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Deconstructing Fatalism: Ethnographic Perspectives on Women's Decision Making about Cancer Prevention and Treatment

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Abstract

Researchers have long held that fatalism (the belief in a lack of personal power or control over destiny or fate) constitutes a major barrier to participation in positive health behaviors and, subsequently, adversely affects health outcomes. In this paper, we present two in-depth, ethnographic studies of rural women's health decisions surrounding cancer treatments to illustrate the complexity and contestability of the long-established fatalism construct. Narrative analyses suggest that for these women, numerous and complex factors—including inadequate access to health services, a legacy of self-reliance, insufficient privacy, combined with a culturally acceptable idiom of fatalism—foster the use of, but not necessarily a rigid conviction in, the notion of fatalism.

Keywords

fatalism; Appalachia; cancer; prevention; health decisions

Fatalism has been defined as “a philosophical doctrine holding that all events are predetermined in advance for all time and human beings are powerless to change them” (Webster's Dictionary 2010). The construct has been used in a variety of research areas, including accounting for adolescent unemployment and psychological distress, approaches to coping with food safety, and numerous studies on health behavior and decision-making.

In the health sciences, the fatalism construct increasingly has been applied to account for health behavior and even health outcomes. Investigators classify as fatalistic those individuals who believe that health is “a matter of fate or luck and beyond an individual's control” (Straugham and Seow 1998). For example, when an individual decides to engage in risky sexual practices without the use of a condom or opts out of getting an HIV/AIDS diagnostic test when pregnant, researchers have evoked fatalism or other related psychosocial constructs to help explain such decisions. Constructs related to fatalism include locus of control (Rotter et al. 1962), optimism (Steginga and Occhipinti 2006), and expectancy for the future (Christensen et al. 1999). Risk behavior, another associated concept, is predicated on the idea that people's willingness to engage in risky activities may be linked to how much control they believe they have over its outcome. Hopelessness is another related construct—if you feel hopeless, you will believe that you cannot shape your own destiny (Kalichman et al. 1997). Questions have been raised about the implications of fatalism for genetic testing, with researchers noting that if people perceive a health condition to be genetic, they may feel that its course is out of their control; hence, there is little they can do to prevent or control the condition (Macintyre 1995).

Within the public health literature, a widely used construct known as cancer fatalism, defined as the belief that “death is inevitable when cancer is present” (Powe and Finnie 2003:454), has received growing attention. Like many of the works exploring health fatalism generally, the focus of cancer fatalism studies has been to understand the reasons that people do not follow the presumably “rational” recommendation. Cancer fatalism has been at the center of efforts to identify why people either forgo cancer screenings known to be efficacious in early detection of tumors, do not follow up on a detected abnormality, or refuse a particular course of treatment (Gregg and Curry 1994).

Most work on cancer fatalism has taken a purely cognitive orientation, beginning and ending at the idea that fatalistic perspectives shape, and possibly determine, cancer prevention and treatment behaviors. While other factors are also acknowledged as influencing behaviors and outcomes (e.g., lack of access to services, competing priorities, inadequate knowledge) (Dignan et al. 1994; Freeman 1989), cancer fatalism has been attributed to directing behavior. Cancer fatalism—and fatalism overall—tends to be used extensively when examining traditionally underserved populations, including ethnic minorities, rural residents, and individuals with low socioeconomic status.

Indeed, a major concern with the application of the fatalism construct involves a consistent focus on the “other.” Most studies that have drawn on fatalism as a possible explanation for health behaviors have involved populations that tend to be viewed as problematic or ignorant. Those with an external locus of control are said to believe that health is governed by external, uncontrollable factors and, thus, are perceived as irrational and ignorant and requiring health education (Straughan and Seow 1998). Those with an internal locus of control, however, have embraced “modern” values that align closely with “good lifestyle choices.” As Davison and colleagues note, when viewed through this dichotomous lens, optimizing health behavior becomes “a struggle between a modern belief in lifestyle and an atavistic culture of ‘fatalism’ ” (Davison et al. 1992:676).

Thus, it is not surprising that a significant portion of the cancer fatalism research has involved traditionally underserved populations, mostly African American and older women (Powe 1996, 2002; Underwood 1997; Wolff et al. 2003). Researchers might justify these decisions because of the greater likelihood of African Americans to experience later stage disease or premature death. However, other explanations, like tangible barriers and substandard medical care, are seldom implicated in these adverse outcomes, suggesting a stigmatization of traditionally marginalized populations, even though researchers have acknowledged that the same people deemed fatalistic also tend to lack health insurance (Conrad 1996); have less education (Lannin et al. 1998); and frequently have no common source of medical care (Harris et al. 2003).

Although Appalachian populations are predominantly white, they have endured persistent stereotyping and have been the focus of curiosity seekers since mid-19th century. “Always part of the mythical South, Appalachia continues to languish backstage in the American drama, still dressed, in the popular mind at least, in the garments of backwardness, violence, poverty, and hopelessness once associated with the South as a whole. No other region of the United States today plays the role of ‘other America’ quite so persistently as Appalachia” (Eller 1999:ix). According to Mary Anglin, the local color movement “orchestrated a kind of cultural politics” that “projected nationalist concerns onto an emergent ethnic category, the ‘southern mountaineer’ ” (1992:105). The “Appalachian Americans” were also referred to as “yesterday’s people” (Weller 1965), and “our contemporary ancestors” as if they were the surviving remnant of a white, isolated pioneer culture.

Sandra Barney provides a compelling historical perspective on how the discourse of Appalachian fatalism as a cultural tradition can be traced to early-20th-century settlement workers. In her description of the transformation of regional health care from 1880 to 1930 (2000), Barney notes that these settlement workers blamed fatalism for rural residents' rejection of modern medical services. As Barney argues, however, "Mountain poverty and isolation, not tradition, prevented Appalachian residents from obtaining medical care. ... Mountaineers exhibited a healthy resistance to the imposition of modern practices, choosing instead to carefully select the innovations they wished to employ" (Barney 2000:27:117). Barney's work implores us to move beyond a simplistic attachment to fatalism and to consider instead the social and political economic contexts within which illness is experienced and health care is imagined, sought, and utilized.

Several additional shortcomings of the fatalism construct raise questions about its utility as a major determinant of adverse health behavior and outcomes, at least as fatalism currently is conceptualized and measured. Just as the absence of a more complex and socially embedded discussion of fatalism raises questions about its theoretical legitimacy, the fatalism construct has been marred by imprecise and questionable measurement issues. Fatalism's conceptualization and operationalization remain plagued by inconsistencies, overly general statements, and questionable validity and assumptions (Powe et al. 2005). For example, fatalism researchers sometimes employ double-barreled phrases like, "as a result of the AIDS threat, I have resolved to be more responsible in my approach to sex" (Moore and Rosenthal 1991:217). Other researchers tend to make sweeping generalizations by dichotomizing people into "nonfatalistic" and "fatalistic," belying the complexities of the construct (Harris et al. 2003). Recognizing the limitations in treating "cancer fatalism (as) ... an all-or-none phenomenon" (Powe and Finnie 2003:456), some are conceptualizing fatalism as a continuum.

Indeed, inadequate theoretical development appears to have stymied construct validity. Harris and colleagues (2003) categorized as fatalistic those women who believed their chances of surviving breast cancer were fair or poor, while women who believed their chances to be excellent, very good, or good were considered nonfatalistic.

The Intuitive Appeal of Fatalism

The growing number of studies that focus on cancer fatalism and its related constructs suggest that there is something intuitively appealing about the connection between fatalism and health behavior. There are several reasons why fatalism is held in such high regard.

First, there is an intuitive and well-documented connection between health beliefs and health behavior. Numerous studies demonstrate that even when "controlling" for other determinants of cancer screening and treatment, such as access to medical care, screening rates remain low among those populations that score highest on fatalism indices (Lannin et al. 1998). When examining lack of screening among African-American women with stages III and IV breast cancer, Conrad and colleagues concluded that fatalism played a large role in lack of screening (and suboptimal health outcomes) for breast cancer. Their letter, published in the *Annals of Internal Medicine*, noted:

We previously postulated that the poor outcome among black women was caused solely by relative unavailability of medical care and the cost of methods of detection. However, when we provided medical care and screening procedures for free, few patients belonging to a minority group participated. [Conrad 1996:942]

To assess reasons for this lack of screening, these investigators interviewed African American women with stage 3 and 4 breast cancer, asking them to complete sentence stems that might explain their delay in receiving treatment. They continued,

Most responses described elements of fatalism. Often, this fatalism had a religious connotation; some of these respondents believed that one's actions cannot influence outcome or that cancer was a punishment for wrongdoings.

Although the authors did not appear to focus on other psychosocial constructs or lifecourse events, they then concluded that

fatalism is prevalent in poor and less educated populations and that this factor is an important reason why some persons fail to seek medical care at an early stage of disease and do not use methods for early detection of cancer. Whether fatalism is primarily a problem in the southern United States and whether it is a significant problem in other minority populations are not known. [Conrad 1996:942]

There is substantial evidence of the strong association between higher rates of fatalism and lower rates of cancer screening (Lannin et al. 1998), the latter of which is linked to higher cancer mortality. These findings have been confirmed for screenings to detect breast cancer (Mayo 2001; Straugham and Seow 1998), cervical cancer (Chavez et al. 1997), colorectal cancer (Powe 1995), and skin cancer (Michelieutte et al. 1996).

Second, for researchers who are looking beyond description and toward application and program recommendations, focusing on fatalism makes sense. Unlike older age or lower education level, two factors frequently associated with low rates of cancer screening, fatalism is factor that can be altered. Moreover, addressing cognitive or attitudinal issues tends to be an easier proposition than, for example, ensuring a consistent source of medical care, which is also associated with lack of screening (Harris et al. 2003).

Finally, fatalistic perspectives are quite common; people really do express what might be considered fatalistic notions and apply them to health. Attempting to examine this popularity empirically, Hoffman-Goetz (1999) performed a content analysis of articles about cancer within the most popular African American-oriented magazines and found that over one-third contained expressions of cancer fatalism (i.e., bad luck, fate, acceptance of the inevitable). Hoffman-Goetz is careful to point out that close to three-quarters of the articles described positive fatalism feelings (i.e., deliverance from death, beating the odds).

Freeman's poverty-cancer spiral concept offers insights into why traditionally underserved populations articulate and employ fatalistic perspectives (Freeman 1989). Freeman notes that poverty and its associated ills—undereducation, lack of employment, poor housing, lack of health care access, poor health outcomes—create a downward spiral, a self-fulfilling prophecy, and, ultimately, adverse health outcomes. Freeman describes the process by which poverty intersects with medical care and creates fatalism. First, unless there are discernible symptoms, poverty oftentimes forces people to focus on a day-to-day existence that stands in sharp contrast to a health prevention mode. By the time cancer symptoms are present, the disease has progressed beyond the localized stage, which necessarily limits treatment options and leads to poorer outcomes. Poor outcomes decrease the likelihood of survival and increase suffering, ultimately reinforcing fatalistic perspectives, as families and community members witness this cycle of late stage cancer diagnosis, more complicated, disfiguring, and painful treatments, poor outcomes, and, ultimately, death (Shankar et al. 2002).

Narratives replete with descriptions and stories that exhibit fatalism demonstrate support for this poverty—cancer spiral concept (Balslem 1991; Mayo 2001; Shankar 2002). Using quantitative instruments, including Powe's Fatalism Inventory and a host of other attitudinal

scales, researchers have demonstrated that certain groups of people consistently respond in more external or fatalistic ways than others, with many concluding that there is an association between these fatalistic expressions and adverse health behaviors and outcomes (Powe 1995; Powe and Weinrich 1999; Straughan 1998; Wolff 2003). Acknowledging the use of fatalistic rhetoric, we sought to explore the legitimacy of fatalism as an explanatory construct for decision making about cancer prevention and treatment.

Methods

Two distinct field work experiences in central Appalachia allow us to deconstruct the fatalism construct. For both case studies, we provide background, including a brief methods description, focusing on the results and their implications for the fatalism construct. Although the impetus and design of the case studies differ, there are a number of similarities between the projects, including population focus (middle aged Appalachian women); approach (ethnographic design); and contextual backdrop (resource-scarce environments with a history of self-reliance, community connectedness, and geographic isolation). For these two case studies, we highlight only those themes relevant to fatalism; other thematic developments are described elsewhere (Drew 2004; Leach and Schoenberg 2007). The appropriate Institutional Review Boards approved the protocols of both studies.

Case #1: Decision Making about Hysterectomy

Background and Methods

This case study examines the construct of fatalism in the context of women's decision-making about hysterectomy, the surgical removal of the uterus. Tracking hysterectomy trends in the United States, the Centers for Disease Control and Prevention (CDC) reports approximately 600,000 women undergo hysterectomy each year (Whiteman et al. 2008). In the United States, poor, less educated women are more likely to receive hysterectomy than wealthier, more educated women (Kjerulff et al. 1993), and hysterectomies are more prevalent in the south than in all other regions of the United States (Whiteman et al. 2008).

In order to examine the fuller context of decision making about hysterectomy in eastern Kentucky, the first author conducted 18 months of ethnographic fieldwork in Coal County, Kentucky (a pseudonym). In 2002, the population of the county was approximately 32,000. Less than 3 percent of the population was African American (U.S. Census Bureau). The median household income was approximately \$18,000 per year, compared with \$33,000 in the state. Approximately 33 percent of individuals, or 42 percent of families with children fewer than five years of age, were reported as living below poverty, with female-headed households reporting the greatest burden at 50 percent.

In the study, women were asked to talk about the factors influential in their decision making about the surgery and whether or not they felt a sense of choice and control over the decision. In total, we conducted in-depth, semistructured interviews with 26 women (31 to 79 years of age). We recruited women through snowball sampling and the interviews, about two hours each, were conducted at participants' homes, the county library, or at a nearby community center. After administering informed consent, we tape-recorded the interviews with permission from the participants. We also conducted one focus group with 10 African American women who had had a hysterectomy.

Following verbatim transcription of the interviews and the focus group recording, we conducted open coding (Emerson et al. 1995) with the assistance of the qualitative data analysis software The Ethnograph v.5.0. Once these codes were identified, we used focused coding to identify subthemes. Next, we identified recurring themes and began to categorize

or cluster pieces of text that related to different themes. The final stage involved axial coding in which we linked various codes by making connections along thematic axes. The coding process continued until no new themes emerged. For purposes of this examination, we focus on those themes directly relevant to the fatalism construct.

Findings

Women's narratives about the decision to have a hysterectomy revealed a complex negotiation of factors, including fears about cancer, competing time demands, consideration of different emotions and meanings associated with the body and reproduction, seeking information and advice from others, and seeking access to trusted providers and affordable treatment. Nearly all of the women interviewed mentioned delaying treatment or follow-up for months and in many cases, years, following a recommendation to have a hysterectomy. Only after the symptoms worsened and became unbearable did they return for treatment, stating "My choice was function or not function. It was just that simple." Women with diagnoses of cancer told me that they delayed treatment until they were convinced that "It was have the hysterectomy or die."

Such delays in treatment seeking are often explained in terms of a fatalistic subculture in which women postpone or delay treatment because they believe that the fate of their bodies is predetermined and beyond their personal control. "If I'm going to get cancer...then I'm going to get cancer" or to a strong sense of divine fatalism, or "the belief that health outcomes are inevitable and/or determined by God" (Franklin et al. 2008). "It's in God's hands—not mine." Older women in particular told us that "they'd rather not know about cancer ... I'd rather die from it than know I have it." While only several of the women had hysterectomies based on formal cancer diagnoses, all of the women interviewed were convinced that their symptoms were related to cancer or might "turn into cancer later on down the road."

Yet, in rural eastern Kentucky, where the economy has shifted tremendously over the last century through cycles of boom and bust, and where health care has been established but unable to provide a range of alternatives in the area of women's health, delaying treatment has become a cost-effective primary health strategy for women. Moreover, given rampant debate about environmental contamination, the eminent cancer threat, and problems in access to care, women with the fewest economic resources are most vulnerable. These women emphasized that if alternatives to surgery were available, they were not informed about them, and even if they had been, the doctors providing their care were not trained and they could not afford the resources (money, time, transportation, etc.) to seek out alternatives offered elsewhere. Alternatives such as dilation and curettage or taking hormones, for example, to try to regulate irregular and heavy bleeding would not only add to the cost of treatment and number of visits to the clinics, but also too often served as only a short-term solution.

In several cases, physicians wanted to schedule surgery immediately, either when cancer had been detected or when uterine tumors could not be biopsied until after removal of the uterus. For example, Annie, at age 21, delayed treatment seeking for a seven months and then returned to her doctor because of her worsening symptoms, including severe lower abdominal pain and constant bleeding. She said, "If they found the problem in my female organs, I had signed the papers that they could remove them ... I mean, I had no choice ... I just decided that I could not go through life in constant pain. I was 21 years old and scared. My oldest sister died of leukemia a year before that, when she was 32. I was very scared of it—scared of dying and leaving my kids." In contrast, Helen, at age 48, delayed having a hysterectomy for 15 years. She suffered chronic uterine bleeding, explaining "I just kept putting it off and it just got so bad—when you wear two hospital-sized pads and you can't

walk from the bathroom to the living room without having to drop clots on the floor as big as your hand ... finally it was just too much.”

Often the women admitted that fears about cancer were so overwhelming in the midst of already constrained lives that they chose to delay medical treatment to prepare for the possibility of “bad news.” Despite what appears to be a wasteful time delay prior to formal medical treatment, both Annie and Helen regularly sought advice from friends and family members, rearranged work–life demands to accommodate worsening symptoms, and ultimately decided to seek medical attention and undergo hysterectomy.

Most of the women traced the source of their reluctance to go in for screening or other test beyond the fear of cancer and death, but to the reality of not being able to afford treatments if cancer was discovered. Rita, who worked as an LPN and RN in the local hospital for years, explained, “If you have cancer, it's there whether you know it or not. Not wanting to know doesn't change the reality of it, but I have heard that a lot though over the years. Like, if they don't want to know, they don't want to know. Or the other thing, and I hear this a lot even out where I work, ‘Well, if I went to the doctor, I wouldn't be able to afford the medicine. Couldn't afford the treatments, so what's the point of knowing?’”

Given their rural and underresourced environment, many women felt that “waiting it out” and enduring the symptoms was their only option. As Betty points out, searching out alternatives would prove far more costly in the long run for women without transportation and little or no health insurance. After all, more sophisticated tests or procedures: “would mean how many trips to the doctor? And to what city? Because they don't offer the latest technology down here. We don't have quality care here. I don't want to have cancer and live here. If I lived in the city, I maybe would want to deal with something a little more. But here, I don't want to deal with that.”

In summary, these social and economic constraints shaping women's health seeking strategies provide a more nuanced explanation than the accusation that Appalachian women are merely fatalistic because they delay seeking treatment for symptomatic reproductive conditions. Indeed, as the above cases reveals, while women may express fatalistic attitudes at the onset of symptoms, such attitudes do not necessarily signify powerlessness or hopelessness. Rather, such expressions are a culturally acceptable way of expressing oneself in times of great challenge and when facing constrained choices.

Case #2: Decision Making about Obtaining a Pap Test

Background and Methods

This case study examines another complex health decision, screening for cervical cancer by obtaining a Pap test. The early diagnostic efficacy of Pap tests has rendered invasive cervical cancer (ICC) nearly preventable; however, 13,000 new cases of ICC are diagnosed each year, with 4,600 resulting deaths (American Cancer Society 2009). While nationally, women have experienced a 75 percent reduction in cervical cancer mortality in the past six decades, rural Appalachian women continue to shoulder disproportionately high cervical cancer rates (Huang et al. 2002). Pap tests use, known to be significantly lower among Appalachian women than their national counterparts, is a focal point in rectifying this cancer burden. To account for these lower rates of Pap tests, researchers have examined barriers like transportation and health care professional shortages, high levels of poverty, and cognitive factors like fatalism (Rimer et al. 2001).

To update these observations and insure that the full range of barriers to Pap tests are understood, we undertook 25 in-depth interviews with rarely or never screened middle-aged

Appalachian women from Kentucky and West Virginia. Participants were recruited by local interviewers from various locations (a community college cafeteria, a low-income housing project, and a senior citizen center) and through snowball sampling. The Kentucky county had 42,421 inhabitants, of which 30 percent lived below the poverty level and 39 percent had less than a high school education. The West Virginia county had 37,710 people, of which 24 percent lived below the poverty level and 63 percent had less than a high school education.

If agreeable, interviews were conducted in participants' homes. Interviewers administered informed consent and, if acceptable, tape recorded the semistructured interviews. The guided interviews were shaped by ecological theories of behavior that focus on the individual, social networks, provider and health care system, and community environment (Rimer et al. 2001). On completion of the transcription, researchers engaged in line-by-line or axial coding (Strauss and Corbin 1990), established numerous versions of codebooks, and employed methods to increase rigor and verification including coding identical text portions, frequent debates and establishing intercoder reliability ratios, and returning to the communities for member checks (Bernard 2002).

Results

Numerous factors appear to contribute to women's decisions not to obtain a Pap test. These factors—competing demands for time and resources, perceived lack of need, concern about privacy and suboptimal treatment, among others—undermine the speculation that fatalistic beliefs are at the heart of not obtaining Pap tests (Schoenberg et al. 2006). However, when describing the challenges they and other women in their communities face in obtaining Pap tests, many informants did indeed make references to influences and outcomes beyond their control. For example, a 54-year-old woman's explanation for why it is difficult for some women to get Pap tests was common.

Fear. I think a lot of it rests on fear. Not of the test itself...most of your women know that it won't be all that bad. But I think it's fear of finding out that you got a bad result. I think a lot of us don't want to know and are afraid of knowing. So I say its fear.

The fear of knowing the outcome of an early detection test plays such a considerable role in women's perceptions of Pap tests for several reasons. First, the women in our study fear having to change their lives to accommodate or address the illness that seems like an overwhelming and worrisome challenge.

I just can't imagine it, you know I can't bring myself to even thinking about what I would do if they came back to me and said, "Glenda, you got cancer." I don't know what I would do first, how to handle all that I got going on, everyone who I care for, and everything. I can't even bring myself to thinking about this. So I don't.

In addition to the fear of having to change a complicated life where others depend on you, women expressed a fear of the treatment itself and of having to live with the worry of the cancer returning. A 61-year-old woman told of her own mother's struggle with a late-stage diagnosis of cervical cancer. Not only did the informant witness her mother's adverse reaction from multiple therapies, but she also described the stressful vigilance during those years when the cancer seemed to be in remission. Ultimately, she concluded that "mother would have been better off without knowing. She would have at least had her final year without the doctors and the hospital." Her narrative resonates with Freeman's poverty spiral theory:

I seen other people brought down by cancer before, too ... the horrible things they got to go through, the chemo and the radiation and you know what happens? They

die anyways. Oh, they might live another year or maybe two or three. But all that time, they're waiting for it to come back, just to have to start the treatment again, feel bad and then this time they do die. No thank you, ma'am, I'd rather not know. Just let me go.

It appears that when women express these fears and do not want to know the outcome of Pap tests, it is not because of a belief that God or some other external force will “take care of it”. Rather, most women describe their fears and decisions to avoid Pap tests as rooted in their constrained realities. When asked about whether women lack knowledge about Pap tests, one 48-year-old woman who had not had a Pap test for five years, explained the fine distinction between awareness, fatalism, and realism.

I'm not certain that women don't know about Pap tests—you hear about them everywhere and women who are my age and younger, most had them when they went in for birth control or when they were having babies. So, I can't think that they don't know about them or believe in them. But there probably is some truth to some ladies not wanting to know about how their test came back, but for the simple reason that they might not be able to do much anyways.

She continues,

Well, I know this lady who got a call from the doctor's office saying that the test came back and she needed to come in and talk to the doctor and do it again or something. So, she got real worried about it, stayed up half the night, and then told her boss that she'd have to take the afternoon off to go to the doctor's. Okay, but she had already taken time off for some family sickness or something, so be quick about it. When she got there, the doctor just told her that he couldn't say it was cancer, but they better keep an eye on it, do the test over in a few months. But, see, she couldn't keep taking off work, shelling out the money for the test, and then not even know if it was cancer. So, she kinda figured that she would just do her best with it. ... So, see, she wanted to know, but the test didn't tell her much and there were other things to worry about.

In an environment where worries are plentiful and compete for attention, women report having to push such health threats into a small corner of their minds rather than making it the predominant life issue. Many informants echoed these themes of realistic concerns about obtaining a diagnosis, citing personal examples of people they knew who had been told they had cancer, but lacked resources to make frequent medical visits, purchase medications, or undergo expensive and uncomfortable diagnostic procedures. Considering these challenges to preventing a progression to a cancer diagnosis or obtaining treatment, pursuing watchful waiting or even leaving it up to a higher power begins to make sense.

Study Limitations

Given the methods of sampling and recruitment for the two studies, it is recognized that the findings are neither directly generalizable to all women in the sample counties, nor to rural women in other parts of central Appalachia. In addition, since the two case studies were based on self-report, some researchers may question the accuracy of women's memories and accuracy of recall. However, high reliability and validity of women's self-reports of their medical histories surrounding hysterectomy has been reported (Brett and Madans 1992; Green et al. 1997; Horwitz and Yu 1985). Green et al. (1997) report that women demonstrate good recall of their hysterectomy experiences such that self-reports provide accurate assessments of the experience and long-term effects of surgery. In addition, Brett et al. emphasize that “associations obtained with self-reported hysterectomy information are not unduly biased” and that “investigations of the sociobehavioral characteristics associated

with hysterectomy use will obtain valid results using either data collection method” (1992:1655).

Discussion

The two case studies presented above alert us to three important areas for discussion: taken together, these women's illness narratives (1) reveal attempts at agency despite constrained choices; (2) belie many assumptions—that religiosity leads to adverse health behaviors, or that fatalism is an irrational response; and (3) demonstrate the importance of considering context, rather than one isolated psychological construct, fatalism.

First, the illness narratives described by the two case studies reveal that women do attempt personal control, or to exert agency, despite constrained choices. Indeed, women's hysterectomy and Pap test decision making narratives illustrate how attempts to control their health and bodies is played out using culturally acceptable fatalistic perspectives and resources within their grasps. “If I'm going to get cancer ... then I'm going to get cancer” or to a strong sense of divine fatalism, or “the belief that health outcomes are inevitable and/or determined by God” (Franklin et al. 2008). “It's in God's hands—not mine.” Older women in particular told us that “they'd rather not know about cancer ... I'd rather die from it than know I have it.”

Given that health care in Appalachian Kentucky is marked by physician shortages, lack of specialists, greater distance to clinics and hospitals, and diminished access to medical technologies, along with the disproportionate burden of cervical cancer (Lengerich et al. 2003), it is not surprising—and in fact, it is completely understandable—that the women in this study expressed constrained choices about their personal health. There is a complex and multiple structuring of the concepts of control and choice such that delays in treatment or not obtaining preventive care are not solely attributable to cognitive factors but, rather, a complex negotiation of cognitive, socioeconomic, and environmental realities.

Moreover, narratives offered by our participants provide evidence that, in such constrained environments, women operate on a continuum of possible responses ranging from an active pursuit for various biomedical “goods and services,” to active resistance, to ambivalence, to compliance with biomedical authority. Betty's attempt to “wait it out” demonstrates that she is simultaneously constrained by her illness experiences as well as her social and economic reality, yet she still attempted to assert her sense of “choice” and agency in the decision to have a hysterectomy.

While cancer prophylaxis generally is regarded as a benefit for all elective hysterectomies, the assessment of a patient's risks of cancer may be inappropriately weighted against the potential risks of the surgery itself. This issue certainly merits consideration in Kentucky, since it is possible that physicians are more inclined to recommend hysterectomy for cancer prophylaxis because of the disproportionate burden of cervical cancer among rural women in Appalachia in general, and Appalachian Kentucky in particular (Lengerich et al. 2003). Likewise, it is possible that many women in Appalachian Kentucky actually prefer hysterectomy to nonsurgical alternatives in part because of their perceptions of elevated risk for cervical and ovarian cancers. Whichever scenario is more appropriate, it is the possibility of control in light of cancer burden, and an under resourced environment that shapes such complex decision making.

Perceptions of elevated cancer risk, such as Annie's concern about cervical cancer, are not merely cognitive constructs or irrational worry but instead are corroborated by empirical evidence; Appalachian women experience ICC incidence rates of 15.0/100,000 approximately 67 percent above the national average (9.0/100,000) (Hopenhayn et al. in

press; Ries et al. 2005). The age-adjusted mortality rate from ICC in Appalachian Kentucky was 2.91 compared with 2.61 for the state and 2.4 nationally (Kentucky Cancer Registry N.d.). Although ovarian cancer incidence rates in Appalachian are similar to national rates, the age-adjusted ovarian mortality rate for Appalachian women was slightly higher, suggesting a later stage of diagnosis or inadequate treatment among Appalachian women (Altekruse et al. 2010).

A second major theme raised by the women's illness narratives in both case studies is that the narratives belie many assumptions, including the idea that fatalism thwarts positive health behavior; that there is an adversarial relationship between fatalism, religiosity, and optimal health behavior; and that fatalism is an irrational response to well intentioned recommendations. Most existing health behavior models and empirically based studies demonstrate an association between beliefs and behaviors; however, the relationship is not necessarily linear or causal. For example, Chavez and colleagues found that while Latinas scored higher on fatalism indexes than other women, the women do not mention fatalism when discussing their reasons for not getting Pap tests (Chavez et al. 1997).

Women's hysterectomy narratives provide evidence of the hazards of assuming an association between religion, fatalism, and adverse health behaviors. As Powe notes, "the belief in God's will or God's divine plan for one's life cannot and should not automatically be considered fatalism" (199:137). Indeed, our research and others have demonstrated that religiosity and spirituality can actually encourage proactive behaviors. For example, the religious metaphor "the body is a temple" may instill the idea that people are responsible to be good stewards of their own health, or that "God works through doctors" (Cohen and Nisbett 1998; Powe 1995). Indeed, several women in both case studies described a confident, nonfatalistic, understanding of faith and the power of their own prayers to positively influence health outcomes.

In addition, the assumption that fatalism is a problematic or irrational response to a health threat privileges certain viewpoints by delineating what constitutes rational behavior. Some of the same questions posed by medical anthropologists in the 1980s about the supposed irrationality of nonadherence can be asked about the reasoned thoughts of fatalism. Experiential knowledge from the traditionally underserved women we interviewed suggests that cancer might very well be a death sentence; they have witnessed their family and friends diagnosed, subjected to painful and sickening treatment, and then hospitalized, only to succumb to cancer shortly thereafter (Shankar et al. 2002). What would any rational person conclude from these experiences? Similarly, the fact that, if left untreated, 85 percent of HPV resolves itself within one year of exposure (Gravitt and Jamshidi 2005), makes understandable the idea of watchful waiting, particularly when confronting numerous barriers to medical care and, in the case of HPV, potential social stigma.

The third key theme to emerge from the two case studies is that women's illness narratives demonstrate the importance of considering context, rather than one isolated psychological construct, such as fatalism. Indeed, many researchers focusing on fatalism do so in the absence of understanding the more complex and socially embedded origins of fatalism. Issues known to affect health behavior, including tangible barriers to cancer screening or early treatment, are often overlooked (Powe and Finnie 2003). As Rita, an RN, explained, "I hear this a lot even out where I work, 'Well, if I went to the doctor, I wouldn't be able to afford the medicine. Couldn't afford the treatments, so what's the point of knowing?' "

Even when researchers do consider such tangible barriers to care, they often treat them in social isolation. Thus, Conrad's conclusion—that lack of access was not a primary factor in African American women's lack of early detection participation because their group offered

free screenings—overlooks a long history of stymied access to care, medical mistrust, and salient poverty issues (Schoenberg and Drew 2002). Simply offering free or reduced cost services is not equated with unfettered access. In another study, investigators provided fecal occult blood test kits to rural, African-American older adults, thereby, in the researchers' minds, "controlling access and costs" (Powe and Finnie 2003). Such a conclusion fails to account for the many years of frustrations and inadequate access that, in part, create reasoned patterns of avoidance of care. Indeed, the vast majority of work on cancer fatalism is located within the nonwhite community, purportedly because of "different" health beliefs that thwart appropriate action (Luquis and Villanueva 2006; Perez-Stable et al. 1992; Spurlock and Cullins 2006).

Why does it matter if researchers overlook the social context that may contribute to fatalistic thoughts? Some, including Harold Freeman (Freeman 1989), former associate director of the National Cancer Institute (NCI) and former director of the NCI Center to Reduce Cancer Health Disparities, argue that an inadequate understanding of why fatalism develops leaves one with a theoretically void and obscured view on determinants of health behavior and how to address the problem of lack of screening or treatment. Freeman's poverty–cancer spiral concept—that poverty serves as a prism through which fatalism can be viewed—addresses the contextual void of most uses of fatalism by acknowledging the socially embedded origins of the construct (Freeman 1989). Freeman argues that it is insufficient to simply make an association between fatalism and people who are poor (or African American or Latino or any traditionally underserved group) without embedding this connection in a context that shapes opportunities, experiences, beliefs, and ultimately, behaviors.

Conclusion

Health decision making is a very complex series of activities that tend to be made with the backdrop of an individual's life circumstances, with heavy contributions from familial, local, cultural, and national influences (Davison et al. 1992). Perceptions of personal risk and approaches to minimize such risk is always set in a larger framework or context—generally a risk balancing framework that "takes account of other pathogenic or salutogenic influences" (Hunt 2000:132). These considerations include "real life" circumstances and constraints; perceptions of risk because of power and agency, family history that intersects with experiential knowledge and health care provider interaction (Angus et al. 2005; Davison et al. 1991); and many other factors that belie easy description and only one of which is cognition shaped by "culture." Rather than reducing complex health decision making to those "factors" that remain once other predictors show no statistical significance, we propose that a complex and interacting consideration of circumstances, predilections, and experiences underlie women's decisions to have a hysterectomy, get screened for cervical cancer, and any other decisions.

In Western mainstream culture, where the expectation is to be autonomous, independent, self-directed and a manager over one's future, expressions of fatalism strike many as benighted, irrational, and counterproductive. Yet as our case studies reveal, "fatalism is an entirely rational way of coping with a world in which one feels powerless and has potential benefits, such as enhanced enjoyment of the present that Western, achievement oriented cultures tend to discount" (Heyman et al. 1997:51). Indeed, we argue that fatalism in the context of our two case studies represents a form of what medical anthropologist Mark Nichter refers to as "cultural idioms of distress," which "are socially and culturally resonant means of experiencing and expressing distress in local worlds ... evocative and index past traumatic memories as well as present stressors, such as anger, powerlessness, social marginalization and insecurity, and possible future sources of anxiety, loss and angst" (2010:405).

As Powe and colleagues have described, even when patients themselves do not express fatalistic perspectives, many providers' assumptions of patient fatalism results in lack of screening recommendation. (Powe et al. 2005). When providers suspect that patients will not follow up on recommendations to obtain cancer screenings because of fatalism or other barriers, they fail to strenuously advocate for screenings and may not mention them at all. Health care providers may do well to reexamine their assumptions of patients' fatalism and the implications of such assumptions for their medical practice, including advocating for cancer screenings. Similarly, Shankar's article draws attention to the differences in the ways that health care providers (and presumably researchers) think about patients' fatalism versus how actual lay people really do think about it. Both patients and providers describe the pervasive fear and stigma associated with cancer, cancer fatalism, misperceptions of cancer, and competing priorities. Providers, however, tended to emphasize fatalism more than patients while lay people described their concerns about providers and long histories of poor medical care. Providers might rethink the foundations of fatalism, focusing on the totality and context of medical care experiences rather than attributing behavior *sui generis* to fatalism. Similarly, researchers developing health education interventions targeting fatalistic perspectives risk overlooking the significant contextually and historically situated circumstances that have shaped health beliefs (Smedley and Syme 2000).

Our work and others indicates that people actually do express fatalistic ideas. What we propose is that there is good reason why they express these ideas, and that such a reason tends to be located within resource-constrained conditions, such as those found in the Appalachian context. Furthermore, our narratives suggest that such rhetoric is not the primary determinant of health behavior but rather a culturally acceptable idiom of distress. Seeking a middle ground, we reject attempts to either toss out this frequently used idiom or to use the construct as an explanatory factor in supposed irrational health decisions. Instead, we advocate for a great appreciation of the complexities and nuances of fatalism.

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References Cited

- Altekruse, SF.; Kosary, CL.; Krapcho, M.; Neyman, N.; Aminou, R.; Waldron, W.; Ruhl, J.; Howlander, N.; Tatalovich, Z.; Cho, H.; Mariotto, A.; Eisner, MP.; Lewis, DR.; Cronin, K.; Chen, HS.; Feuer, EJ.; Stinchcomb, DG.; Edwards, BK., editors. SEER Cancer Statistics Review, 1975–2007. National Cancer Institute; Bethesda, MD: 2010 [accessed August 11, 2009]. based on November 2009 SEER data submission, posted to the SEER website, http://seer.cancer.gov/csr/1975_2007/
- American Cancer Society. Cancer Facts and Figures. 2009 [accessed December 3, 2009]. http://www.cancer.org/docroot/STT/STT_0.asp
- Anglin, Mary. A Question of Loyalty: National and Regional Identity in Narratives of Appalachia. *Anthropology Quarterly*. 1992; 65(3):105–116.
- Angus J, Evans S, Lapum J, Rukholm E, St. Onge R, Nolan R, Michel I. “Sneaky Disease”: The Body and Health Knowledge for People at Risk for Coronary Heart Disease in Ontario, Canada. *Social Science and Medicine*. 2005; 60(9):2117–2128. [PubMed: 15743659]
- Balshem M. Cancer, Control, and Causality: Talking about Cancer in a Working Class Community. *American Ethnology*. 1991; 18:152–172.
- Barney, Sandra. *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880–1930*. University of North Carolina Press; Chapel Hill: 2000.
- Russell, Bernard H. *Research Methods in Cultural Anthropology*. AltaMira Press; London: 2002.

- Brett, Kate M.; Madans, Jennifer H. Hysterectomy Use: The Correspondence between Self-Reports and Hospital Records. *American Journal of Public Health*. 1992; 84(10):1653–1655. [PubMed: 7943489]
- Chavez LR, Hubbell FA, Mishra SI, Valdez RB. The Influence of Fatalism on Self-Reported Use of Papanicolaou Smears. *American Journal of Preventive Medicine*. 1997; 13(4):418–424. [PubMed: 9415785]
- Christensen, Alan; Moran, Patricia; Ehlers, Shawna; Raichle, Katherine; Karnell, Lucy; Funk, Gerry. Smoking and Drinking Behavior in Patients with Head and Neck Cancer: Effects of Behavioral Self-Blame and Perceived Control. *Journal of Behavioral Medicine*. 1999; 22(5):407–418. [PubMed: 10586379]
- Cohen D, Nisbett RE. Are There Differences in Fatalism between Rural Southerners and Midwesterners? *Journal of Applied Social Psychology*. 1998; 28(23):2181–2195.
- Conrad ME. Fatalism and Breast Cancer in Black Women. *Annals of Internal Medicine*. 1996; 125(11):941–942. [PubMed: 8967685]
- Davison C, Davey-Smith G, Frankel S. Lay Epidemiology and the Prevention Paradox: the Implications of Coronary Candidacy for Health. *Sociology of Health and Illness*. 1991; 13(1):1–19.
- Davison C, Frankel S, Davey-Smith G. The Limits of Lifestyle: Re-Assessing Fatalism in the Popular Culture of Illness Prevention. *Social Science and Medicine*. 1992; 34(6):675–685. [PubMed: 1574735]
- Dignan M, Michielutte R, Wells HB, Bahsson J. The Forsyth County Cervical Cancer Prevention Project-I. Cervical Cancer Screening for Black Women. *Health Education Research*. 1994; 9:411–420. [PubMed: 10150457]
- Drew, Elaine. Ph.D. dissertation. Department of Anthropology, University of Kentucky; 2004. Just Get Rid of It! The Cultural Politics of Hysterectomy in a Rural Appalachian County.
- Emerson, Robert; Fretz, Rachel; Shaw, Linda. *Writing Ethnographic Fieldnotes*. University of Chicago Press; Chicago: 1995.
- Eller, Ronald D. Foreword. In: Billings, Dwight; Norman, Gurney; Ledford, Katherine, editors. *Confronting Appalachian Stereotypes: Back Talk from an American Region*. University Press of Kentucky; Lexington: 1999. p. ix-xi.
- Franklin, Monica; Schlundt, David; Wallston, Kenneth. Development and Validation of a Religious Health Fatalism Measure for the African-American Faith Community. *Journal of Health Psychology*. 2008; 13(3):323–335. [PubMed: 18420767]
- Freeman, H. *Cancer and the Socioeconomically Disadvantaged*. American Cancer Society; Atlanta: 1989.
- Gravitt PE, Jamshidi R. Diagnosis and Management of Oncogenic Cervical Human Papillomavirus Infection. *Infectious Disease Clinics of North America*. 2005; 19(2):439–458. [PubMed: 15963882]
- Green, Adele; Purdie, D.; Green, L.; Dick, M.; Bain, C.; Siskind, V. Validity of Self-Reported Hysterectomy and Tubal Sterilization. *Australian and New Zealand Journal of Public Health*. 1997; 21(3):337–340. [PubMed: 9270164]
- Gregg J, Curry R. Explanatory Models for Cancer among African American Women at Two Atlanta Neighborhood Health Centers: The Implications for a Cancer Screening Program. *Social Science and Medicine*. 1994; 39(4):519–526. [PubMed: 7973851]
- Harris DM, Miller JE, Davis DM. Racial Differences in Breast Cancer Screening, Knowledge, and Compliance. *Journal of the National Medical Association*. 2003; 95(8):693–701. [PubMed: 12934865]
- Heyman B, Swain J, Gillman M, Handyside EC, Newman W. Alone in the Crowd: How Adults with Learning Disabilities Cope with Social Network Problems. *Social Science and Medicine*. 1997; 44(1):41–53.
- Hoffman-Goetz L. Cancer Experiences of African-American Women as Portrayed in Popular Mass Magazines. *Psych-Oncology*. 1999; 8:36–45.

- Hopenhayn C, Bush H, Christian A, Shelton BJ. Comparative Analysis of Invasive Cervical Cancer Incidence Rates in Three Appalachian states. *Preventive Medicine*. 2005; 41(5–6):859–864. [PubMed: 16199083]
- Horwitz RI, Yu EC. Problems and Proposals for Interview Data in Epidemiological Research. *International Journal of Epidemiology*. 1985; 14:463–467. [PubMed: 4055212]
- Huang B, Wyatt S, Tucker T, Bottorff D, Lengerich E, Hall H. Cancer Death Rates: Appalachia, 1994–1998. *Morbidity and Mortality Weekly*. 2002; 51(24):527–529.
- Hunt, Kate; Davison, Charlie; Emslie, Carole; Ford, Graeme. Are Perceptions of a Family History of Heart Disease Related to Health-Related Attitudes and Behaviour? *Health Education Research*. 2000; 15:131–143. [PubMed: 10751372]
- Kalichman SC, Kelly J, Rompa D. Fatalism, Current Life Satisfaction, and Risk for HIV Infection among Gay and Bisexual Men. *Journal of Consulting and Clinical Psychology*. 1997; 65(4):542–546. [PubMed: 9256554]
- Kentucky Cancer Registry. N.d. Cervical Cancer Mortality Rates by Appalachian Region in Kentucky. [accessed July 15, 2010]. http://cancer-rates.info/ky/index_mort.php
- Kjerulff, Kristen; Langenberg, Patricia; Guzinski, Gay. The Socioeconomic Correlates of Hysterectomies in the United States. *American Journal of Public Health*. 1993; 83(1):106–108. [PubMed: 8417592]
- Lannin D, Mathews H, Mitchell J, Swanson M, Swanson F, Edwards M. Influence of Socioeconomic and Cultural Factors on Racial Differences in Late-Stage Presentation of Breast Cancer. *Journal of the American Medical Association*. 1998; 279(22):1801–1807. [PubMed: 9628711]
- Leach CR, Schoenberg NE. The Vicious Cycle of Inadequate Early Detection: A Complementary Study on Barriers to Cervical Cancer Screening among Middle Aged and Older Women. *Preventing Chronic Disease*. 2007; 4(4):A95. [PubMed: 17875270]
- Lengerich, EJ.; Tucker, T.; Powell, R.; Colsher, P.; Ward, A.; Wyatt, S. Cancer Incidence in Kentucky, Pennsylvania, and West Virginia: Disparities in Appalachia. American Public Health Association (APHA) 131st Annual Meeting and Exposition; San Francisco. November 15–19. 2003
- Luquis RR, Villanueva JJ. Knowledge, Attitudes, and Perceptions about Breast Cancer and Breast Cancer Screening among Hispanic Women Residing in South Central Pennsylvania. *Journal of Community Health*. 2006; 31(1):25–42. [PubMed: 16482764]
- Macintyre S. The Public Understanding of Science or the Scientific Understanding of the Public? A Review of the Social Context of the “New Genetics.”. *Public Understanding of Science*. 1995; 4:223–232.
- Mayo RM, Ureda JR, Parker VG. Importance of Fatalism in Understanding Mammography Screening in Rural Elderly Women. *Journal of Women and Aging*. 2001; 13(1):1–19.
- Michelieutte, Robert; Dignan, Mark; Sharp, Penny; Boxley, Jeanne; Wells, Bradley. Skin Cancer Prevention and Early Detection Practices in a Sample of Rural Women. *Preventive Medicine*. 1996; 25(6):673–683. [PubMed: 8936569]
- Moore SM, Rosenthal DA. Condoms and Coitus: Adolescents' Attitudes to AIDS and Safe Sex Behavior. *Journal of Adolescence*. 1991; 14:211–227. [PubMed: 1744252]
- Nichter, Mark. Idioms of Distress Revisited. *Culture, Medicine and Psychiatry*. 2010; 34:401–416.
- Perez-Stable EJ, Sabogal F, Otero-Sabogal R, Hiatt RA, McPhee SJ. Misconceptions about Cancer among Latinos and Anglos. *Journal of American Medical Association*. 1992; 268:3219–3223.
- Powe, Barbara D. Fatalism among Elderly African-Americans. *Cancer Nursing*. 1995; 18:385–392. [PubMed: 7585493]
- Powe, Barbara D. Cancer Fatalism among African-Americans: A Review of the Literature. *Nursing Outlook*. 1996; 44:18–21. [PubMed: 8650004]
- Powe, Barbara D. Cancer Fatalism: Spiritual Perspectives. *Journal of Religion and Health*. 1997; 36(2):135–144.
- Powe, Barbara D. Promoting Fecal Occult Blood Testing in Rural African American Women. *Cancer Practice*. 2002; 10(3):139–146. [PubMed: 11972568]
- Powe, Barbara D.; 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(8):318–324. [PubMed: 16045592]

- Powe, Barbara D.; Finnie, R. Cancer Fatalism: The State of the Science. *Cancer Nursing*. 2003; 26(6): 454–465. [PubMed: 15022977]
- Powe BD, Weinrich S. An Intervention to Decrease Cancer Fatalism among Rural Elders. *Oncology Nursing Forum*. 1999; 26(3):583–588. [PubMed: 10214599]
- Ries, LAG.; Eisner, MP.; Kosary, CL.; Hankey, BF.; Miller, BA.; Clegg, L.; Mariotto, A.; Feuer, EJ.; Edwards, BK., editors. *SEER Cancer Statistics Review, 1975–2002*. National Cancer Institute; Bethesda, MD: 2005.
- Rimer, Barbara K.; Meissner, Helen; Breen, Nancy; Legler, Julie; Coyne, Cathy A. Social and Behavioral Interventions to Increase Breast Cancer Screening. In: Schneiderman, Neil; Speers, Marjorie; Silva, Julie M.; Tones, Henry; Gentry, Jacquelyn H., editors. *Integrating Behavioral and Social Science with Public Health*. American Psychological Association; Washington, DC: 2001. p. 177–202.
- Rotter, JB.; Seeman, M.; Liverant, S. Internal versus External Control of Reinforcement: A Major Variable in Behavior Theory. In: Washburn, NF., editor. *Decisions, Values, and Groups*. Pergamon; London: 1962. p. 473–516.
- Schoenberg, Nancy E.; Drew, Elaine M. Articulating Silences: Experiential and Biomedical Constructions of Hypertension Symptomatology. *Medical Anthropology Quarterly*. 2002; 16(4): 458–475. [PubMed: 12500617]
- Schoenberg, Nancy E.; Hopenhayn, C.; Christian, A.; Knight, E.; Rubio, A. An In-Depth and Updated Perspective on Determinants of Cervical Cancer Screening among Central Appalachian Women. *Journal of Women and Health*. 2006; 42(2):89–105.
- Shankar S, Selvin E E, Alberg AJ. Perceptions of Cancer in an African-American Community: A Focus Group Report. *Ethnicity and Disease*. 2002; 12(2):276–283. [PubMed: 12019938]
- Spurlock WR, Cullins LS. Cancer Fatalism and Breast Cancer Screening in African American Women. *Journal of the Association of Black Faculty in Higher Education, Inc*. 2006; 17(1):38–43.
- Steginga, Suzanne K.; Occhipinti, Stefano. Dispositional Optimism as a Predictor of Men's Decision-Related Distress after Localized Prostate Cancer. *Health Psychology*. 2006; 25(2):135–143. [PubMed: 16569104]
- Straughan PT, Seow A. Fatalism Reconceptualized: A Concept to Predict Health Screening Behavior. *Journal of Gender, Culture, and Health*. 1998; 3(2):85–100.
- Strauss, A.; Corbin, J. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Sage; Newbury Park: 1990.
- Smedley, BD.; Syme, SL. *Promoting Health: Intervention Strategies from Social and Behavioral Research*. National Academy Press; Washington, DC: 2000.
- Underwood S. Cancer Risk Reduction and Early Detection Behaviors among Black Men: Focus on Learned Helplessness. *Journal of Community Health Nursing*. 1997; 9(1):21–31. [PubMed: 1556578]
- Webster's Dictionary. Fatalism. 2010 [accessed June 30, 2009].
<http://www.websters-dictionary-online.org/definitions/fatalism?cx=partner-pub-0939450753529744%3Av0qd01-tldq&cof=FORID%3A9&ie=UTF-8&q=fatalism&sa=Search#922>
- Weller, Jack. *Yesterday's People*. University of Kentucky Press; Lexington: 1965.
- Whiteman MK, Hillis SD, Jamieson DJ, Morrow B, Podgornik MN, Brett KM, Marchbanks PA. Inpatient Hysterectomy Surveillance in the United States, 2000–2004. *American Journal of Obstetrics and Gynecology*. 2008; 198(1):34.e1–7. [PubMed: 17981254]
- Wolff M, Bates T, Beck B, Young S, Ahmed S, Maurana C. Cancer Prevention in Underserved African American Communities: Barriers and Effective Strategies: A Review of the Literature. *Wisconsin Medical Journal*. 2003; 102(5):36–40. [PubMed: 14621929]
- U.S. Census Bureau. American FactFinder, Geographic Comparison Table, Kentucky – County. 2010 [accessed July 1, 2003].
http://factfinder.census.gov/servlet/GCTTable?_bm=y&-geo_id=04000US21&-ds_name=DEC_2000_SF1_U&-_lang=en&-redoLog=false&-format=ST-2&-mt_name=DEC_2000_SF1_U_GCTP6_ST2&-CONTEXT=gct