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Religion, Fatalism, and Cancer Control: A Qualitative Study among Hispanic Catholics

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Abstract

Objectives—To assess cancer perceptions among churchgoers and to examine the potential influence of fatalism and religious beliefs on the use of cancer screening tests.

Methods—Eight semi-structured focus groups were conducted among 67 Hispanic Catholics in Massachusetts.

Results—In this sample, there were few references to fatalistic beliefs about cancer and nearly universal endorsement of the utility of cancer screening for cancer early detection. Most participants reported that their religious beliefs encouraged them to use health services, including cancer-screening tests. Although participants agreed that God plays an active role in health, they also affirmed the importance of self-agency in determining cancer outcomes.

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Conflicts of Interest Statement
The authors declare no conflicts of interest.

Human Subjects Statement
The Harvard School of Public Heath Institutional Review Board approved all study protocols and procedures prior to data collection.

Conclusions—Our findings challenge the assumption that fatalism is an overriding perspective among Hispanics. Catholic religious beliefs may contribute to positive health attitudes and behaviors.

Keywords

fatalism; cancer fatalism; religion; Catholic; Latinos; Hispanics; cancer; cancer screening

While cancer incidence and mortality rates are decreasing among Hispanics, cancer remains the leading cause of death for this population.[1] Regular utilization of cancer screening methods can facilitate early diagnosis, and when accompanied by timely and appropriate treatment, can reduce morbidity and mortality.[2] However, cancer screening remains underutilized among Hispanics.[3] National data reveal that Hispanics are significantly less likely than non-Hispanic Whites to have had breast, cervical, and colorectal cancer screening, as per recommended intervals.[4]

Fatalism, or the propensity to believe that negative life events are predetermined by some external or unseen power such as fate, has been associated with cancer screening behaviors.[5] Fatalism about cancer, in particular, describes a set of beliefs about the causes, preventability, and curability of cancer,[6] which are often accompanied by feelings of hopelessness, powerlessness, and social despair.[7,8] The public health literature often describes Hispanics as being fatalistic and '*fatalismo'* as a "cultural trait" that influences Hispanics' health behaviors and cancer screening practices.[9,10] However, the commonly-held assumption that fatalism is a culturally-based and widespread belief system among Hispanics may be unfounded.[9] The majority of published studies reporting high levels of fatalism among Hispanics specifically studied low socioeconomic status samples,[5] making it difficult to disentangle whether fatalism is a product of culture, or a function of larger structural forces such as poverty. Moreover, in some studies, differences in fatalism between Hispanics and non-Hispanics disappear after controlling for relevant covariates such as age and socioeconomic status.[11,12] Additionally, the majority of studies on cancer fatalism among Hispanics consist of samples with mostly Mexican Americans, so we are unable to draw conclusions about the pervasiveness of fatalism among Hispanics as a whole, or across heterogeneous Hispanic subgroups. Finally, some research runs counter to the assumption that Hispanics are fatalistic about cancer. For example, Hispanics are equally likely as non-Hispanic Whites to agree that breast or cervical cancer could be cured if detected early and that they would be willing to undergo painful and unpleasant treatment if it would improve survival.[13]

Questions also remain about the utility of fatalism as a predictor (versus correlate) of low participation in cancer screening among Hispanics.[9] Some studies report associations between fatalism and lower intention to obtain screening,[14] less positive beliefs about check-ups,[15] as well as decreased mammography,[16,17] cervical,[16,18] and colorectal cancer screening.[19,20] Other studies have found little or no evidence of an association between fatalistic beliefs and screening among Hispanics.[21–24] A recent systematic review concluded that there is *preliminary* evidence of an *inverse* association between fatalism and Hispanic women's utilization of cancer screening services.[25] However, the studies included in that

review were subject to the conceptual confusion that plagues research on fatalism. Notably, more than half of the studies reporting an association between fatalism and decreased screening used indices of fatalism that contained questionable items, such as fear.

One unexplored area is the extent to which fatalism constitutes a religious trait among Hispanics. *Religious fatalism* is a construct developed to distinguish fatalistic beliefs linked to religion/spirituality.[26] Divine control – the belief that God or a higher power controls both positive and negative outcomes – often is conceptualized as a component of fatalism,[27–29] and people who believe in divine control often are perceived to be fatalistic. The philosophy here is that belief in divine control, as an external locus of control, fosters a sense of powerlessness that encourages passivity in health matters (eg, cancer-related behaviors). While fatalistic attitudes may arise from or interact with religious beliefs to inhibit cancer screening, the existence of such links has yet to be established.

Given that over half of U.S. Hispanics identify as Roman Catholic,[30–32] it is important to explore links among religious, cultural, and health beliefs and to examine how these beliefs may influence cancer screening among this population. Roman Catholic teaching encourages individuals to develop a close personal relationship with God,[33, 34] and to consider the possibility of "divine healing" from God in times of illness.[35] Roman Catholic teaching also invites adherents to pray to saints, fellow believers in heaven, and to invoke their intercession for a range of issues, including health.[34–40] These teachings may lead Hispanic church-going Catholics to adopt fatalistic health attitudes that promote passive, avoidant cancer control behaviors. However, inadequate research has been conducted in this area. Only a few studies have explored religious dimensions of fatalism among racial/ethnic minorities,[26,27,29,41–49] and, notably, none of these studies have focused on the specific links between religion, fatalism, and cancer control among Hispanic Catholics.

Understanding *if*, *how*, *when*, and *in what context* fatalism affects cancer screening behaviors among Hispanics is of major public health interest, given that Hispanics are the nation's fastest growing demographic group.[50] A qualitative study among Hispanic Catholics may provide insight about the presence, origins and nuances of fatalistic beliefs among Hispanics and the potential links among Catholicism, fatalism, and health. Such insights may also inform the development of cancer screening interventions, particularly those delivered in Catholic religious settings. This goals of this study are to: a) describe the extent, manifestations, and context of cancer-related fatalistic beliefs in a sample of Hispanic Catholics; b) assess Hispanics' perceptions about how Catholic religious teachings may influence health beliefs and attitudes, and in particular - fatalistic beliefs about the causes, preventability and curability of cancer; and c) examine the extent to which Catholic religious teachings reinforce, buffer, or challenge fatalistic beliefs about cancer.

METHODS

In this qualitative study, we conducted 8 semi-structured focus groups between April and July 2011 in 4 Catholic parishes in Massachusetts. Each group included 8–10 participants and lasted 1–2 hours. The focus group protocol was developed based on prior work,[34,51–54] and with extensive input from the study's Community Advisory Board (CAB). The CAB for

this study met biannually and consisted of a group of community leaders, pastors, and lay health workers who provided critical input for enhancing the acceptability, cultural appropriateness, and face validity of the focus group protocol.

The protocol consisted of open-ended questions designed to elicit participants' cultural explanatory models of cancer,[55–58] which involve cultural beliefs and attitudes, personal life experiences, and both biomedical and popular explanations of health and illness. See sample questions in Table 1.

Recruitment, Enrollment, and Data Collection

Participants were recruited by study staff through posting of flyers, announcements in bulletins, and word of mouth. Parishes were selected by convenience from the 4 cities (Boston, Lawrence, Springfield, and Worcester) in Massachusetts with the largest Hispanic population. Men and women eligible for participation had to be members of the participating parishes, self-identify as Hispanic, speak Spanish or English, aged 18 years or older, and had no prior or current diagnosis of cancer.

Experienced, bicultural, native Spanish-speaking staff moderated the focus groups according to standardized methodology.[59] The moderators self-identified as Hispanic-American prior to the start of each focus group, which we believe helped to facilitate an atmosphere of trust. Focus group interviews were mainly conducted in Spanish, although sometimes English was intermingled during conversation. Male and female participant focus groups were held separately to allow for increased comfort in discussing sensitive or gender-specific topics (eg, Pap tests). After obtaining verbal consent, we asked participants to complete an anonymous demographic questionnaire that assessed age, education, income, nationality, health insurance status, and the number of years as a parish member. A research assistant audio-recorded the interviews and took notes during each session. Participants received a $50 gift card for their participation. The Harvard School of Public Heath Institutional Review Board approved all study protocols and procedures.

Data Management and Analysis

The focus groups were transcribed verbatim and translated from Spanish to English by certified Spanish translators. Transcripts were later reviewed by Spanish-speaking research staff against the original audio files to ensure accuracy of transcription. Focus group transcripts were systematically analyzed using a hybrid process of inductive/deductive thematic analysis.[60, 61] Lead investigators created an initial list of coding categories deductively, based on the stated goals of the research study and our interview protocol, and then inductively derived code categories based on additional themes that arose in the interviews. Through a multi-stage iterative process, these themes were compared and discussed until consensus was reached among the research team about a higher level coding scheme. Crosscutting themes and concepts were allowed to emerge from the data. Any disagreements in coding and theme development were resolved through discussion with the team. A Qualitative Research Specialist then conducted line-by-line coding using QSR International NVivo10 Software (2011). During this process, new code categories were added as necessary to accommodate emergent themes and some codes were collapsed and

re-organized. Thematic analysis of texts focused on the general agreement among participants in each group and the consistency of findings across groups.[62] Qualitative phrases are used to convey the level of agreement with a statement or attitude, as is standard in qualitative research.[59] Male and female focus groups were initially analyzed separately to determine whether there were any significant differences in themes based on sex. There was extensive overlap in concepts raised by male and female participants, and very few discernable differences with respect to the topics under study; therefore, we combined our results from the female and male groups to provide a more contextualized understanding of the overall findings.

RESULTS

An approximately equal number of male (N = 33) and female (N = 34) Hispanic Catholics participated. Nearly 58% had more than a high school education and over half of those who disclosed their income reported an annual household income of $30,000 or less. The majority reported having health insurance (85%), which is mandatory in Massachusetts. Most were born in Puerto Rico (46%) or the Dominican Republic (37%). About half (54%) had been members of their respective parishes for more than 10 years. See Table 2.

Key qualitative findings are described below and are organized based on our evaluation of the major themes and sub-themes.

Fatalism and Cancer Control

On the whole, Hispanic Catholics in this study expressed few fatalistic beliefs with regards to cancer. Instead, participants generally believed that cancer was preventable, that they had a personal responsibility to maintain their own health, that illness was due to unhealthy behaviors, that cancer screening was important, and that having cancer was not an automatic death sentence.

Cancer is preventable—The majority of participants strongly believed in the efficacy of preventive health behaviors, screening tests, and treatment. They also attribute a role to God in shaping health outcomes. Most participants believed that illnesses, including cancer, could be avoided if one takes the necessary "*precauciones*" (safeguards), including eating healthy foods, exercising regularly, and seeking medical care (eg, going to the doctor, getting check-ups, and participating in cancer screening). A few participants from one male focus group did express the belief that cancer was not preventable. These statements, however, were often made in the context of personal stories of family and close friends who had lost their lives to cancer. One participant shared: *"Cancer is something that I have been seeing in my family since I was little. My grandfather died of cancer, my mother died of cancer, and I have several uncles and aunts who have died of cancer. My two first cousins who were 19 and 20 years old also died of cancer. I probably will get cancer too."* On the whole, however, the majority thought that there were measures that one could take to preserve their health.

Fate, destiny, and locus of control—The belief in fate was not universally endorsed. On the contrary, the majority of participants expressed that, while God has a role in shaping

health outcomes, God also grants the power of "free will". Participants believed that faith did not negate their personal responsibility for maintaining their health. This interplay is reflected in participants' awareness about genetic (eg, family history), environmental (eg, pollution), *and* behavioral factors (eg, preventive health visits) as causes of cancer and health outcomes. Instead, participants often attributed cancer to other causes, including food, stress, and "*going to the doctor after it is too late.*"

Beliefs about preventive measures—Participants generally believed that illness was largely a consequence of unhealthy behaviors, but that illness could be prevented by living "*una vida sana*" (a healthy lifestyle). Most placed special emphasis on the importance of "*una buena alimentación"* (good nutrition) for health, and when probed, described specific behaviors and lifestyles that reduced risks of developing cancer. For some, it was reducing exposure to the sun: "*if you're going to sunbathe put something on…"* For others, it was eating well, avoiding smoking, "*knowing your body,"* getting checkups, and participating in cancer screening tests. This was evidenced by one woman's statement: *"You're the only one who knows your body, so any time you feel something is different or strange, you must go get a checkup, talk with your doctor, like what I did."* Participants' beliefs about preventive measures were shaped by both their cultural/familial traditions and their religious teachings, which we discuss later.

Beliefs about the importance of regular checkups and cancer screenings—Participants repeatedly emphasized the importance of "checkups" for maintaining health and preventing disease: *"The best prevention is to be on top of it and not miss the appointment"*. Doctors were perceived as the most trusted source for information about cancer screening tests, and most participants relied on their physicians to provide screening recommendations. Participants universally agreed that cancer screening tests could prevent and/or detect cancer at early stages: *"Well if you go to the doctor and get the tests, you can find cancer before it is too late. You can prevent colon, uterine, ovarian, breast…all that."* Men were supportive of their wives participating in screening, as were women of their husbands. One male participant described the importance of mammography: "*… it's very important that [my wife] gets it because… cancer it's something that can happen in a matter of minutes."* Among those with a family history of cancer, checkups were especially important: *"Cancer can be prevented by getting regular checkups. My family has a long history of colon cancer and checkups was what saved our lives."*

Although the majority of participants believed that cancer screening was important, many acknowledged that not all Hispanics engage in these practices: *"If we follow the doctor's instructions, we can put a stop to cancer. But sometimes we're like a crazy goat and we just let it be. We don't go to the doctor."* Participants frequently noted that Hispanics often fail to obtain screening in a timely manner. These delays were attributed to numerous barriers, including fear of going to the doctor, or getting a screening test, cancer diagnosis, or having to undergo treatment. Time constraints, conflicting priorities, embarrassment to be seen by a doctor, "*negligencia"* (neglect), cost concerns/lack of insurance, legal issues/fear of deportation, language barriers, and difficulty navigating the health system were also commonly mentioned barriers. However, participants emphasized that culturally appropriate

information about the importance of screening tests and church-based health programs could counter these barriers. Participants wanted to be educated about strategies to prevent, screen, and treat disease, such as cancer.

Cancer does not always lead to death—When asked about the first thought that comes to mind after hearing the word "cancer," multiple participants in each of the focus groups uttered "*muerte*" (death). Participants also associated cancer with pain, suffering, and grief. While negative affective associations with cancer were pervasive across participants' narratives, participants did not necessarily view cancer as an automatic death sentence. Most conveyed confidence on the ability of doctors and modern medicine to effectively treat and cure cancer while consistently remaining open to divine intervention to operate healing.

Religion and Health

While traditionally understood fatalistic beliefs about cancer were largely missing, Hispanic Catholics in this study noted the central roles that God, Catholic teachings and the Church play in healing, coping with illness, and even medical science.

God, saints, and divine healing—Participants emphasized that spiritual health, prayer, and maintaining a strong relationship with God could help people prevent illness. Repeatedly, participants emphasized that God wants people to be healthy – in mind, body, heart, and spirit. They ascribed curative powers to God and viewed divine healing as proof of God's sovereignty. As summarized by participants, "*We have health when there is faith*" and "*If they don't have faith, we are not going to receive healing*." Across the focus groups, participants related experiences from personal accounts, as well as stories from friends and family members where they believed God had cured disease.

"Faith moves mountains": religious coping and faith during illness—While in the context of prevention and cancer screening, participants emphasized the role of health behaviors; in the context of illness, participants underscored the importance of having faith in God to deal with the situation and overcome it, never doubting that "*God is in control*". In times of illness, "*surrendering control*" to God was considered an active and deliberate process that provided relief from anxiety, worry, and stress in order to focus on aspects of disease that are controllable (eg, self-care behaviors). The process of "*putting cancer in God's hands*" was considered a positive coping mechanism that enables God to work on one's behalf. Participants talked about trusting in God no matter what the outcome may be: "we *have to believe that God knows what He is doing. If He wants to cure us, He will cure us…He has the last word. He decides*."

The relationship between religion and medicine—Participants stressed that a close relationship with God does not replace the contribution that medical providers can make. Participants described a sense of shared responsibility with God regarding their health. "*God heals*", they frequently said, but they too must "*do their part*": "*Like God says, 'take care of yourself and I will take care of you'*".

Doctors were viewed as *"instruments of God"*. Across groups, participants declared that people should use doctors to take care for their health: "*God says to put yourself in the hands of the doctors."* Notably, a physician's ability to treat disease was considered a gift from God: *"God gives doctors the science and the medicine…we should use them."* Nonetheless, participants believed that while doctors deliver the treatment, healing comes from God: "*It is God who heals, not the doctors*"

Participants also emphasized that Catholic religious practices specifically work hand-in-hand with medicine to promote health, particularly through prayer. One participant explained: "*We are not fundamentalists; we don't say, 'we will pray for you and that's the only thing that will cure you', no, no! We pray for you so that God provides the doctor with the tools and the medicine. You see, we and science go hand in hand. We are not divorced from science. We go together*."

Parish leaders, health teachings, and the Church—Participants described at length the role of the Catholic Church in promoting health, and highlighted that the Church is invested in promoting wellness by integrating health and spirituality. They described the Church's longstanding emphasis on wellness for the *whole* person, wherein body and spirit live and grow together. The Church's commitment in health is most clearly visible in its ministry to the sick and the healing mass; however, participants also described the breath of parish-based activities in the areas of wellness promotion, as well as the provision of health information: *"the Church puts a strong emphasis on people going to the doctor to get checked up."* Some parishes, they mentioned, have formal health ministries where wellness check-ups and health screenings are provided.

In every focus group, participants described that clergy advocated for their parishioners' spiritual, emotional, and physical health. Pastors in particular, often are involved in promoting health at the parish-level as well as in the community: Believing "*the body as the temple of God*" (1 Corinthians 6:19), parish leaders often gave clear directives to parishioners regarding their health: *"the priest gives you all kinds of information, they provide information in the bulletins and they hand out pamphlets and flyers about any activity that's going on, for example, mammograms."*

DISCUSSION

The study examined health beliefs in a sample of Hispanic Catholics of largely Puerto Rican and Dominican origin to understand the potential influence of fatalistic beliefs and religion on cancer screening. Fatalistic attitudes were infrequently expressed, and when present, generally occurred alongside statements endorsing the belief in one's personal control over health matters. While relying on God to help prevent cancer and cure it if present, religious beliefs did not appear to be linked with more global fatalistic views about health. Instead, most participants emphasized that Catholic religious teachings encouraged health behaviors and supported the use of health care.

Our findings are consistent with prior research. Flórez and colleagues conducted a qualitative study among 25 Hispanic women from the Dominican Republic and found that

respondents held complex ideas of health locus of control that encompassed both internal factors (eg, self-determination, health practices) and external factors (eg, God's will, genetics, family history).[49] The authors proposed that the multidimensional concept of "*destino"* (destiny), which encompasses both personal agency and pre-destination, may help to explain Hispanic's views about cancer prevention and survival more accurately than fatalism. Although the concept of destiny did not explicitly emerge in our data, our participants did acknowledge that "*God has a plan*" for every human being, and that while "*God is in control*", people's actions and behaviors also play a role. This concurrent belief in internal and external locus of control suggests that the relationship between fatalism and behavior is a nuanced and complex one.

As in many other studies among Latino and non-Latino participants,[22,52,63] the majority of participants immediately associated the word cancer with death. However, these same people also believed in being proactive about cancer screening; many of the participants openly shared their cancer screening experience and encouraged others in the group to be screened. Our results suggest that thinking about death when one hears the word cancer does not deter Hispanic Catholics from screening. That cancer was not preventable was only raised in one focus group by a few participants. However, we found that these perceptions were embedded in negative experiences with cancer (eg, family deaths) and health care barriers. This suggests that pessimistic beliefs about cancer may be more of a consequence of poverty, obstacles to healthcare, and past personal experiences rather than the influence of religion or other cultural worldviews.[64–66]

Overall, our qualitative study lends credence to the potential beneficial role of Catholic religious beliefs and spiritual practices in promoting health among Hispanics. Prior studies show that religious commitment and attendance is associated with improved physical and mental health.[67–69] Studies also show that religiosity is positively associated with health care utilization and cancer screening, across racial and ethnic groups.[51,70–72] However, less is known about the mechanisms underlying these relationships. Participants in our sample held positive attitudes about cancer screening, emphasized the importance of being proactive about health matters, and had a desire for more information about how to maintain and improve their health. Moreover, participants universally agreed that being concerned and proactive about one's health were practices that were both implicitly and explicitly encouraged and reinforced by Catholic teachings and parish leaders. This encouragement came in the form of health promotion, health information, and social support, as well as prayer, fellowship, and other religious practices. Taken together, these findings suggest that among Catholics, religious teachings about health (eg, the body is the temple of God) may, in part, be driving relationships between religion and health. This notion certainly warrants further exploration.

Our findings also provide support for the idea that Catholic religious beliefs may provide powerful coping mechanisms. In our study, Hispanic Catholics underscored that their faith and religious engagements provide valuable strategies for managing stress (eg, through prayer) and that religious networks can be an important source of social support during difficult times. Some participants associated illness with 'God's will", a belief that may help people make meaning and come to terms with (or "accept") their illness. However,

acceptance was not viewed negatively as it is often depicted in the literature. “Surrendering control” to God was viewed as an active and deliberate process that promotes mental health by funneling attention away from aspects of disease beyond individual control. While these ideas are consistent with the premise behind fatalism, the psychological underpinnings and behavioral manifestations are quite distinct.

These findings are consistent with several studies in this area. A qualitative study by Keeley, et al suggests that fatalistic attitudes are highly contextual; in certain situations such as during illness, fatalistic statements have personal and social functions that include stress relief, uncertainty management, avoidance of self-blame, and meaning making of health outcomes.[73] In a random telephone survey conducted by Franklin, et al, religious fatalism only partially predicted health behaviors and outcomes. Therefore, the authors suggested that religious fatalism may represent a response to illness rather than a contributor to unhealthy behaviors.[26] Our findings in combination with these prior studies suggest that rather than encouraging fatalistic attitudes and deterring people from participating in self-care behaviors, religious beliefs may be more important for understanding how Hispanic Catholics cope with illness.

While not the main focus of this study, it is important to note that fear/dread emerged as the most critical factor to screening (emerged variously as a facilitator and a barrier). Consistent with prior research,[74, 75] embarrassment was also a theme. Although the importance of affective factors in cancer-related behaviors has been previously demonstrated,[76–79] they are seldom the target of screening interventions. Traditionally, interventions have relied on cognitive or psychosocial theories that largely ignore the role of affective factors in behavioral decision making.[80] Prior studies indicate that people with fearful attitudes toward cancer have more fatalistic beliefs,[45,81] and fear has been negatively associated with screening among Hispanics.[81] Better understanding of how fear and other affective factors (eg, embarrassment, worry, distrust, anticipated regret, anxiety, and shame) are related to fatalism and how they can facilitate behavior change may provide an opportunity for improving screening adherence among Hispanics.

It is important to acknowledge limitations of our study. This qualitative study recruited a small convenience sample from a limited geographic area, and therefore, generalizability is limited. Nevertheless, several of the main themes revealed in our data replicate those of previous studies.[49] Our strategy to recruit respondents from different parishes located in 4 cities in Massachusetts still resulted in a sample that was highly homogenous with respect to country of origin; that is, that majority of participants were Puerto Rican or Dominican. We also reached a relatively low income group, with the majority of participants (30%) reporting an annual household income of <$10,000. While these characteristics reflect the demographics of the population from which the data were collected, we recognize that our findings may not apply to all Hispanics (eg, Mexican Americans, Cubans, upper-middle or high-income groups). Hispanics are not a monolithic group and it is well-known that there exist important differences in beliefs, behaviors, and cultural practices within intra-ethnic subgroups and across Hispanics of varying income levels. Investigations on other Hispanic sub-groups and on higher-income Hispanics are therefore needed. Because prior studies on Hispanics include mostly populations of Mexican origin, the composition of our sample may

also be considered a strength, in that it expands research on other Hispanic subgroups. For example, although Dominicans now constitute the fifth largest population of Hispanics in the United States,[82] little is known about the beliefs and health profiles of this group. There is also a need for research among other religious denominations, especially given the shifting religious identity of Hispanics in the U.S.[32] While most US. Hispanics continue to identify as Roman Catholic, the Catholic share of the Hispanic population is declining, while rising numbers of Hispanics are Evangelical Protestants or unaffiliated with any religion.[32] In light of these trends, studies that include participants from varied denominations would allow for meaningful comparisons across these diverse religious groups. While it is important that our findings be interpreted with the appropriate caution, we provide insight into the complex relationship between religion and fatalism about cancer, which to date has received inadequate attention. Our qualitative approach allowed us to situate people's perspectives in context, explore normative meanings, and elucidate contextual, psychosocial, affective, and religious influences on cancer prevention behaviors.[83] Additional research is needed to further disentangle the relationships among religious beliefs (eg, belief in God as miracle maker, belief in divine control), fatalism, and health behaviors across the cancer control continuum (eg, follow-up to abnormal results, treatment adherence, distress management).

Our findings from this qualitative study of Hispanic Catholics suggest that fatalism among Hispanic communities may be less pervasive and more nuanced than previously thought. As such, we caution against thinking of fatalism as a universal 'cultural attitude' among Hispanics. Public health practitioners and health providers should recognize that not all Hispanics hold fatalistic views about cancer. In addition, fatalism, even if present, need not be considered a complete barrier to individual action, particularly among church-going populations.

Although our findings cannot speak directly to the impact of limited income and lack of knowledge about cancer—these factors may be important contributors to the development of fatalistic attitudes toward cancer. Given that the majority of Hispanics in the US are Catholic, with a large proportion attending religious services weekly,[30–32] it is possible that combining religious teachings with health messages could promote more optimistic attitudes about cancer prevention and screening behaviors. Incorporating religious teachings (eg, the body as the temple of god, biblical scriptures on health) into health communication interventions may also enhance their impact.[84–86] Religious beliefs and practices could also be harnessed to motivate people to engage in healthy behaviors. For example, the belief that taking care of one's health is a form of praising God may provide intrinsic motivation for the initiation and maintenance of behavior change.

Health promotion programs in Catholic churches may also be effective at motivating Hispanics to seek cancer screening, especially when they are culturally, religiously, and faith-based. Many parishes have health ministries that could organize and implement cancer control programs. These programs can leverage the social support provided by parish members, the influencing power of parish leaders, the physical and communication infrastructures of parishes, and Catholic teachings about health to promote lifestyle changes that result in better cancer outcomes for individuals, as well as the population as a whole.

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Table 1

Focus Group Questions

Content area	Questions
General perceptions about cancer	When you hear the word “cancer”, what’s the first thing that comes to mind? What is cancer? How does it start? Are all cancers the same? Does cancer lead to death? Have you had any past experiences with cancer?
Cancer causes	How does a person develop cancer? What causes cancer? Do things people do cause cancer? Are there spiritual causes of cancer? Is cancer a matter of luck? God’s will? Can people put themselves at risk for certain types of cancer?
Cancer preventability	Can cancer be prevented? How? What are some things people can do to prevent or reduce their risk of cancer?
Cancer screening	How is cancer detected? What tests do you know about that can find or detect cancer early? What do you think about cancer screening tests? Are they effective? Are they useful? Have you ever heard of/had a mammogram/pap test/colonoscopy/FOBT? What do you think about these tests? What keeps people from obtaining cancer screening tests?
Cancer treatment	What are your views on cancer treatment? How is cancer treated? What are the best ways to treat cancer?
Cancer curability and survivability	Do you think a person with cancer can be cured? How is cancer cured? Can God cure cancer?
Catholicism and health	In what ways, if any, do your religious beliefs and practices (eg, prayer) influence your health and your beliefs about health? What religious messages, themes, or ideas encourage people to care for their health?
God, faith, and divine healing	Does God have a role in health? How about faith? What are your views on divine healing?
Role of the Catholic Church in health	What role, if any, does the parish play in your health? What types of support or assistance could you rely on from your parish if you have a problem, such as a health issue?
Interest in learning more about cancer	Are you interested in learning more about ways to reduce your risk of cancer? What kinds of educational programs would you like to see?

Table 2

Characteristics of Focus Group Participants (N = 67)

Characteristic	N %
Age (mean = 54.8)	
18–39	10 (15)
40–49	14 (21)
50–59	16 (24)
60+	25 (37)
Missing/Don't know	2 (3)
Education	
< 5th grade	22 (18)
≤ HS	27 (40)
Some college	16 (24)
College 4 or more years	10 (15)
Missing/Don't know	2 (3)
Annual household income	
<$10,000	20 (30)
$10,000–$29,999	12 (18)
$30,000–$49,999	12 (18)
$50,000+	12 (18)
Missing/Don't know	11 (16)
Gender	
Male	33 (49)
Female	34 (51)
Years as a member of the parish (mean = 16.6)	
0 to 10 years	26 (36)
11 to 20 years	15 (23)
21 or more years	21 (31)
Missing/Don't know	5 (7)
Country of origin	
Colombia	2 (3)
Puerto Rico	31 (46)
Salvador	2 (3)
Honduras	2 (3)
Nicaragua	1 (1)
US	4 (6)
Dominican Republic	25 (37)
Health insurance	
Yes	57 (85)
No	7 (10)
Missing/Don't know	3 (4)
Employment status	

Characteristic	N %
Employed	31 (46)
Unemployed	13 (19)
Retired	8 (12)
Missing/Don’t know	15 (22)