Published in final edited form as:

J Appl Commun Res. 2009 November 1; 37(4): 397–417. doi:10.1080/00909880903233176.

Naming and Claiming Cancer among African American Women: An Application of Problematic Integration Theory

Elisia L. Cohen

Assistant Professor in the Department of Communication at the University of Kentucky

Abstract

This study examines how a sample of African American women understands the uncertainties fundamental to cancer risk communication. Utilizing data from four focus groups, Problematic Integration (PI) theory is applied as an interpretive lens for illustrating their felt difficulties of talking openly about cancer and breast cancer in everyday life. The women describe worry about cancer and its prevalence among African American women; ambivalence and uncertainty; belief that what is not uncertain is certain and awful; fear and avoidance; contradictions in “claiming” and “rebuking” cancer; and hopefulness.

Keywords

Cancer Communication; Fatalism; African American Women

Despite lower overall cancer incidence among African American women compared to women overall, African American women evidence later cancer screening and higher mortality risk for certain cancers, such as breast cancer in the United States (American Cancer Society, 2007; Breen, Kessler, & Brown, 1996). Explanations include lower income, lack of access to health care, no medical insurance, and later diagnosis. Many of these explanations are unsatisfactory as access to health care, screening, and treatment options alone do not eliminate the disparities. Moreover, these explanations offer little help to health communication researchers interested in understanding effective cancer prevention and detection promotion strategies.

This study examines how African American women understand the many uncertainties fundamental to cancer risk communication, particularly in the breast cancer context. First, I review fatalistic cancer risk perception frameworks as well as concepts from Problematic Integration (PI) theory to identify current scholarship assessing individual understandings of cancer risks. Second, I explore interpretations of cancer risk perceptions and communication practices among African American women troubled by “naming and claiming” cancer in their everyday lives.

Communicating Cancer Risks, Fears and Fatalism

Fear of cancer diagnosis and cancer fatalism¹ has been explored in African American populations to explain later breast cancer screening rates and higher risk of breast cancer

Correspondence to: Elisia L. Cohen, 231 Grehan Bldg., Lexington, KY 40506-0042, elisia.cohen@uky.edu.

¹Powe (1995) identified cancer fatalism as an important construct that taps into “the belief that death is inevitable when cancer is present” (p. 385). The Powe Fatalism Inventory has been adapted for use in studies of breast and other kinds of cancer (Powe & Finnie, 2003). Research has identified sociocultural correlates to cancer fatalism that include lower education, poorer self-rated health, and a less optimistic outlook on life (Farmer et al., 2007; Kreuter et al., 2003).

mortality among African American women than women overall (Schmidt, 2007). Public health researchers have considered the ways that individuals' cancer beliefs, fears, and fatalistic thinking influence decision-making about disease prevention (Niederdeppe & Levy, 2007), stymie cancer prevention education efforts (Schmidt), and correlate with low trust of doctors and other health professionals (Powe, Daniels, & Finnie, 2005). Perceived ambiguity of detection and prevention, as well as treatment efficacy also may reduce early cancer detection, diagnosis, and treatment opportunities (Niederdeppe & Levy). Fear of cancer diagnosis and cancer fatalism is associated with dismissing the probability of diagnosis with a good treatment outcome (futility) (Powe, 1995; Powe & Finnie, 2003).

Farmer, Reddick, D'Agostino, and Jackson (2007) conclude that "Cancer fatalism may be fueled in part by knowing women who have had late diagnoses and poor breast cancer outcomes" (p. 122). Indeed, African American women are more likely to have had a friend or loved one die from breast cancer than women from other ethnic or racial groups (Powe & Finnie, 2003; Thomas-Vadaparampil, Champion, Miller, Menon, & Skinner, 2003). African Americans' decisions to forgo late-stage cancer treatments, or to avoid breast cancer screening altogether, is influenced by their cancer fears and fatalism (Champion, Menon, McQuillan, & Scott, 1998; Powe, 2001; Schmidt, 2007).

Considering how individuals communicate such fatalistic beliefs and cancer fears to others is important. Cancer screening, diagnosis and treatment situations are ripe with complex, unpredictable, and probabilistic uncertainties that may be managed by communication practices (Brashers, 2001; Ford & Babrow, 1996). Formative research into African American women's cancer and breast cancer communication practices can offer additional insights into individuals' appraisals of cancer uncertainties, which is needed to explore how cancer fatalism may be a dynamic variable, where substantial individual variation can occur in considering the diverse and contingent meanings individuals associate with cancer. Variations in the meanings of cancer risk to individuals point to different ontological and epistemological understandings of the nature of health and disease, and suggest different courses of action for patients, practitioners and researchers. Divergent meanings of illness and disease elicit different responses from individuals confronting uncertain risks, which are grounded in ontological and epistemological appraisals of uncertainties and threats (Babrow & Dutta-Bergman, 2003). These understandings can be observed in the contingent meanings of cancer developed in the stories that individuals share.

Given this sensitivity to how individuals articulate risk, Problematic Integration (PI) theory is an appropriate framework for studying the complex, uncertain, risk communication challenges African American women confront in talking about cancer and breast cancer in their everyday lives (Gill & Babrow, 2007). PI theory offers a broad communication perspective on two intersecting orientations to uncertainty.

Problematic Integration (PI) Theory

Babrow's (1992, 1995, 2001, 2007) problematic integration (PI) theory posits that individuals form probabilistic and evaluative orientations to their experiences. To review briefly, in the case of breast cancer, probabilistic orientations arise as individuals consider their likelihood of developing the disease, of being diagnosed early in the disease progression, of obtaining appropriate treatment, and so on. These probabilistic orientations are malleable, changing from lesser to greater perceived likelihood (or vice versa) in light of ongoing encounters with relevant information. Similarly, evaluative orientations arise as women consider how good or bad it would be to develop breast cancer, to be diagnosed early in the disease progression, to obtain appropriate treatment, and so on. Such probabilistic and evaluative orientations undoubtedly

shape women's communication about breast cancer, both enabling and constraining the messages they formulate as well as interpretations of messages they receive.

The second and third propositions in PI theory are, respectively, that probabilistic and evaluative orientations must be integrated, but that integration is often problematic. Integration involves the influence of probabilistic on evaluative orientations (and vice versa) and their joint influence on lines of action. Gill and Babrow (2007, p. 136–137) review four situations demonstrating how PI theory explains difficulty integrating evaluations, including situations highlighting “divergence” (“when expectations and desires are at odds”), “uncertainty” resulting from confronting “non-trivial positive or negative evaluations” (i.e., how “to sort out” conflicting options), “ambivalence” (e.g., where action has known positive and negative consequences), and “the impossibility of something positively valued” (i.e., the impossibility of a cancer cure).

PI theory postulates that the situational dilemmas involving the resolution of seemingly incommensurate probabilistic and evaluative orientations are resolved through a transformative process (Babrow, 2007; Gill & Babrow, 2007). Problematic meanings (such as initial uncertainty in the odds of receiving a cancer diagnosis) may be transformed into fear of a certain, horrible death with a cancer diagnosis, which may then chain from one focus on a personal diagnosis to other related family issues (will my cancer burden my loved ones?).

Babrow (1995, 2007) establishes that communication is a source and resource which enables individuals to respond to integrative dilemmas. For purposes of this study, PI theory is a helpful meaning-centered theoretical framework for identifying both probabilistic and evaluative meanings communicated about cancer and breast cancer. Furthermore, it suggests that communication about cancer gives rise to dilemmas centered on integrating divergent meanings with related values and beliefs. The question for empirical investigation is how do exigencies for cancer risk communication offer communicative opportunities and constraints? Given that the PI experience may chain over time and occurs within a broader discursive framework requiring transformation or change of perspective, the theory may illuminate challenges African American women experience in articulating their cancer fears and cancer fatalism in the context of interpersonal experiences and broader socio-cultural understandings of risk about cancer.

Data Gathering

This research advances an interpretive approach to supplement current assessments of risk comprehension and sociocultural correlates of breast cancer fatalism, placing lived experiences of individuals and the meanings about cancer at the heart of this study. Zoeller and Kline (2008) maintain interpretive work, based on careful analysis of naturally occurring sense-making, “demonstrates the ways that individuals define and make sense of risks, illness, and health through factors such as personal experiences, interpersonal negotiations, cultural backgrounds, and class frameworks” (p. 98). Focus groups allow researchers to develop formative descriptions of participants' perspectives on the meanings of cancer and breast cancer experiences and risk communication practices (Kasper, 1994). Consistent with Hines, Babrow, Badzek and Moss's (1997) use of qualitative interviews to gain understanding of the divergent and contingent meanings of “uncertainty” of illness to individuals, focus groups are well suited to examine the dynamic communication and decision-making processes concerning cancer risks. Such interviews allow researchers to ground results in the participants' voice, rather than the voice of researchers. A communicative approach to meaning-making requires observation of the give and take of social discourse on a specific topic (e.g., cancer) (Frey & Fontana, 1993).

Recruitment Protocol

Following approval by Institutional Review Board for the protection of human subjects, African American women were recruited from within the Grand Center region of Saint Louis, Missouri. Flyers were placed on the Saint Louis University campus and distributed to community listservs and neighborhood civic groups requesting African American women² between the ages of 21–65 to volunteer to participate in focus group discussions about cancer, breast cancer and mammography. Phone calls and letters of inquiry were also mailed to previous participants in formative research associated with the Saint Louis Center for Excellence in Cancer Communication Research. Participants were recruited based on their demographic similarity to the target audience of a related cancer communication study of Black newspaper readers (Caburnay et al., 2008; Cohen et al., 2008). Although the study did not exclude younger women, the majority of the women (83%), were above the age of 40 (the age recommended for routine mammography).

Over sixty respondents answered the recruitment advertisements. In a one month period, researchers re-contacted a total of fifty-seven eligible individuals for recruitment. Individuals were given an equal opportunity to participate, although scheduling conflicts afforded twelve to fourteen individuals to be scheduled for each focus group session.³ To increase the participation of lower income, African American women who often lack health insurance (often excluded from research), fliers were distributed to social service and non-profit organizations (e.g., Habitat for Humanity). The second of the four groups was convened of a lower-income group of women recruited from social service or non-profit organizations.

Four focus groups (group 1: $n = 11$, Age $M = 51$; group 2: $n = 13$, Age $M = 52$; group 3: $n = 12$, Age $M = 42$; group 4: $n = 13$, Age $M = 45$) were held on three different days during the month of June, 2005. Participants received a parking or bus voucher, or transportation services to attend the focus groups and were compensated \$50 for their time.

Interview Protocol

Each focus group took approximately 2 hours. The moderator began the discussion by introducing herself and the research team to build rapport with participants. Participants were provided with and signed IRB-approved informed consent documentation, and were reminded that the responses they provided would be kept confidential. Each session was videotaped and audio-taped with participant's consent. A research assistant took notes throughout the session.

Usually in communication research, the ideal size of focus groups range from 6–12 people, with larger groups as more appropriate for topics where diverse perspectives are solicited (Lengua et al., 1992, p. 163). Here, participants responded to a variety of open-ended questions and each person had the opportunity to participate in the discussion. The participants were asked to describe the last time they heard or read about cancer in general, and breast cancer specifically; to share their thoughts and feelings about breast cancer; and to describe who they talk with about breast cancer. The discussion was dynamic, with the moderator encouraging

²This study is part of a larger research project that collected data from focus group participants in response to cancer communication in media. Black newspaper readership was utilized as a sampling frame to solicit individuals familiar with free local Black media storytelling practices and to ensure basic literacy among participants. After contacting Black women from a formative research participant pool database no women were excluded from this initial round of recruitment as all women were familiar with and reported reading the newspaper, although other recruiting materials solicited Black newspaper readers. The local Black newspaper considered in this study is free, widely available to diverse populations, and purports to have the highest readership penetration of any metropolitan newspaper in the city. However, given that this sample consists of women reading Black newspapers, the women participating in this research may be more concerned with social issues.

³Individuals who did not attend their scheduled session were invited to reschedule. Although women responded to the recruitment advertising and were recruited individually, the groups included some women who were acquainted with one another from social service agencies and non-profit organizations.

each participant to share their experiences. To elicit narrative accounts, each participant was asked to tell the group a story about talking about cancer with a friend, family member, or loved one. Participants also were invited to tell the group a story about their experience talking about breast cancer with others. Probe and follow-up questions were included to clarify issues and interpretations of participant responses. Member checking with participants was carried out informally in the interview process, with the moderator asking follow-up questions for clarification in the focus group discussion before moving on to the next question set. At the conclusion of the session the participants were thanked, compensated for their time, and debriefed on the study's purpose.

Data Coding Procedures

Audiotapes were professionally transcribed verbatim, and research assistants used audio and videotapes to de-identify the records. At the conclusion of the focus groups, the principle investigator, with input from collaborators involved in the data collection, developed an initial list of themes expressed in the participants' responses to each question.⁴ Analytic coding (Lindlof & Taylor, 2002) was used to identify categories suggested by extant literature sensitizing the researchers to problematic integration in cancer communication. Following Braithwaite and Baxter's (2006) recognition that the meaning of something (cancer communication) rests with understanding its attributes or characteristics, data analysis focused on open and *in vivo* coding for "characteristics" of cancer communication disclosed by women. As Lindlof and Taylor (p. 220) recommend, recording instances of vivid language helped "anchor conceptual categories," and functioned to supply quotations for the analysis.

After open coding that included the use of theoretical notes to ground interpretations, an axial coding process (see Lindlof & Taylor, 2002, pp. 220–221) determined connections between the categories, including the relational and situational constraints on cancer communication for African American women, "context" for cancer communication, the "problems" involved in women's cancer communication with others, and the "consequences" of the problems that they identified. The identification of orientations to cancer communication was an inductive and iterative process. Axial coding also explored how the African American women describe their struggles to integrate differing orientations to cancer communication (probabilistic and evaluative) and illustrated salient cancer risk communication beliefs and thematic foci: pervasive worry about cancer and its prevalence among African American women; ambivalence and pervasive forms of uncertainty about cancer; knowledge that what is not uncertain about cancer is certain and awful; fear and avoidance; contradiction in "claiming" and "rebuking" cancer; and hopefulness. The sections which follow address problematic concerns central to African American women's orientations to communicating about cancer and breast cancer.

Findings

Women in the focus groups told numerous stories about the last time they thought about cancer. The women also expressed the problematic integration of their loved ones' cancer and breast cancer experiences with their personal beliefs about cancer (and orientation to cancer communication). As this analysis will explore in detail, these women had no trouble recounting their cancer experiences; their discussion evidenced recurring problems shared by African American women integrating conflicting and uncertain beliefs about cancer and breast cancer.

⁴Following axial coding, two available participants reacted to the conclusions drawn from these data to provide further feedback. The participants were particularly helpful in confirming the twin themes of spirituality and hopefulness in the discourse, specifically as a counterpoint to what prior research has suggested may be underlying pessimism (and fatalism) about cancer diagnosis.

Theme #1: Pervasive Worry about Cancer and its Prevalence among African American Women

Women expressed the belief that when they think about cancer, they think about the number of people they know who have died from cancer among family and loved ones and their pervasive worry. Such pervasive worry required acknowledgement and the negotiation of the relational and situational meaning of cancer. And, women often recounted the number of people in their lives afflicted with cancer. For example, one participant reported:

My grandmother, she died, she had both breasts removed before she died. And moles on her face, she had those removed, too, she had cancer. But every day, I think about cancer. I work with people every day that's got cancer. I work with a lady, where I work, she's got cancer. She's had all the radiation ... I work with her every day. And my friend, one of my best friends, she has cancer now, and she's not doing so well ... it's a constant thing. (4a: 479–484, note: Parenthetical notations include focus group number, participant identification letter and line numbers from the transcript.)

Women were comfortable acknowledging the many times they thought about cancer, particularly as a diagnosis accompanying the news of their loved ones' death:

... I think about it a lot. I have had relatives who have had it. And then I have a constant reminder that something always happens, like somebody that you know died, like a couple months ago a young lady died that I didn't even know ... she was a school friend ... she had breast cancer and she died. (1d: 370–374)

Discussion also revealed knowing cancer as a cause of illness within a family depends on a person's family history. Several discussions across groups reflected the sentiment that many women did not grow up going to the doctor frequently, and often did not have a cancer diagnosis or received one when it was "almost too late." One participant acknowledged "Cancer is really prevalent on both sides of my family and both of my grandfathers have passed away before they even got the chance to acknowledge it" (2e: 574–576).

Participants documented a lay understanding of cancer consistent with the belief that cancer is something that is lurking but available to be discovered. As one participant opined:

Yeah. That's what is so urgent about cancer. You may not even know you have it and all of a sudden, you go to the doctor and they say, "You've had this for years," or whatever. It's like it lays dormant in your body, so it's really important for that information to be out there. And it's almost impossible not to have cancer in the back of all of our minds because many times you're conscious of your body and you look in the mirror at yourself, you know that you can be a potential cancer risk. It can happen. (4b: 531–537)

They also spoke of the difficulty reconciling their probabilistic orientation not to "acknowledge" the urgency of cancer and the fear of death is "constant," with their distrust of doctors as well as their need for information and cancer detection. This difficulty reflected a felt ambivalence and uncertainty about cancer clearly expressed by these women.

Theme #2: Ambivalence and Pervasive Forms of Uncertainty

Women's stories touched on the ambivalence about hearing methods to prevent cancer and expressed a variety of pervasive uncertainties associated with a disease diagnosis. Ontological uncertainties can be understood from an individual's conception of what risk is, or how individuals appraise the unpredictable course of cancer diagnosis and treatment as a way of being or living in the world. Furthermore, the felt indeterminacy of cancer's causality, which can be multiple and require understanding the complex iatrogenic effects of disease, means cancer uncertainties can take on ontological meanings in everyday life (Babrow, 2001). In

contrast, other risk appraisals consider questions of epistemological uncertainty. Epistemological uncertainty underpins what Babrow (pp. 558–559) identifies as the qualities and use of risk information, the nature of a range of probabilities, or the nature of knowing about a problem (“lay epistemology”). In the cancer context, epistemological uncertainties may be considered as a matter of individual knowledge about cancer, or ways of knowing about risk-taking and personal health (e.g., both subjective and objective knowing of personal wellness and illness).

One exchange between participants suggested how individual’s ambivalence toward doctors, cancer fears and epistemological uncertainty regarding medical testing are often resolved by inaction, whereby women do not take their mammograms:

Participant 3a: But there are so many people afraid to go to the doctor. They’re afraid of what they’re going to hear ... There’s so many black women that have got cancer and don’t even know it.

Participant 3b: Women, period. But it seems to me a lot ... There’s a lot of women that are not getting treatment ... (415–425)

This finding is consistent with prior research exposing concerns over “risk factors, causes, symptoms, testing and diagnosis options, quality of medical care, treatment options, prognosis, and the possibility of a cure” (Gill & Babrow, 2007, p. 139; see also Babrow, Kasch, & Ford, 1998).

Beyond describing traditional cancer uncertainties in epistemological concerns (see Gill & Babrow, 2007, p. 141) regarding the uncertainties surrounding the adequacies of prevention options and unavailability of a cure, women’s discussion focused on women’s cancer fears and fatalism, which reflected their search for ontological meanings. That is, often, without any prompting, women’s stories would characterize their understanding of the word “cancer,” and its problematic integration (to live with cancer as a condition of being) into everyday vocabulary and conversations, their familial relations, their spirituality or religiosity, and their evaluation of cancer as a lurking, natural and unpredictable event (“laying dormant” 4b: 533). One participant described fearing cancer in part due to her pervasive family cancer history and her uncertainty about personal risk and prognosis:

.... My sister died from throat cancer. My other sister died from diabetes and colon cancer. And my mother just died from stomach cancer. And I still don’t know ... What really is cancer? And I think that I need to read about cancer. I don’t understand it. It’s like it’s a word out there but I want to know because I want to know if me or my children are going to get it. There’s so many people dying from it. (2a: 544–551)

Focus group participants acknowledged how uncertainty in understanding a friend or loved ones’ cancer death also makes women ambivalent towards talking about cancer. Many women did not believe talking about cancer was a “normal topic” of everyday conversation.

Participant 3c: I wanted to say a lot of black women don’t like ... it’s not a conversation because a lot of black women don’t like to talk about cancer. Cancer isn’t a big word, as far as breast cancer, it’s not a normal topic and that’s how come a lot of people ... a lot of black women don’t know that they have breast cancer because they’re afraid to go get a mammogram. So that’s my biggest thing, is that’s how come I think that cancer is scary to those who take a mammogram and not know ... the unknown ... and have to wait for results. That’s why I think a lot of black women don’t take mammograms.

Moderator: So you don’t think a lot of women even talk about it?

Participant 3c: No, no, they don’t.

Participant 3d: They don't.

Participant 3e: Not unless it happens to someone close to you ...

Participant 3c: That's why it's so important to get it out there because the unknown can really kill you. (429–448)

The women expressed uncertainty about the unknown and their ambivalence about hearing from a doctor “You’ve had this for years” (4b: 522) to conceptualize a very unpleasant ontological experience: a world ripe with a fundamentally unpredictable and deadly disease. This discourse constructs cancer as either fundamentally uncertain (difficult or impossible to predict or control), or as certain, horrible (certain to arise, disfigure, or kill) and possibly a death sentence.

Theme #3: What is Not Uncertain about Breast Cancer is Certain and Awful

Beyond expressing concern over cancer’s uncertain, but lurking pervasiveness, women reported associating cancer with thoughts and feelings such as “ugly,” “disfigurement,” “being scared,” “suffering,” “chemo,” “going to die,” and “death.” Women described the difficulty of coping with their loved ones’ cancer diagnosis, in part because of the painful, awful experience of chemotherapy and treatment that they witnessed. As one woman described:

... one of my co-workers is going through chemotherapy because she had breast cancer. And she says she’s a survivor and she has to go back because the chemo affected other parts of her body and she’s now working on pain. ... we all pray for her ... But it’s always there. ... It’s always in the back of your mind. You try not to just actively dwell on it. But I always think, my goodness, I would not like for this to happen to me. (1c: 428–446)

Another woman described her sister’s illness after mammography, detailing how her sister “had four different types of chemo that she was taking. And she was very, very sick” (1a: 391–392).

Women confirmed the certain, lay wisdom they gained from watching women they knew suffer from not only the disease, but also from its disfiguring and debilitating treatment. They told stories of women who had their hair fall out and skin change after chemotherapy and who died after radiation and surgery (including women who had both breasts removed before they died). They expressed their fears about the pervasiveness of cancer after only brief periods of remission. One woman wondered “how could something like cancer just take over somebody’s body, when they don’t even have the will to fight no more?” (2f: 585–587). Others reported the pervasive worry about cancer’s consequences because she didn’t know survivors:

I think cancer is such a scary word, because we don’t see ... I haven’t seen a lot of people get past it. Those survivors, like you see them all running downtown is beautiful, wonderful stories, but close up, at least people ... I speak for myself, *that I know* ... don’t survive it. (emphasis in original, 4g: 824–827)

This participant noted that she often didn’t see African American women survivors as part of the Komen “Race for the Cure” media coverage. Her comment that cancer is a scary word shows how the language of cancer, itself, can become stigmatized (Goffman, 1963). Cancer carries a stigmatized meaning for individuals believing death from cancer is inevitable and intimately connected with their evaluations of cancer risk in their community.

Theme #4: Fear and Avoidance

There were instrumental reasons women explained fearing cancer and avoiding diagnosis. Women mentioned lack of insurance and money as chronic obstacles to testing and treatment.

These obstacles can magnify women's fears that if they receive a cancer diagnosis, they will not be able to afford the treatment to care for themselves:

That's another thing in our black women, is they be scared, they hear of cancer. If they don't have insurance, they're not going to the doctor. They're not going to take care of themselves because ... and then when they get ... when it's too late, then that's when they go to the doctor. That's what I think. (2h: 786–789)

However, many also described fearing a cancer diagnosis in part due to their uncertainty of prognosis. The fear that diagnosis would require surgery was one reason women reported avoiding screening. Fear and reluctance to go to a doctor or undergo surgery or to be “cut up on” was also mentioned by individuals across focus groups, particularly among older women.

One participant frankly disclosed her evaluative belief that cancer is deadly, but also her prior orientation toward “self-doctoring” and to “not recognize” cancer.

... it's deadly; because I didn't ... I didn't recognize cancer. I had a girlfriend of mine that died of cancer, still didn't really acknowledge cancer until my father had it. But we didn't know that he had cancer. We treated it as if he had a cold. ... so we gave him cough medicine and all this, until one day ... he was looking peaked, or whatever you want to say. I took him to the hospital to emergency and they examined him, and we sat there and I asked the doctor, I said, “Well when can he go home?” He said, “We are going to keep him for awhile.” And it wasn't until we went up to his room and we asked the doctor, “Well, what's wrong with him?” And the doctor said, “He has lung cancer.” I mean both his lungs had collapsed. He lived two days. We had no idea. (4d: 514–524)

Here, acknowledgement was associated with pessimistic thinking and an inevitable terminal diagnosis. Refusing to acknowledge cancer was probed more deeply after it was offered by these women as a means of transcending the problematic situation.⁵

Fear of disrespecting an individual's privacy also led focus group members not to ask loved ones about their cancer history or diagnosis. Women discussed a norm “not to worry” their loved ones and to keep terminal illnesses hidden:

Participant 3f: ... they like to keep it hid. And you don't know how to come about asking them, like; you don't know how do they feel, because they think you're into their business.

Moderator: Are there others that feel that way? If you try to hold conversations people say you're into their business?

Participant 3g: I think they just don't want you to worry, especially like when my grandmother had it ... she had colon cancer ... she used to tell my father and his brother that it was something else ... it's just that they don't want you to worry. (581–591)

Participants avoided discussing cancer so as not to burden family members or loved ones. One participant mentioned her trouble with a girlfriend whose friends knew she was fighting cancer, but would never discuss cancer openly:

I think what's odd though with conversation is that some people will not tell you they have cancer. I mean, it's like ... I have my girlfriend who had it ... we knew but she would never, never participate in anything where she had to discuss it. ... when we

⁵This theme regarding why individuals, family members and loved ones do not talk about cancer was identified and explored in greater detail in theme #5 which follows.

found out my sister had cancer, she was having a lumpectomy and someone went to the hospital because her friend she told got scared that something may happen and why she didn't tell us, she said it was because she didn't want us to worry. So that a lot of times happens with families, they don't want us to worry about them. (1a: 553–560)

Women's desire to respect their loved ones' autonomy coupled with their loved ones' desire to guard them from an unpredictable and uncertain outcome, or a certain and awful one, meant that conversations about cancer were often not realized. However, there were also deeper, spiritual beliefs that kept participants from acknowledging cancer or from asking a loved one about their cancer openly. Uncertainty coupled with evaluative anxiety put individuals with a cancer diagnosis at odds when talking about cancer or acting on their risk perceptions.

Theme #5: Contradictions in “Claiming” and “Rebuking” Cancer (Spiritually)

Across focus groups, women spoke simultaneously of their need to refuse to acknowledge cancer or to ‘rebukey’ it in more spiritual terms. Women described an unwillingness to “name” cancer, or to “claim breast cancer on myself or others” (2i: 1332–1333). Others described how their family members “cursed” or rebuked cancer:

... my mother was saying once ... she was praying ... and ... no doctor had never told her anything about cancer. But while she was praying this came out of her mouth, “I curse the very root of cancer.” And she said, “Did this come out of my mouth?” When she went to the doctor the nurse said that cancer was probably forming itself and so the Lord revealed it to her. She cursed the root of cancer. (3k: 1052–1057)

Participants also believed that faith in a higher power could help them overcome cancer. Rather than grimly accept a diagnosis— a subtext that also appears when women speak of reasons behind fear and avoidance, the certain, awfulness of cancer— women expressed an active desire to “rebukey” cancer as a way of challenging fate. One woman described cancer in spiritual terms as “a negative energy that violates the spirit and your body. I believe it starts in the mind. If I don't acknowledge it, I don't feel that I would be privy to it” (2l: 1478–1479). Such beliefs concerning personal control exert an important influence on a person's health practices and assessment of illness risks (Brenders, 1989).

Related to control, spirituality (and rebuking cancer) may be considered as an efficacious voluntary coping strategy in situations where individuals believe that instrumental strategies will be ineffective to cope with chronic disease. While instrumental strategies involve coping strategies aimed at individual problem solving (i.e., information seeking), clearly other coping strategies are also available (i.e., wishful thinking).

For many, prayer offered a powerful means of coping with disease uncertainties. Women reported “rebuking” cancer as an active strategy to cope with a problematic cancer diagnosis:

... she [my mother] calls me crying and I'm like, “What's wrong with you?” And she said, “He's dying.” And I'm like, “Who's dying?” ... and then she went on to tell me about my brother. So I called my brother and I said, “What's going on?” And he said, “They said I have liver cancer.” And I said, “No, you don't have liver cancer.” I said, “No, you don't have liver cancer.” And he said, “Well ...” And I said, “That's what they're saying.” So anyway ... we did have a little faith meeting, with prayer and all that, and then he went to the doctor and there were spots on his liver, but they couldn't find the cancer. So now ... we talk about it, ... with my faith and the faith that I have, I talk about it, but I pray about it also. ... I asked God to ... all ... diseases, sickness, mechanical failure ... anything like that I ask Him to rebuke all that. That's just my

belief. That's what I believe, and now they can't find any cancer in his body. ... (4g: 619–637)

Women also revealed at times contradictory beliefs in the power of medicine and prayer to heal. For some women, there was inherent tension between “claiming cancer” (and communicating openly about it with different types of healers doctors and ministers) and having faith or relying on spirituality as a reliable source of external control. There was also a felt ontological and epistemological contradiction expressed by women's belief that they could go to the doctor for reliable diagnostic tests, and their concomitant spiritual questioning of giving such tests “power.” Concern that ‘naming’ an illness or a disease can enhance its power in the world resonated with women:

Participant 1d: ... A lot of times if we think if we name it, we're claiming it. [Inaudible - several speaking]

Participant 1l: My mama always says, “Don't claim it.”

Participant 1d: Sometimes like, even with my mom, because she had two brothers die from it and her sister died from it, she feels like she has it. So she's always going to the doctor. We're always talking about it. Going to the doctor and have her test run [Inaudible]. She said, this may be cancer. And my sister says, “You've got to stop saying that stuff, making everything that you have could be cancer.” So, I think, that's one of the things that people say. That if you don't say it, then we're not giving it that power. We're not letting it take control. Unfortunately, a lot of cancer doesn't work like that. It's a good thing that she does go to the doctor and that she does get herself checked out. But she just gives it too much power. (590–603)

Interestingly, in the face of ontological uncertainties about cancer, some participants expressed the belief that cancer was the work of the Devil (a reason why a diagnosis called for individuals to rebuke it). As one participant opined, “Wherever cancer come from, it's coming. I don't know where ... how the Devil works, but I'm just saying, you know, it's from anywhere” (2j: 1157–1159). Such spiritual claims require an individual to think the work of the Devil is beyond their control (in terms of prevention) and as a matter of fate unless they reach out to a higher power to challenge it. The power of prayer also helps individuals cope with their cancer fears and ambivalence. One participant expressed “If it was in some way I was to get breast cancer ... I'm not claiming it ... If you're a strong individual and you believe in God, and you keep your faith, you can get through anything” (2d: 1552–1561).

Testimony and prayer are offered as a rhetorical strategy that allows individuals to symbolically endow a person or set of problematic circumstances with “a new identity” as “healed.” However, women also expressed ambivalence about whether prayer alone could transcend the problem of disease:

You go to church ... we go to church a lot ... people will give testimonies about how they went to the doctor and they said that they told them initially they had cancer but then they prayed about it and they never claimed it and it went away. So religion plays a large role in the black community. And ... older people, they're for real, serious, like, if I don't believe in my heart that I don't have it, then I don't have it. And if I pray long enough and have enough people pray for me, it will just go away. And ... I guess it could be a problem ... I mean, I have a lot of faith. And I think a lot of times if you really have faith, I do believe you can be healed. But other times, you just need to go get checked out. You need to be realistic about it. And I think sometimes our religious ambitions get in the way of healing, real healing. (1e: 609–620)

Some participants suggested a preference to remain strategically ambiguous towards healing through faith and medicine. This view is also consistent with their faith in an active God who can heal or remove cancer through the scientific work of modern medicine.

However, “rebuking” cancer and “prayer” is clearly a strategy of PI adopted by individuals witnessing a cancer diagnosis to advance a “purified perspective” in a direct effort to overcome the perceived negative circumstances of “claiming” cancer. Women also expressed the belief that it was important that individuals have faith so that they may be healed. At the same time, some women noted the felt difficulty they had in accepting “religious ambitions” at the expense of “real healing” or opportunities to treat cancer with medical intervention. In sum, spirituality was discussed in tension with concerns about claiming cancer, and offered as a means that individuals use as a secondary or external mechanism of control, when there was a disbelief in internal control (that individual prevention or treatment was possible), a sense of pervasiveness and inevitability (Theme #1), and ambivalence about embracing the uncertainties (Theme #2), or claiming the awful certainty (Theme #3) of a cancer diagnosis.

Theme #6: Hopefulness

Despite concerns that cancer was a certain, awful illness (Theme #3), across all groups women told contradictory experiences of their resistance to their loved ones and friends’ statements that cancer is a death sentence. Women reported avoiding open talk with family members and friends (e.g., Theme #4). Additionally, there were contradictions present in how women discussed the power and danger in spirituality (e.g., “It’s a good thing that she does go to the doctor and that she does get herself checked out. But she just gives it too much power,” Theme #5). Yet, women also discussed hopefulness from PI as they learned the importance of mammography from other women who were diagnosed with breast cancer.

One woman told how her grandmother handled her cancer diagnosis “like a pro,” there were both uncomfortable moments and moments filled with humor after her diagnosis. The grandmother showed her family her mastectomy scars and saw the situation as a difficult but teachable moment. Her granddaughter recounted that although painful to watch, her grandmother offered her “a learning experience” that breast cancer was survivable:

Participant 1d: We would joke about it at times because there was some stories where actually she misplaced her breast once and ... [would] leave without her breast ... and my grandmother was like the lady like you’re describing, that just kept on going and you never knew she was sick. And we never really had a lot of cancer in our family. It’s mostly hypertension and diabetes and things like that. So when that came about it scared me but she handled it like a pro. (477–487)

Women expressed discomfort with their loved ones’ cancer fears and avoidance, and encouraged their loved ones at risk to take preventive action (e.g., eating a healthier diet rich in vegetables). One participant recounted in response to her husband who said that cancer was “just his family’s death sentence,” she would “keep telling him it doesn’t have to be” (4f: 691–692). As the person responsible for cooking and buying groceries she tried to change the way he ate.

African American women reported having difficulty talking to their loved ones about cancer, but discussed how as caregivers they had a degree of control over the family diet and doctor’s appointments. Here, the discussions highlighted how African American women felt the unique demands of what sociologists refer to as “kinkeeping” (Rosenthal, 1985), or the process by which individuals work to establish ongoing strength and stability of a family network. When placed in such a “kin-keeping” role, in contrast to reticence to talking about cancer (Theme #4), in the face of pervasive family cancer history (Theme #1) women reported passing along stories along to other family members and recommended screening. Although women

discussed mistrust of the medical establishment, fears of cancer and cancer diagnosis, they also reported wanting to learn more about cancer given their uncertainties (Theme #2).

In general, participants felt uncomfortable talking about cancer as an everyday topic. However, they offered divergent, even hopeful stories of individuals who encouraged them to take cancer screening seriously—these stories featured an active cancer survivor involved in uncomfortable communication about cancer at home, in the work place, at church, and in other everyday settings. One participant noted that one of her co-workers now tries to teach others in the workplace the importance of talking about cancer prevention:

Participant 3b: ... one of my co-workers was just diagnosed with bilateral breast cancer. And one of the things that she makes very clear to all the women, everyone there, is to make sure you get your mammograms. This is a very professional woman that put herself off. She just didn't do it because a lot of people feel it just won't happen to me.

Participant 3h: Right.

Participant 3b: And when she was diagnosed and it was found in both breasts and then she was staged and I think her staging was a three and a lot of that could have been circumvented. And she was aware. She knows ... a lot of people will make themselves last. And a lot of them don't want to know. And so now that she has been diagnosed, she's going through her treatment, and she's doing well, she's got all of us on the job ... it's just making everyone aware of that early prevention for breast cancer. So that's ... the family, her children, everybody. It's just like a common word. That's what everyone is talking about. Prevention. (654–670)

Similarly, women who had a cancer experience offered confirmatory evidence concerning the role of breast cancer survivors as cancer educators in the African American community. This testimony came from a woman in a group who identified herself as a breast cancer survivor. She used her story as a “thriving” not merely “surviving” African American woman to transcend the common problems of avoidance and reticence to “name” cancer she confronted when she spoke to women (Themes #4 and #5). She offered herself as “testimony” to other women she would talk to in everyday encounters (e.g., meetings in line at grocery stores) by wearing a breast cancer awareness pin in hope of generating questions from people she met. Thus, her survival story was consistent with others who recalled uncomfortable communicative moments that addressed cancer fears in ways that gave others hope.

Practical Implications

The most obvious and perhaps important lesson from this analysis is that many African American women report feeling torn about communicating openly about cancer. To speak openly about cancer requires they speak cancer “into the air” and confront their probabilistic and evaluative orientations toward cancer: probabilistic uncertainties about their susceptibility to disease and heart-wrenching evaluative ambivalence about their family members and loved ones cancer experiences. Nevertheless, many African American women wanted openness because it would allow them to allay fears and offer social support to their family members and loved ones. These observations and relevant theory can be practically applied to suggest less problematic, more helpful cancer communication in everyday life.

First, culturally appropriate cancer communication requires that individuals match relevant cancer information to individuals' cultural understandings of cancer. The foci of problematic integration rendered by these group discussions highlight the quite understandable coping strategies some African American women use (wishful thinking and avoidance; fatalism; rebuking cancer; spirituality) that at the same time might exacerbate their risks for late cancer

diagnosis and missed treatment opportunity. Health providers and advocates may consider the ways that traditional means of understanding (e.g., explaining family history of cancer), talking about, or avoiding cancer fears are significant contributors to risk.

A related caveat to this implication is that public health professionals should be trained to develop recommendations that are sensitive to their patient or client's faith or spiritual sensitivities. This recommendation is consistent with the finding that health communication messages tailored to religiosity may encourage mammography (Kreuter et al., 2003, p. 14). Beyond consideration of fatalism as a *destructive* construct (articulated as predetermination), faith in a higher being or spirituality may be a *constructive* source for individual optimism or inspiration to confront cancer fears. That is, although women express fear of "naming" or "claiming" cancer, they also express a concomitant voluntary and engaged desire to claim "healing." Thus, medical screening and faith need not be competing methods of resolving risk uncertainty, and health communication researchers may find communication strategies to encourage women to pragmatically resolve tensions—to claim medical and spiritual healing as successful in some populations.

Clearly, cancer risk communication must occur with due respect for the practical problems of unequal access to health food, preventive care, screening, and treatment options that research shows are obstacles for African American women after considerations of education and income. Recognizing and responding to women's cancer fears entails connecting individuals with the financial resources for prevention and treatment (e.g., free mammography), in addition to finding social support and opportunities for open cancer communication (e.g., connection with cancer survivors and support groups for African American women). PI theory helps explain women's difficulties in managing uncertainties when confronting conflicting cancer risk assessments and recommendations (e.g., whether from competing sources of expertise such as clergy or doctors, or interpreting the reliability of differing messages). Similarly, PI theory can speak to the relational and situational constraints women face as they maintain their family values, while caring for themselves as an individual. Consistent with prior research, establishing trust between family members and health care providers is important to consider before broaching delivering bad news, discussing financial uncertainties, and palliative care options.

A third suggestion is that public health professionals should avoid simplification about the obstacles many individuals face in communicating openly about cancer. Put simply, if some African American women largely understand breast cancer uncertainties in ontological terms, efforts to speak to them in epistemological terms (the strategy of giving more and "better" information) are destined to fail. Researchers should not promote information-seeking or uncertainty reduction approaches to cancer across culture (Babrow & Kline, 2000), because encouraging people to "talk" with family, loved ones, or health professionals about cancer, or simply promoting a particular information-seeking strategy, propels African American women along to the limits of such efforts: conflicting probabilistic and evaluative orientations to information (including lack of financial and social resources to cope with the disease), a spiritual concern about talking about bad news and disease, and not finding appropriate survivor models (e.g., not finding African American women who "get past it").

A clear, related implication from this line of research is that African American women need help confronting their cancer fears, which may be accomplished through messages about the ways women can reduce their cancer burdens. Formative research suggests that African American women's breast cancer discourse illustrates the likely inappropriateness of "loss framed" messages and fear appeals. Indeed, these women are quite afraid perhaps terrified of breast cancer risks.

Given African American women's evident level of fear, and the encompassing swirl of PI that accompanies their experiences, one promising area for future research is to develop strategies for assisting African American women to cope with their uncertainties, information-processing, and their emotions in the cancer context. Health communication theory and research often miss important opportunities to tell divergent and meaningful cultural stories about the cancer experience and disease uncertainties. The implication for clinical communication means that health care professionals should sensitize themselves to the multifaceted sources of resistance to recommendations, even when such ontological uncertainties about cancer risks and fears are not grounded in "scientific-technical rationality" consistent with practitioners' paradigms of evidence-based medical risk assessment (Babrow & Dutta-Bergman, 2003, p. 306).

Finally, considering a broader array of perspectives or individual orientations toward uncertain cancer communication can benefit future research. One important potential uncovered in conversation with African American women is the apparent source credibility of African American cancer survivors talking openly about cancer, of encouraging women that spiritual hope and medical treatment remain a viable course of action, and of charting ways to engage in frank and constructive cancer communication critical to reducing cancer mortality. Therefore, this research begins to suggest how alternative and hopefully more health promoting constructions of cancer communication may be fostered. How to train health professionals to be sensitive to the ways in which religiosity and spirituality influence patient decision-making is a significant area for future health communication research.⁶

Discussion

African American women interviewed cited probabilistic and evaluative beliefs about cancer acting as barriers to communicating openly about cancer. These beliefs include the pervasive worry about cancer and its prevalence, ambivalence, and uncertainty of living with cancer, a belief that cancer is awful and can result in certain death, instrumental fear of cancer treatment (e.g., pain, disfigurement, and surgery), fear of doctors and the cost of screening and treatment, fear of burdening family and loved ones, as well as the expressed spiritual desire not to "claim" cancer. Many women perceived their family members would not want them "to worry" about their cancer diagnosis. Added concerns include uncertainty over who is responsible for initiating conversations about cancer and discomfort with talking to loved ones diagnosed with cancer. Despite this discomfort, a cancer diagnosis was often named by women as an uncomfortable but productive moment for communication with loved ones about cancer, particularly as mothers, wives, sisters, and daughters.

These group conversations revealed that challenging opportunities exist for cancer communication. Problematic issues for cancer risk communication among African American women touch concerns of ontological and epistemological uncertainties; certain and problematic evaluations of disease outcomes; fear and avoidance of cancer communication; and contradictions in "claiming" and "rebuking" cancer. Given that many women experience ontological uncertainties associated with cancer and do not want "to worry" their family with a cancer diagnosis, clearly cancer patients and cancer survivors might miss opportunities to inform their loved ones of their cancer history and feel ambivalent about the importance of early cancer screening. These divergent orientations demonstrate the next step for researchers: to develop culturally appropriate cancer communication interventions to offer hope by

⁶Linking God, spiritual or religious faith to the promotion of cancer prevention behavior is a concern that must be systematically examined. Harris, Parrott, and Dorgan (2004, p. 114–115) caution against "experts in communication" using "strategies to achieve particular aims that may actually limit an audience's care consideration of an action." However, Harris, Parrott, and Dorgan conclude that neglecting the spiritual dimensions to health communication research "presents an ethical dilemma of its own" (p. 115).

addressing these problematic obstacles to cancer risk communication, prevention, and treatment efforts.

Acknowledgments

The author thanks the following individuals for their help with developing the interview protocol, formative research, recruiting participants, editing and coding transcripts, and reviewing relevant literature: Patreece Boone-Broaddus (focus group moderator), Kim Kennedy, Shana Albright, Amy George Rush, Joselyn Howell, Christina Williams. She also acknowledges Ross Brownson, Matthew Kreuter, and Doug Luke at Washington University for help with research design, and Kate Sauerwin and Amber Williams at the University of Kentucky for their research assistance.

An earlier version of this paper was presented at the 58th Annual Conference of the International Communication Association, Quebec, Canada, in May, 2008. Funding for this research was supported from a grant from the National Cancer Institute's Center of Excellence in Cancer Communication Research program (CA-P50-95815).

References

- American Cancer Society. American Cancer Society cancer facts & figures 2007. Atlanta, GA: American Cancer Society; 2007.
- Babrow AS. Communication and problematic integration: Understanding diverging probability and value, ambiguity, ambivalence, and impossibility. *Communication Theory* 1992;2:95–130.
- Babrow AS. Communication and problematic integration: Milan Kundera's "Lost Letters" in *The Book of Laughter and Forgetting*. *Communication Monographs* 1995;62:283–300.
- Babrow AS. Uncertainty, value, communication, and problematic integration. *Journal of Communication* 2001;51:553–573.
- Babrow, AS. Problematic integration theory. In: Whaley, BB.; Samter, W., editors. *Explaining communication: Contemporary theories and exemplars*. Hillsdale, NJ: Lawrence Erlbaum; 2007. p. 181-200.
- Babrow, AS.; Dutta-Bergman, MJ. Constructing the uncertainties of bioterror: A study in U.S. news reporting on the anthrax attack of Fall, 2001. In: Grant, CB., editor. *Rethinking communicative interaction: New interdisciplinary horizons*. Amsterdam: ohn Benjamins; 2003. p. 295-315.
- Babrow AS, Kasch C, Ford LA. The many meanings of uncertainty in illness: Toward a systematic accounting. *Health Communication* 1998;10:1–24. [PubMed: 16370987]
- Babrow AS, Kline KN. From "reducing" to "coping with" uncertainty: Reconceptualizing the central challenge in breast self-exams. *Social Science and Medicine* 2000;51:1805–1816. [PubMed: 11128268]
- Brashers DE. Communication and uncertainty management. *Journal of Communication* 2001;51:477–497.
- Braithwaite DO, Baxter LA. You're my parent but you're not": Dialectical tensions in stepchildren's perceptions about communicating with the nonresidential parent. *Journal of Applied Communication Research* 2006;34:30–48.
- Breen N, Kessler LG, Brown ML. Breast cancer control among the underserved An overview. *Breast Cancer Research and Treatment* 1996;40:1573–7217.
- Brenders DA. Perceived control and the interpersonal dimension of health care. *Health Communication* 1989;1:117–135.
- Caburnay CA, Kreuter MW, Cameron G, Luke DA, Cohen EL, McDaniels L, et al. Black newspapers as a tool for cancer education in African American communities. *Ethnicity & Disease* 2008;18:488–495. [PubMed: 19157255]
- Champion VL, Menon U, McQuillen DH, Scott C. Validity of self-reported mammography in low income African-American women. *American Journal of Preventive Medicine* 1998;14:111–117. [PubMed: 9631162]
- Cohen EL, Caburnay C, Luke D, Rogers S, Cameron GT, Kreuter M. Cancer coverage in general-audience and Black newspapers. *Health Communication* 2008;23:427–435. [PubMed: 18850390]

- Farmer D, Reddick B, D'Agostino R Jr, Jackson SA. Psychosocial correlates of mammography screening in older African American women. *Oncology Nursing Forum* 2007;34:117–123. [PubMed: 17562638]
- Ford L, Babrow A. Social support messages and the management of uncertainty in the experience of breast cancer: An application of problematic integration theory. *Communication Monographs* 1996;63:189–207.
- Frey, JH.; Fontana, A. The group interview in social research. In: Morgan, DL., editor. *Successful focus groups: Advancing the state of the art*. London: Sage; 1993. p. 20-34.
- Gill EA, Babrow AS. 'To Hope or to Know': Coping with uncertainty and ambivalence in women's magazine breast cancer articles. *Journal of Applied Communication Research* 2007;35:133–155.
- Goffman, E. *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall; 1963.
- Harris T, Parrott R, Dorgan K. Talking about human genetics within religious frameworks. *Health Communication* 2004;16:105–116. [PubMed: 14979854]
- Hines SC, Babrow AS, Badzek L, Moss AH. Communication and problematic integration in end-of-life decisions: Dialysis decisions among the elderly. *Health Communication* 1997;9:199–217.
- Kasper A. A feminist, qualitative methodology: A study of women with breast cancer. *Qualitative Sociology* 1994;17:263–281.
- Kreuter MW, Steger-May K, Bobra S, Booker A, Holt CL, Lukwago SN, et al. Sociocultural characteristics and responses to cancer education materials among African American women. *Cancer Control* 2003;10(Suppl 5):69–80. [PubMed: 14581907]
- Lengua LJ, Roosa MW, Schupak-Neuberg E, Michaelles ML, Berg CN, Weschler LF. Using focus groups to guide the development of a parenting program for difficult-to-research, high-risk families. *Family Relations* 1992;41:163–168.
- Lindloff, T.; Taylor, BC. *Qualitative Communication Research Methods*. 2. Thousand Oaks: Sage; 2002.
- Niederdeppe J, Levy AG. Fatalistic beliefs about cancer prevention and three prevention behaviors. *Cancer Epidemiology, Biomarkers, and Prevention* 2007;16:998–1003.
- Powe BD. Fatalism among elderly African Americans. Effects on colorectal cancer screening. *Cancer Nursing* 1995;18:385–392. [PubMed: 7585493]
- Powe BD. Cancer fatalism among elderly African American women: Predictors of the intensity of the perceptions. *Journal of Psychosocial Oncology* 2001;19(3):85–96.
- Powe BD, Daniels EC, Finnie R. Comparing perceptions of cancer fatalism among African American patients and their providers. *Journal of the American Academy of Nurse Practitioners* 2005;17:318–324. [PubMed: 16045592]
- Powe BD, Finnie R. Cancer fatalism: The state of the science. *Cancer Nursing* 2003;26:454–465. [PubMed: 15022977]
- Rosenthal C. Kinkeeping in the familial division of labor. *Journal of Marriage and the Family* 1985;47:965–974.
- Schmidt C. Fatalism may fuel cancer-causing behaviors. *Journal of the National Cancer Institute* 2007;99(16):1222–1223. [PubMed: 17686819]
- Thomas-Vadaparampil S, Champion VL, Miller TK, Menon U, Skinner CS. Using the Health Belief Model to examine differences in adherence to mammography among African-American and Caucasian women. *Journal of Psychosocial Oncology* 2003;21(4):59–79.
- Zoeller, HM.; Kline, KN. Theoretical contributions of interpretive and critical research in health communication. In: Beck, C., editor. *Communication Yearbook*. New York: Routledge; 2008. p. 98-117.