their lives. However, at the same time, many of them talked about concerns regarding marital relationships. A Hispanic woman was concerned about her husband's alcohol issues, which recurred after her cancer diagnosis.

The girl [her daughter] hasn't spoken to me in two years and now I will not try for her to talk to me just out of pity, but the boys are wonderful to me and offer their help in whatever. My husband . . . I guess he is having one hell of a time dealing with my illness since he went back to drinking, and he confided one day that he was afraid of losing me, but I reassured him that I was not planning on going anywhere for quite awhile. But he still drinks. I guess I just ignore him whenever he says words that are not nice and I pray for him a lot and for God to grant me peace and serenity through all of this ordeal.

Some of the participants were satisfied with the current support from their family members, local resources, and healthcare services. Others reported that the current resources were not meeting their needs. Some were using the Internet for information related to their diseases, and others were using message boards and chat rooms to get emotional support. One African American woman said

My family was very supportive during this whole ordeal. The chemotherapy left me with neuropathy, which I am still dealing with. My younger nieces and nephews massage my feet to help with the pain. My cancer has affected my whole family. It really is a family disease. The younger ones in my family did not take my diagnosis well. I just constantly remind them that I am doing well and that everything is okay. They have questions about cancer, and I answer those questions for them.

An Asian woman mentioned

There were a few negatives of family response to my diagnosis within the extended family. Take for example my dad's sister, who I do not care for anyways, but she is what you could describe as a "hypochondriac" in that she feels she has anything someone else has. . . . She's been this way for all my life as far as I can remember. So she was always into eating only certain foods. . . . Well, not even a week after my diagnosis, she was at our house and she told me and my parents that the reason I had cancer was due to my diet. She insisted I ate the wrong foods my entire life and then talked about doing herbal/alternative methods of treatment. Needless to say, my parents and I were not happy with that conversation and have never forgotten it.

Many of the participants talked about their hesitance to interact with their family members, relatives, and friends and about their self-isolation from others.

One of my major concerns during this whole thing is the loss of friendships. I am not able to spend time with my friends like I used to. And there is a major change in my personality. I am more selfish with my time; I refuse to spend time on nonsense. I don't want any of my time wasted because I feel that I need every moment. I do a lot more things for me. I take the time to relax and do things that I enjoy. I've started taking yoga and I try to surround myself with beautiful things.

Some ethnic minority participants mentioned their mistrust of healthcare providers. An African American woman expressed her difficulties with her healthcare providers while

mentioning the racism and financial issues embedded in the U.S. healthcare system. An Asian woman talked about her mistrust of the medical equipment that was used to diagnose her disease.

I felt the lump myself and went to see my doctor. The doctor could feel it, but thought it not alarming at all. I did a mammogram, but it didn't show the lump. Again, I was sent to the surgeon. This time the surgeon could not even feel the lump. The surgeon agreed to do one more thing, the ultrasound, and this time it came back suspicious. The biopsy of course confirmed it was a tumor. I was lucky that the cancer was caught early. However, it also points out a big problem, why the mammogram could not detect it? If I didn't insist to get all available tools, what would the consequences be? My case may have been delayed for at least another year and the mammogram may still have come back negative, right? How many women are underserved because we believe the doctors or the medical equipment know everything?

Discussion

In the literature, needs of patients with cancer are categorized into physical, psychological, information, support, and communication (Foot, 1996; Foot & Sanson-Fisher, 1995). The first theme of "from side effects to racism" reflects parts of these needs.

Studies also have indicated that socioeconomic status (SES) and available social support are associated with patients' needs (Clarke, Booth, Velikova, & Hewison, 2006; McIlmurray et al., 2001; Sanson-Fisher et al., 2000). Low SES has been reported to influence cancer screening behaviors (Cui et al., 2002; Jacobellis & Cutter, 2002; Lannin et al., 1998; Li, Malone, & Daling, 2003), which have a direct effect on stage of tumor at diagnosis and, therefore, patient needs. Patients with low SES tend to experience delays in presentation, referral from primary care, and diagnosis, which result in later stage of disease at presentation and differences in treatment of cancer (Pollock & Vickers, 1998; Wrigley et al., 2003). The present study's findings echo certain influences of SES, employment, and health insurance on patients' needs for help and their ongoing efforts to deal with financial issues with few resources.

Studies have reported certain gender differences in patients' needs. As mentioned earlier, women are more likely to report significantly more concerns than men (Hill et al., 2003). Men are more likely to seek information, whereas women are more likely to seek encouragement and support (Dale et al., 2004; Klemm et al., 1999; Sharf, 1997). A gender difference exists in help-seeking behaviors (Smith, Pope, & Botha, 2005). Some recent studies have reported certain gender differences in physical needs (Feine et al., 1991; Vallerand, 1995). The second theme of "same or double stress" reflects how the participants perceived gender differences in their cancer experiences and subsequent needs for help in the contexts of their cultures. Because the Confucian culture prescribes that women be wise mothers and good wives, Asian women were suffering from double burdens from doing household work while struggling with cancer. Because of their cultural attitudes stigmatizing cancer of sexual organs and emphasizing "macho men," some Hispanic men might not be able to seek help because of possible embarrassment.

The third theme of "cultural hesitance and God" agrees with the findings of previous studies among Hispanic, African American, and Asian patients with cancer. Studies have reported that the ethnic minority groups tend to stigmatize cancer itself because they believe that cancer is a genetic or transmittable disease (Bailey, Erwin, & Berlin, 2000; Lipson & Dibble, 2005; Phillips, Cohen, & Moses, 1999). The stigmatized nature of cancer might make ethnic patients with cancer withhold information about their diseases and interfere with them openly seeking help. Also, the findings reported in this article agree with previous findings of heavy reliance on God among African American and Hispanic patients. Studies have reported that reliance on God to cure cancer without medical intervention was prevalent among African Americans (Lannin, Mathews, Mitchell, & Swanson, 2002; Mitchell, Lannin, Mathews, & Swanson, 2002; Wilson-Ford, 1992).

The fourth theme of "a family disease with mistrust" is consistent with the importance of family in Hispanic and Asian cultures and their cultural attitudes toward cancer and needs for help. As mentioned earlier, other studies have reported that white patients with cancer place the highest priority on their own individual experiences and interests and want to have control of their own bodies and lives, whereas patients in Asian and Hispanic cultures prioritize the welfare of family (familism) (Pinquart & Sorensen, 2005). Also, family-centered models of decision making among Chinese American and Mexican American families coping with cancer have been reported frequently (Nakamura, 1999; Orona, Koenig, & Davis, 1994). Furthermore, studies among Asian patients have reported their belief that even thinking about cancer may cause the disease (Bottorff et al., 1998; Owens & Randhawa, 2004; Sadler, Nguyer, Doan, Au, & Thomas, 1998). Also, studies have indicated that Asians did not discuss cancer outside their families because future marriage chances of their children could be affected. Asians also were reported to place their families' needs over their own and to be reluctant to seek help from healthcare providers, particularly for the intimate parts of their bodies, because of cultural values about personal modesty (Bottorff et al.; Im, Lee, & Park, 2002; Im, Park, Lee, & Yun, 2004; Owens & Randhawa; Sadler et al.).

Conclusions and Implications

The current study explored gender and ethnic differences in needs for help among patients with cancer using a qualitative online forum. The overriding theme found among the responses was a marginalized experience of ethnic minority patients with cancer. Patients felt marginalized because their cultural backgrounds stigmatized cancer and inhibited them from seeking help to meet their own needs. Yet the findings should be interpreted carefully and considered preliminary because the study included only four ethnic minority patients and three men. The sample was limited to online participants, who tend to be a select group. Online patients with cancer tend to be highly educated with high incomes (Fawcett & Buhle, 1995; Im, Chee, Tsai, Lin, & Cheng, 2005). Therefore, generalization of findings should be done carefully, and further studies with more systematically sampled group of patients are needed for more generalizable findings.

However, some suggestions are offered for future research on gender and ethnic differences in patients' needs for help.

First, further in-depth studies with larger numbers of ethnic minority patients are needed to develop a knowledge base on similarities and differences in patients' needs for help according to gender and ethnicity following a cancer diagnosis. The study findings reported here indicate some similarities and differences based on gender and ethnicity; however, because of the small number of ethnic minority patients, their ethnic-specific needs for help could not be explored in depth.

Second, researchers should include cultural needs as a separate category of patients' needs for help. Again, the overriding theme of the current findings was ethnic minority patients' marginalized experience as patients with cancer because of their cultural backgrounds. When cultural needs are not met,

other needs (physical, psychological, information, support, and communication) also may not be fully met.

Finally, researchers must consider that patients' needs for help are influenced not only by gender and ethnicity, but also by other contextual factors influencing their daily lives. As the findings indicated, the participants of this study reported several contextual factors that influenced their needs for help, including financial issues, family relationships, marital relationships, and work and social environments.

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