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Why did I get cancer? Perceptions of childhood cancer survivors in Korea

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Abstract

This study explored whether and how childhood cancer survivors in Korea ask and resolve the question of what may have caused their cancer. Thirty-one childhood cancer survivors participated in in-depth interviews about their self-questioning process in this regard. The findings indicate that Korean childhood cancer survivors pondered this question alone due to the stigma attached to cancer in the family and society. Their answers included internal factors (doing “bad things,” having unhealthy eating habits, engaging in magical thinking, having a stress-prone personality, or having a biological susceptibility) or external factors (stressors, random events, the environment, or medical conditions). How they perceived the cause of cancer had an impact on aspects of their current lives. Psychosocial care standards or guidelines are needed in regard to the provision of a safe environment in which Korean cancer survivors and their parents can share their perceptions and process their thoughts.

Keywords

Attribution; cancer cause; childhood cancer survivors; qualitative; South Korea

A cancer diagnosis can be devastating for most people and raises two fundamental questions for the sufferer: “Why?” and “What can be done?” (Kleinman, 1988). Human beings make sense of chaos by repeating and pondering questions, creating theories, and attributing causes to their situations (Kelley & Michela, 1980). When the causes are not known, individuals create their own explanation for why things happened to them (Weiner, 1985; Wong & Weiner, 1981). Such causal attribution is a value-loaded process (Gonzalez et al., 2015).

In Weiner’s (1985, 1986) attribution theory, attributions are classified according to three major dimensions: *locus of causality*, *stability*, and *controllability*. Locus of causality refers to the location of a cause that reflects on either the person or the environment (internal-external). Stability refers to the changeability of the cause over time (stable-unstable).

Controllability concerns whether causes are subject to volitional control (controllable-uncontrollable). Understanding the dimensions and impact of attributions is important to an individual who is diagnosed with cancer because specific causal attributions may increase the individual's perception of control, which could affect his or her overall adjustment to the cancer diagnosis (Berckman & Austin, 1993). For example, internal, unstable, and uncontrollable attributions (locus of causality) are related to decrements in self-esteem, increased expectancies for coping success (stability), and feelings of guilt accompanied by the belief that something can be done (controllability dimension; Weiner, 1986). Controllability is especially important in assessing cancer survivors for intervention programs because feeling in control may help them to believe that they have control over a cancer recurrence, making it more likely that they will modify their behavior (Costanzo, Lutgendorf, Bradley, Rose, & Anderson, 2005; Rabin & Pinto, 2006).

Evidence suggests that culture affects individuals' attributions (Choi, Nisbett, & Norenzayan, 1999; Mason & Morris, 2010). For instance, East Asian individuals emphasize integration of and balance between body and mind (Lin, 1981), leading them to view illness as a personal failure that could bring embarrassment and shame to themselves and their families (Lee, Diwan, & Yeo, 2010). As a result, individuals from these countries, including Korea, may make attributions for illness that are different from those of the dominant biomedical perspective of Western culture (Lee et al., 2010; Park et al., 2013). In 2014, 1,084 children (0–14 age group) throughout South Korea had cancer, where the 5-year survival rate (for 2010–2014) for childhood cancer is 81.7% (Korea Central Cancer Registry, National Cancer Center, 2016). Illness attributions have begun to be examined in East Asian cultures (e.g., Gonzalez et al., 2015; Hsiao, Klimidis, Minas, & Tan, 2006; Wang, Lam, Wu, & Fielding, 2014), but no studies have investigated Korean individuals with cancer to understand their causal attributions regarding their disease. Understanding these cultural impacts on attributions could contribute to more culturally competent care (Hinton, Franz, Yeo, & Levkoff, 2005).

How illness is attributed may vary depending on one's developmental stage, but existing studies on attribution among cancer survivors have focused on adults (e.g., Ferrucci et al., 2011; Thomson et al., 2014; Willcox, Stewart, & Sitas, 2011). In particular, beliefs about cancer risk factors differed by demographic factors, such as age or education (Lizama et al., 2016). These studies have found that adult cancer patients under-identify modifiable lifestyle factors, which suggests a psychological dissonance when survivors view their own behavior as contributing to their cancer diagnosis (Willcox et al., 2011). In a study of breast cancer patients, Thomson et al. (2014) found that attributing one's cancer to external factors may protect the individual from self-blame. Related research has examined parents' attributions in regard to childhood cancer (Eiser, Havertnans, & Elser, 1995; Ruccione, Waskerwitz, Buckley, Perin, & Hammond, 1994) or professionals' attitudes (Zachek et al., 2015). For example, Zachek et al. (2015) examined pediatric professionals' beliefs regarding childhood cancer causes, and their responses included genetics (92%), health status (25%), environmental exposures (78%), and "none of the above" (7%). Studies on the perspectives of childhood cancer survivors, however, are scarce (Bearison, Sadow, Granowetter, & Winkel, 1994; Burgess & Haaga, 1998). Bearison et al. (1994) examined the attributions of both pediatric oncology patients and their parents and found that their making external types

of attributions assisted in a more positive way than did their making internal types of attributions.

Cancer survivorship research, however, has inadequately addressed the issues faced by adolescents and young adults who may experience unique developmental challenges, including the transition from school to employment, becoming financially independent, and starting a family (Burgess & Haaga, 1998). Challenges associated with these transitions can lead young adults to create more internal, self-blaming attributions, which may hinder their ability to cope with negative events and lead to an increase in depressive symptoms (Määttä, Nurmi, & Majava, 2002). Because the adolescent and young adult population faces additional challenges associated with life transitions, it is important to understand how this group makes causal attributions.

To address these gaps in the literature, we need to increase our understanding of Korean childhood cancer survivors' attributions. This study aimed to understand Korean childhood cancer survivors' self-questioning process and attributions of what may have caused their cancer. Identification of these attributions will help clinicians to develop psychosocial interventions for childhood cancer survivors who are at risk of developing psychological distress due to inappropriate causal attributions on the journey to cancer survivorship.

Methods

Participants

Participants consisted of 31 cancer survivors between 15 and 39 years of age who were diagnosed before the age of 19 as having cancer and who had completed their cancer treatment. A total of 16 males (51.6%) and 15 females (48.4%) participated in the study. The mean age was 24.1 years ($SD = 4.5$), with a range from 17 to 36 years. Most survivors ($n = 30$, 96.8%) were single. Of the sample, 22 (71%) had been diagnosed with a hematological cancer, 5 (16.1%) with a solid or soft tissue tumor, and 4 (12.9%) with a central nervous system or brain tumor. The average age at diagnosis was 11.8 years ($SD = 2.8$), and the mean time since diagnosis was 12.3 years ($SD = 6.0$), ranging from 5 to 25 years.

Interview procedures

Using purposive and snowballing sampling, we recruited adolescent and young adult survivors through online and offline study announcements at advocacy foundations and support groups for parents and survivors in Korea. From June to July 2010, in-depth interviews (about 1 h for each person) were conducted in Korean by the first two authors, who had qualitative research training and research experiences in cancer survivorship. The semi-structured interviews were conducted in a safe place of the participant's choice. No one was present besides the participants and interviewers during the interviews.

Participants were given information about goals of this research from the interviewers prior to the interview. This study focuses on cancer-cause attribution, or perceived causes of cancer, among childhood cancer survivors. The data were drawn from responses to the following interview questions: "Did you think about why you got cancer?" and, "Why do you think you got cancer?" Relevant prompts were provided, such as, "How did you get to

know your diagnosis of cancer?” or, “Did you have anyone to help you get answers to why you got cancer?” Participants received a \$20 book gift card at the end of the interview.

All of the interviews were audio-recorded after participants’ approval. Field notes were made during the interviews, and any notable findings about the participants or interviews were discussed between interviewers after the interviews. Data saturation was discussed among the interviewers during the interview process, and interviews were stopped when two interviewers agreed that the data were saturated. The study was approved by the ethics committee (IRB) of the university with which the principal investigator was affiliated at the time of the study, and oral consent was obtained from all participants.

Data coding and analysis

The interviews were transcribed in Korean, and the transcripts were analyzed by two investigators through a multistep process suggested by the inductive thematic analysis approach of Braun and Clarke (2006). Major themes and sub-themes were identified, derived from the data. First, segments of text were examined line by line and assigned shorter phrases or one- to two-word codes that represented the content of the segment. If a response included multiple causal attributions, a separate code was assigned to each reason. Then, synonymous or similar codes were merged to form clusters, and the contents of the clusters were compared and contrasted, resulting in the creation of higher-level code clusters or themes. One of the themes derived from the data was the possible cancer causes as perceived by the participants. Based on Weiner’s (1985, 1986) attribution theory, we categorized the sub-themes of causes into two groups: *internal causes*, which lie within the self, characteristically or behaviorally, and *external causes*, which lie outside the self.

These processes were conducted using Atlas.ti (Muh, 2009), qualitative data analysis software to make data management systematic. Finally, the researchers selected quotes to illustrate the themes and discussed consistency between the data presented and the findings. Data were coded and discussed in Korean, and selected quotes were translated into English by bilingual-bicultural researchers who are knowledgeable about the cancer population in both English and Korean to ensure accuracy of the translation.

Results

Questioning process

The survivors asked themselves “why” they got cancer but did so mostly alone. Some, however, reached out to medical doctors or searched for information from the Internet or books.

Questioning alone—According to the participants, their questioning why they became seriously ill (even though they did not know their exact diagnosis) began at the moment of hospitalization. Over half of the participants stated that they had not been informed of their cancer diagnosis when they were first admitted to the hospital. Although some had heard from parents or relatives that they were ill, most had been isolated from the medical decisions and did not know the nature of the diagnosis. While suffering without knowing what was wrong with them, they began to ask questions of themselves about the cause of

their illness. They did not speak to their parents or other adults about their illness because they felt that they were not allowed to.

Most participants reported that they had sensed that something was seriously wrong at some point, based on the information gathered from their surroundings. “I felt something was wrong because I had been in the hospital for a couple of months ... but I did not know exactly what it was.” Some accidentally learned of their diagnosis when they received get-well letters from classmates. Lack of information or a diagnosis compounded the patients’ fear of the treatment.

I was in pain and fear. Even getting an ultrasound test was so scary. I didn’t know why I needed to do it and whether it would hurt me. When they were trying to hook me up to the machine, I almost passed out from crying [and] I did not understand what was going on.

Many survivors spent a great deal of time thinking about what caused them to become ill, and many were eager to discuss this topic with the interviewers. They reported that their questioning process occurred when they were alone and that they wished that they had adult support during the process.

If the patient is old enough to be able to think and judge, parents should openly talk about what the disease is, why it was diagnosed, and how it will be treated. Imagine treating someone without him knowing anything about it.

Why, Why, Why?—Although all of the survivors said that they wondered about their illness, some felt particularly agonized, asking themselves, “Why me?” Their questions were more an outward expression of their anxiety and despair rather than a specific questioning of the cancer cause. Such questioning is seen in the following examples: “Why me? Why do they do this to me?”; “I have been living as a good person. Why?”; “Even now, I ask, ‘Why was I sick?’ There was no reason. I didn’t do anything wrong”; “Why should I have this out of so many people?” Some found it intolerable to constantly deal with such unanswerable questions. The agony and sense of despair and helplessness are seen below:

I have thought about the question, but there is no conclusion. Thus, I thought that this was my fate, my destiny. Still, I was angry. I used to be angry at all the creatures in the heavens, including God, Buddha, and all the things I liked, even angry at my favorite cartoon characters. Why do you do this to me? I think this question is unavoidable. I also thought that it would be better if I had never been born.

Some of their outcries were a reaction to the “why” question. Their sense of loss, despair, and frustration was alleviated when they thought that there must have been a reason for their cancer.

Why did that happen to me at such a young age? The burden of trying to answer the question was lifted when I began to think there must be a reason. I really think now that there was a reason for my cancer.

Outreach for questioning—Although most of the survivors questioned themselves alone why they had cancer, a few asked adults. One survivor, who directly sought information from medical doctors, stated:

The doctors called only my mom to discuss my cancer. I did not like it. Nobody talked with me. My parents did not talk with me about my illness. I could not bear it. I asked the doctor why he did not talk with me.

Regardless of knowing the exact diagnosis of their illness, most survivors began to be curious about their illness and symptoms as soon as active treatment started. Some searched the Internet or read books about cancer. Sometimes, the information that survivors found through the Internet or through books caused even more fear. “I was shocked at what I found on the Internet. . . . In most of the cases of [osteosarcoma], they remove the legs. I was so scared.” Particularly, their questions about the cause of their cancer were often persistent. Some discussed their diagnoses when they grew up and met other survivors, who then confirmed their theories of the causes of cancer:

I know what it is. I would not be so confident if it were just my thoughts. But I asked other survivors what they thought when they had cancer. I had my own theories, and [one of the peer survivors] said it was probably stress. He must have been under severe stress.

Possible cancer causes

The survivors developed their own theories about why they were diagnosed with cancer after going through the questioning process alone or with some limited help from outside sources. Although they did not necessarily believe that all of their theories were correct, they gave some thought to each theory. All of the survivors talked about what they perceived to be the cause of the cancer. Few survivors reported that they did not have a definite answer in regard to the cause of the cancer and expressed their frustration, while most survivors provided multiple causes for the cancer diagnosis. Of those survivors who provided their answer about the perceived cause of their cancer, nearly half attributed the cancer to an internal cause. They thought that they had cancer because they were bad children, had unhealthy eating habits, engaged in magical thinking, had a stress-prone personality, or had a biological susceptibility. Some participants expressed strong reservations about self-blaming and, instead, tended to find reasons outside the self, such as stressors, random events, their living environment, or medical conditions. A few survivors attributed the cancer to both internal and external causes.

Internal causes—Five internal causes were noted by participants: being a bad child, having unhealthy eating habits, engaging in magical thinking, having certain personality characteristics, or having a biological susceptibility.

Bad child: Five survivors attributed their cancer to something morally bad that they had done in the past, such as drinking alcohol, smoking, doing something “bad” with girlfriends or boyfriends, fighting with friends, engaging in computer games, or not studying. When these survivors were asked about their thoughts on cancer causes, it took more probing before some finally said that they were to blame. One survivor initially said that he did not

know what the cause was, but, after a while, he answered, “I stole stuff. That is why.” Another survivor linked his bad behavior to spiritual punishment. “I know why. [My mom] gave me ten dollars for a church contribution on Thanksgiving Day, and I didn’t contribute the money.”

Unhealthy eating habits: Unhealthy eating habits in childhood were mentioned by five survivors as cancer causes. Meat, instant and salty foods, and sodas were examples of carcinogenic foods listed by the survivors. Being picky in eating and not having a balanced diet also were given as reasons. Unhealthy eating habits were presented not only as unhealthy eating behaviors but also as disobedient behaviors that deserved bad consequences. Some survivors believed that they got cancer because they did not like to eat the healthy foods that their mothers told them to eat, for example, vegetables, beans, and Kimchi, a traditional fermented Korean side dish made of cabbage.

Magical thinking: Two survivors thought that they had cancer because they had negative thoughts or made negative remarks. One survivor related that he had stated, “I want to disappear,” when his parents had a fight and feared that he might have made this come true. Magical thinking was still present in these adolescent and young adult survivors. “Did I really bring about all this? I had negative thoughts. I did not like anything about the world at that time. Maybe because of those negative thoughts, my life turned in a negative direction.”

Personality: Certain personality characteristics, such as being overly sensitive, irritable, and negative, were reported by four survivors to be causes of cancer. One survivor said that his brother had told him that his cancer must be a result of his personality traits. The participants reported thinking that some people may have stress-prone personalities, such as worrying over trivial matters and frequently complaining, and that being stress prone could cause cancer. One stated, “There is a high prevalence of Type A personalities among cancer patients. It is not definite, but Type A people generally are not assertive, try to please other people, and accumulate anger inside (in Korea).”

Biological susceptibility: One survivor mentioned that his extended family members had leukemia, so that is why he had leukemia. Another survivor stated that he was often asked by doctors whether he had any family members with cancer, which made him think maybe it is genetic. Those who attributed cancer to a genetic cause also expressed concern about whether their children would be likely to have the same cancer. Some said that their cancer was not necessarily due to certain genetics but more because their bodies happened to be somehow susceptible to cancer.

External causes—Four external causes were noted by participants: stressors, random events, living environment, and medical conditions.

Stressors: Six survivors found cancer causes in stressful or traumatic events that they experienced in childhood, such as a parent’s death, occasional fights with their parents, a breakup with a girlfriend or boyfriend, bad relationships between their parents, issues with friends, physical stress from too much exercise, and the family’s financial downturn. They thought that multiple stressors led to a cancer diagnosis, particularly because some had

experienced particularly stressful events right before the diagnosis, as seen in the following quotes from two participants:

I think that my father's death was a major stressor. It was a mental shock. I witnessed death for the first time, and it was my father.

We had to move to a poor neighborhood because of a sudden financial issue. That was a stressor. I was also stressed out because of (relationship with) my friends. I must have had a lot of female hormones, as I could feel a lump like a girl has in my chest. I did not know then that some boys have that, so I was very stressed.

Random events: Seven survivors attributed their cancer to random events. Some survivors repeated quotes from doctors and prevalence statistics. A survivor explained that childhood cancer is “a disease of probability,” based on yearly childhood cancer diagnosis rates. Another survivor analogized getting cancer, as “getting hit by a stone when it is thrown from the sky.” One survivor stated, “I got cancer just by random; I did not have a recurrence. But some people have a recurrence. It is just arbitrary.”

Living environment: Three survivors mentioned the environment as a possible cause of their cancer. One stated, “These days, we are often exposed to chemical materials and medicine. We never know how they might affect us, such as changing our genes.” One survivor stated that electromagnetic fields from computers may be a possible cause of cancer. Pollution and bad air also were mentioned as environmental hazards that cause cancer. “We had lived in a nice apartment but had to move to a cheaper neighborhood with poor air quality because of financial problems.” Another survivor mentioned that poverty may have caused his cancer. “My family was poor. We didn't even have enough to eat. Cheap junk food and instant noodles were our main staple. They are so bad for your health.”

Medical conditions: Three survivors attributed their cancer to a prior medical condition. One survivor mentioned that most of the children with cancer seem to be prone to colds, which the survivor believed led to cancer. Mothers' behaviors during pregnancy also were suspected to be a cause of cancer:

I looked it up in books. It could have been a virus, some infection during labor, or maybe because my mom had me just after my older sister.... I heard doctors' saying that three years apart is the best because the mother needs to recuperate after giving birth. Or it might be because my mom didn't eat right when she was pregnant with me. And I heard that she had an X-ray during the pregnancy. That is bad for the baby.

Discussion

The goal of our study was to increase understanding of Korean childhood cancer survivors' self-questioning process and attributions. Our findings indicate that Korean childhood cancer survivors ponder the “why” question and appear to go through a questioning process alone due to the stigmas attached to cancer, whereby family and doctors are reluctant to discuss the illness with patients and survivors. This study found that all childhood cancer survivors

attributed their cancer to internal or external factors. The internal causes of cancer cited by participants were their being “bad children,” having unhealthy eating habits, engaging in magical thinking, having a stress-prone personality, or having a biological susceptibility. The external causes most frequently cited included stressful events, random events, an unhealthy environment, or a medical condition.

It is notable that survivors received their cancer diagnosis at a mean age of 11.8 years, and yet, in their young adult years, they were still questioning why they got cancer. In fact, many survivors appeared eager to discuss this topic with the research team during the interviews and expressed that their current lives were affected by their questioning and cancer causal attribution. For many of the survivors, participating in the present study’s interviews and talking about their cancer attribution with the research team was the first time ever that they talked about their cancer experience with others.

Because these young adults had to go through the questioning process alone, they tended to rely on sources such as the Internet and books, which do not always provide accurate information. This is consistent with a previous study that found that the Internet, physicians, and magazines were the leading sources of information for breast cancer patients in France (Kadhel, Schuster, Grossat, Janky, & Ghassani, 2016). Not only were some survivors not given a diagnosis, but, when they were, they were not provided with relevant information. As they went through the questioning process alone, they invented their own stories about what could have caused their cancer and often came to incorrect and harmful conclusions that often included the use of self-blame. In this process, survivors experienced a great deal of anxiety and stress, and, even years later, some participants were still questioning why they were diagnosed with cancer.

Our results are consistent with some of the findings of the prior literature. Previous studies have similarly found that families refrain from sharing a child’s cancer diagnosis with the child and that healthcare providers experience whether to tell the child his or her diagnosis as an ethical dilemma (Sigman, Kraut, & Puma, 1993). Research also has shown that U.S. physicians are more likely than are physicians in Japan to communicate directly with a child about his or her cancer diagnosis (Parsons et al., 2007). Although patient autonomy has become an important ethical principle among oncology professionals in the United States (McCabe, Wood, & Goldberg, 2010; Surbone, 2006), cultural values of these physicians, such as autonomy versus beneficence, play a role in how physicians decide how much to disclose to children about their cancer diagnosis (Parsons et al., 2007). Notably, the disclosure of medical information in regard to pediatric patients with a serious illness should consider family beliefs and values (Levine, Johnson, & Baker, 2017).

Our results are consistent with those of Ferrucci et al. (2011), who found that cancer survivors contemplated “why me?” In that study, lifestyle and biological factors were the most common attributions by adult cancer survivors. In our study, childhood cancer survivors provided a range of attributions. In particular, survivors’ self-blame (e.g., in regard to their personality traits and morally bad habits) should be of concern to healthcare professionals. One study found that cancer patients who attributed their cancer to internal causes reported significantly higher self-blame, poorer self-esteem, and higher depressed

affect, anxiety, and anger (Else-Quest, LoConte, Schiller, & Hyde, 2009). In Asian countries, such as Japan, information about a cancer diagnosis and the care plan is usually given to families rather than to patients (Uchitomi & Yamawaki, 1997). Even in some Western societies (Stergiou-Kita, Pritlove, & Kirsh, 2016), as well as in Korean society (Cho et al., 2013b), use of “the C word” is taboo. As noted, cancer survivors experience stigma, including negative attitudes and stereotyping, which appear to be linked to internalized shame and feelings of isolation (Cho et al., 2013a). Thus, when telling children about the diagnosis, parents often use medical terms, such as *sarcoma*, instead of cancer. The survivors in this study stated that, as young children, they did not realize that certain terms meant cancer.

The study’s findings have implications for the care that childhood cancer survivors receive, particularly in societies in which the discussion of cancer is taboo. First, parents and clinicians should consider openly discussing children’s concerns and questions during their diagnosis and throughout their lives. Parents and other adults, including medical staff, likely have good intentions when trying to protect childhood cancer patients from the trauma of a cancer diagnosis. In Matsuoka and Narama’s (2012) study of parents in Japan whose children had died of cancer, the parents’ goal had been to support and protect the child. Despite these efforts, children reported that they knew that something was wrong, and this ambiguous situation led to more fear. Including children in the discussion of the diagnosis and treatment could help lessen their anxieties and fears. Giving children accurate and reliable information regarding their illness could help them to focus on making external, modifiable attributions, which could be beneficial to their psychosocial well-being, rather than making self-blaming attributions (Gotay, 1985; Lavery & Clarke, 1996; Timko & Janoff-Bulman, 1985).

Second, the survivors in this study continued to engage in the questioning process long after their diagnosis, indicating that an individual or group counseling program to encourage survivors to revisit their cancer experiences, using narrative techniques that enables them to make sense of their illness experiences in a supportive and informative environment, is strongly recommended. In South Korea, there are only a few cancer survivorship clinics where childhood cancer survivors can revisit and deal with their cancer experiences in their survivorship journey. A greater number of cancer survivorship clinics and programs are needed. Finally, the results of this study demonstrate the importance of providing education about the illness from the beginning of the diagnosis, which could promote the process of making sense of the illness and healthy adaption in survivorship. Evidence-based psychosocial standards for cancer survivors and their families that include guidelines related to providing such information in each survivorship stage should be developed and disseminated to psychosocial oncology professionals.

Limitations

Several study limitations are worth noting, including that our sample was recruited through support groups, and, thus, participants were likely to have interacted with other cancer survivors. Such interaction could affect their thoughts about cancer causes, and, as such, their responses could have been influenced by peers. In addition, this was a retrospective

study that relied on the participants' memories to identify their cancer attribution. Nevertheless, our study makes a significant contribution to the understanding of cancer attribution of long-term cancer survivors who may be significantly affected by their cancer experiences.

Our findings emphasize the importance of childhood cancer survivors' cognitive appraisals about cancer in their health behaviors. By understanding survivors' perceived causal attributions, clinicians can identify the types of programs that potentially are the most appealing to certain survivors. Parents and clinicians need to openly discuss children's concerns and questions about the cause of their cancer and their cancer experience.

The results of this investigation are important for cancer survivors in the Korean culture, of whom a majority diagnosed with cancer do not even know the name of their disease. Healthcare professionals need to assess the survivor's causal attributions, understand the cultural roots of such attributions, and use the information in providing appropriate care.

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