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ORIGINAL PAPER

Fatalism or Destiny? A Qualitative Study and Interpretative Framework on Dominican Women's Breast Cancer Beliefs

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Abstract *Background* A growing literature on Latino's beliefs about cancer focuses on the concept of fatalismo (fatalism), despite numerous conceptual ambiguities concerning its meaning, definition, and measurement. This study explored Latina women's views on breast cancer and screening within a cultural framework of destino ("destiny"), or the notion that both personal agency and external forces can influence health and life events. *Methods* Semi-structured interviews were conducted with 25 Latinas from the Dominican Republic aged 40 or over. *Results* Respondents reported complex notions of health locus of control that encompassed both internal (e.g., individual action) and external (e.g., the will of God) forces shaping breast cancer prevention efforts. Furthermore, women actively participated in screening because they believed that cancer could become a death sentence if diagnosed late or left untreated. *Discussion* In contrast to simplistic notions of "fatalism", our analysis suggests complex strategies and beliefs regarding breast cancer and cancer screening that speak of resiliency rather than hopelessness.

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Introduction

Among Latina women in the United States, breast cancer is the most common type of carcinoma and it is the leading cause of cancer death [1]. Relative to non-Latina whites, Latinas are more likely to be diagnosed with breast cancer at later stages and to experience a lower 5-year survival rate [2]. Early detection of breast cancer with regular screening is one of the most effective methods of promoting timely treatment and enhancing the chances of survival. Although mammography screening rates among Latinas are now approaching those of non-Latina white women, historical underutilization of screening among Latinas may partially account for disparities in diagnoses and survival [1]. To address this significant public health concern, Healthy People 2010 aims to eliminate breast cancer disparities by promoting cancer screening practices among ethnic minority populations in the US [3].

Various factors contribute to disparities in screening, including limited access to health care (e.g., lack of health insurance, no usual source of health), and low socioeconomic status [4–7]. Over recent years, there has been growing interest in identifying culturally-based factors, such as attitudes, beliefs and values, that account for the differences between Latinas and non-Latinas in cancer screening. *Fatalismo* (fatalism), in particular, has gained increasing popularity as a cultural belief hypothesized to deter Latino men and women from engaging in cancer screening [8, 9]. Findings that Latinos are more likely than whites to believe that little can be done to prevent cancer, that a cancer diagnosis inevitability leads to death [9], and

that fate is a cause of breast and cervical cancer [10, 11], sparked interest in studying whether fatalism among Latinas acts as a deterrent to breast cancer screening.

Although definitions vary, fatalism refers to the general tendency to believe that events are predetermined or caused by external forces and that little, or nothing, can be done to change their course. Indeed, implicit in this world view is the notion that individual will or action exerts little power in changing the course of fate. Fatalistic beliefs centered on cancer, or cancer fatalism, characterize cancer as a predetermined condition that is unavoidable regardless of personal action, or as certain to cause death when it appears [8, 12]. Because this pessimistic outlook potentially could serve as a barrier to cancer screening, much of the health-related literature portrays cancer fatalism as a cultural obstacle to early cancer detection.

Numerous conceptual and methodological problems characterize existing research on cancer fatalism among Latinos [13]. First, there is mixed evidence supporting the hypothesis that fatalism is a prominent world view among Latinos. Although Latinos are more likely than whites to endorse fatalistic statements [9], in some studies, these differences disappear after controlling for potential confounders (e.g., age and SES) [11, 14]. Second, there is inconclusive evidence that fatalistic beliefs among Latinos act as a barrier to cancer screening [13]. Third, the conceptual ambiguity concerning the construct of cancer fatalism is quite problematic. An insufficient amount of attention has been devoted to establishing the construct validity of cancer fatalism. Some measures of cancer fatalism, for example, include items tapping other constructs, such as fear [15, 16] and religious attributions concerning cancer as God's punishment [17], precluding any conclusion about the specific effects of fatalism on screening. Fourth, despite evidence that Latinos simultaneously hold fatalistic *and* optimistic beliefs about cancer screening and survival [10, 11, 18–20] almost no research explores alternative, culturally-based belief systems that might explain these findings. Portrayed as a passive acceptance of life difficulties, the concept of "fatalism" holds a negative connotation, and reflects a deficit model of Latino culture [21]. Research on fatalism overlooks other related concepts, such as *destino* (destiny), that could be explored to examine the extent to which pessimism characterizes Latino belief systems and world views. Finally, the almost exclusive reliance on Mexican-American samples in the cancer fatalism literature weakens any claim that fatalism is a cultural trait present among all Latino groups. This is especially problematic in that Caribbean, South and Central American and other Latino groups comprise a substantial proportion (41.5%) of the Latino population in the United States [22].

Conceptual Framework of the Present Study

This paper proposes an alternative framework to explore the association between Latina women's beliefs regarding breast cancer and their screening practices. We present a theoretical framework based on women's conceptualization of *destino* (destiny), in which the role of agency and external forces shape women's beliefs about cancer survival and their ability to engage in cancer prevention and early detection. Indeed, little is known about the factors that underlay women's successful health-seeking behaviors, particularly among those who have had mammograms. Whereas most studies on cancer beliefs and behaviors rely on standardized tools that may silence women's symbolic constructs of health and disease, our data are framed within an emic perspective that gives voice to women's own assertions of cancer screening, detection and beliefs about survival.

Rather than agreeing with a static concept of fate, which portrays women as passive targets of disease, we argue that they endorse a belief system where early action and religious faith serve as empowerment tools to both prevent and cope with illness. To that aim, we address the following questions: (1) What are women's beliefs about breast cancer (e.g., attitudes and beliefs about disease prevention, detection, treatment, and survival)? (2) To what extent do beliefs about *fatalismo* characterize women's attitudes and practices about breast cancer? (3) What are the cultural beliefs that support women's proactive behaviors regarding cancer screening and early detection, and their views about survival?

The Sample Population: Dominican Women

While Latino subgroups currently living in the United States share important commonalities, cultural differences shaped by national origin and distinct historical and sociopolitical trajectories characterize each population. Understanding the cultural factors that present either barriers or incentives to cancer screening among specific populations may provide important clues to distinguish the similarities and differences within and between Latino groups in the US. To examine some of the main cultural and social factors related to breast cancer screening, this study focuses on Dominican women, one of the largest subgroups of the Latino population. Numbering 764,945 persons, Dominicans follow Cubans (total 1.2 million persons) as the next largest group of Latinos in the United States, making Dominicans the 4th largest group in the nation [22]. New York City currently houses the largest settlement of Dominicans living in the United States [23]. Dominicans in New York City exhibit a particularly low

socioeconomic profile as indicated by the 60% of Dominicans with less than a high school education and the 33.78% of households living below the poverty line [24]. Although there is only a handful of studies on the cancer screening beliefs and practices of this population, the available evidence indicates that Dominican women have lower rates of recent mammography compared with other ethnic minorities, such as African Americans (51.7% vs. 54.2%) [6]. Furthermore, Dominican women in New York City cite lack of a source of health care as the single most important barrier to cancer screening [25]. Understanding the obstacles for this specific population as well as how Dominican women's everyday life experiences shape (if at all) fatalistic attitudes and beliefs about breast cancer can potentially elucidate how public health conceptualizes barriers to health and healthcare-seeking behaviors among other Latina women in the United States.

Methods

Participants and Data Collection

We conducted 25 in-depth face-to-face semi-structured interviews with Dominican women living in predominantly Latino communities of the upper section of Manhattan in New York City. Using a non-probability technique of snowball sampling, respondents who were initially recruited from a community clinic were asked to identify other eligible women living in the community. Eligibility criteria were: self-identification as a Latina woman of Dominican descent, age 40 years or older, and reporting no prior diagnosis of any form of cancer. Data collection began in March 2004 and continued through August 2005, with 88% of the interviews conducted in the respondents' homes. The remaining 12% took place in the homes of friends or relatives of the participants. Respondents received $25 as compensation for their participation.

Interviews lasted an average of 45 min. All interviews were tape-recorded and conducted by trained bilingual research assistants, who all actively participated in the development of the qualitative instrument. All interviews were conducted in Spanish.

Measures

The first portion of the interview guide began with standard demographic questions, followed by questions assessing screening practices, and items on perceptions, knowledge and attitudes. To explore cultural ideas about breast cancer, and views and beliefs concerning cancer fatalism and *destino*, respondents were asked whether they agreed with various statements. Statements used to elicit cultural ideas about breast cancer were drawn from prior studies of Latinos (e.g., "God gives people breast cancer because they have lived a bad life") [8]. Items used to elicit beliefs concerning cancer fatalism and *destino* were borrowed from studies of Latinos (e.g., "If found early, breast cancer can be cured", "Having breast cancer is like a death sentence") [8, 9] and standard fatalism measures (Powe Fatalism Inventory; e.g., "I think if a woman has breast cancer, it is already too late to get treated for it"; "I think if a woman gets breast cancer, it was meant to be") [12]. We made some modifications to these items to reflect the topic of our study, breast cancer. *Destino* narratives were elicited through discussions of two key items in the Powe Fatalism Inventory in which we embedded the concept of destiny ("I think if it is a woman's destiny to have breast cancer, that is the way it will be"; "I think if a woman is destined to get breast cancer, she will get it no matter what she does") as well as a general item that we developed for this study ("We all have a destiny that we cannot change"). We included these destiny-specific "fatalism" items to ensure that all participants engaged in some discussion of the *destino* concept, regardless of their personal connection with the term. Although some women offered the concept of "*destino*" without any prompting, others discussed their views on destiny in response to these specific items.

The procedures we used to elicit responses concerning cultural ideas about breast cancer, cancer fatalism and *destino* were as follows. First, we asked participants whether they agreed with each statement. Then, to explore their beliefs and attitudes, respondents were probed to elaborate on their interpretation of the items and to discuss their reason(s) for agreeing or disagreeing with each statement.

Analysis

Once the data collection was complete, all 25 interviews were transcribed verbatim in Spanish by the same research assistant who conducted the interviews. The semi-structured portion of the interviews were analyzed with Atlas.ti. 5.0 [26]. Demographic and close-ended questions in the instrument were analyzed using SPSS version 12.0 [27].

All stages of analysis were conducted in the original Spanish, which began with a reality oriented approach (i.e., open coding) to identify themes and issues and to generate a broad list of codes [28]. We then used a more focused coding scheme to establish variations within the broader codes. Additional broad and specific codes were added as appropriate by each of the coders. Once the final list of codes was generated, codes were applied to each unit of analysis within the transcript text file in order to compare the extent to which a theme occurred across set of texts

[29]. Segmenting into smaller context units was achieved by assigning a code to participants' responses to an open-ended question posed by the interviewer. Detailed codes were organized along five general categories that included themes on breast cancer, breast cancer screening, general health, fatalism, and the health care system. Coded narratives were then analyzed to yield a conceptual framework representing themes of breast cancer, screening, and fatalism. Overall, this conceptual model was driven by the coded responses illustrating optimistic views regarding women's ability to prevent cancer and/or disease. Summarized by in-vivo codes such as "*la lucha*" (to struggle and persevere), and statements such as "God helps those who help themselves", these expressions were analyzed as emic illustrations of women's agency. This exploration of agency as it related to health, breast cancer, and breast cancer screening served as the analytic framework resulting in the following themes: (1) positive beliefs about screening and early detection, (2) complex beliefs in *destino* (destiny) that involve both agency and external forces (e.g., genetics), (3) beliefs in the divine, and (4) the need to *luchar* (persevere) to maintain health in the face of adversity.

Human Subjects Review

This research was approved by the university's medical center Internal Review Board.

Results

Demographic and Screening Characteristics

Respondents ranged in age from 40 to 74 years, with a mean of 58 years. All of the women were born in the Dominican Republic, and the average respondent lived in the United States for 24 years. Most women in the sample were separated, single, or divorced (76%). The majority had health insurance (80%), most of which were public (36% had Medicaid only; 32% had both Medicaid and Medicare). A substantial proportion of the sample (80%) had household incomes of less than $10,000 per year; the remaining participants reported an income range of $10,000–$19,000 per year. Almost half of the sample (44%) was unable to work due to a disability, 12% were working full-time, and 12% were retired. The majority (80%) of the sample had a high school degree or less, and 20% had some college education. The vast majority of women in the sample ($N = 24$, 96%) had received at least one mammogram. Although the average respondent had received eight mammographies in her lifetime, slightly over half of the sample (60%, $N = 15$) had been screened within the past year. This rate of recent screening in our sample is similar to that reported in another study of Dominican women in New York City [6].

Cancer Screening Contextualized: Beliefs and Attitudes about Mammographies and Breast Cancer

Rather than validating a fatalistic orientation, our findings revealed overarching positive attitudes and proactive behaviors to prevent breast cancer. Women's narratives illustrated a complex set of attitudes and beliefs that supported their cancer screening practices. Specifically, respondents held positive attitudes and beliefs towards disease prevention and detection, including breast cancer. Characterized by a sense of personal responsibility in maintaining good health, women's narratives often involved strategies for preventing disease through a variety of health behaviors. Erika's[1] comments typified these views: "You should physically take care of yourself with what you eat, exercise, and what you do. Do what you know is healthy". Citing such risk factors for breast cancer as heredity and obesity, many respondents attempted to engage in healthy behaviors (e.g., good nutrition and exercise) that they considered effective for preventing breast cancer. As Daniela noted, "My understanding from magazines and books is that eating healthy, a salad, a diet low in fat and things like that [prevent breast cancer]".

In addition to endorsing cancer-prevention health practices, many respondents asserted that regular mammography screening is critical for early detection of breast cancer. Therefore, they considered active screening an important health behavior. They cited detection through screening as a tool of modern science that could not only detect breast cancer, but other diseases as well.

> Yes, [screening] is important. Very important because anything can appear in a mammography, if it appears early it can be cured. But if I don't [get a mammogram], and I have [cancer] I can die of it. (Yolanda)
>
> [Mammograms are] important, that is how you find out what you do and do not have – whatever the exam because a physical is also very important, as well as a pap. Without an exam you do not know what you have. (Carlota)
>
> Well, I tell people that it is good to have [a mammogram] done because you know [breast cancer] is a danger...sometimes by the time we go to the doctor [the cancer] has developed. As you know cancer kills.

[1] All respondent names are pseudonyms.

> But if you go [to the doctor] early and get a [mammogram], if they find something it can be cured. You must get [a mammogram] and always see your doctor, always seek doctors – that's always good. (Alma)

Participants shared the conviction that screening is key to the diagnosis of unobservable and asymptomatic diseases, like breast cancer, and stressed the importance of early screening in relation to curing disease and preventing death. They felt strongly that early detection was the best way to diagnose and treat breast cancer and actively engaged in screening. However, some respondents questioned the efficacy of medical technology in adequately detecting cancer. Citing examples of women who were getting screened, but whose breast cancer went undetected, Hortensia noted:

> Sometimes I say that mammographies are not 100% accurate… this is because I had a friend who died of breast cancer and [she] was getting her mammography. In fact, she had gotten a mammography and three months later she had terminal cancer. She died [immediately].

Themes concerning the problematic nature of early detection were most apparent in narratives about young celebrities who were diagnosed with cancer, or other women personally known by participants. Respondents offered these case examples to describe the "fickle" nature of the disease. Not only did these cases make salient the rarity of breast cancer in women younger than 40 years of age, they demonstrated early detection as an unattainable goal for these young women, as most did not fit the standard guidelines and recommendations for breast cancer screening. As Fátima noted, "I had a friend who was thirty-something years old and died of breast cancer but not before it spread to her lungs".

Despite these narratives, most participants believed that mammograms were the most effective way of detecting breast cancer, even among those participants who had a negative personal experience. That is, although most were deeply aware of the dangers of late diagnosis and the possibility of false negatives, they firmly believed that mammographies could ultimately save lives. Characterized by their call for earlier screening, some participants felt that the current recommendation of annual breast cancer screening beginning at age 40 is inappropriate given the nature of the disease, and that screening should begin much earlier.

> Cancer does not have an age or a time, or sex, [doctors] say after 40 years of age, but I've seen young women, younger than 20, with problems. I think after the age of 18 [women should begin to receive mammograms]. (Anabel)
>
> Well, I would recommend that they forget about age. In my case it was because of my accident that I was able to have a mammography [before] the [recommended] age when they found something...maybe they would have detected [the benign lump] before they did. (Erika)
>
> In my opinion – well, [doctors] always recommend between 35 and 40 years of age yet there are so many young women suffering from breast cancer. (Quiqui)

Issues and ideas concerning early treatment and survival were also implicit in accounts of breast cancer detection. Whereas most participants felt that women could survive breast cancer, almost all added important qualifiers for that possibility to hold: early detection and treatment. Hortensia stated, "If [the cancer] hasn't reached a stage where it has contaminated more cells, it may get treated on time". Indeed, Teresita's remarks illustrated respondents' views concerning early detection as paramount to survival, "Detecting [breast cancer] early is very different from detecting it late because dying of breast cancer is unlikely if it is detected early".

For women in this study, the overarching notion of "prevention" encompassed different dimensions, including the importance of good nutrition and exercise as well as early cancer detection. Screening practices afforded the possibility of identifying breast cancer at an early stage, thereby improving survival. Most participants believed that cancer could be treated effectively, but only if detected early. Women's previous experiences with mammographies and their belief in the effectiveness of screening accompanied their concerns about potential errors, particularly when cancer was mistakenly ruled out.

Is Breast Cancer a Death Sentence? An Exploration of Fatalism

Our exploration of women's perspectives on fatalistic statements illustrated the problematic nature of some of the most popular indicators of fatalism used in the literature. Although at face value participants agreed with many of the statements, a deeper inquiry into their beliefs revealed a synergy between three predominant themes: (1) late detection, (2) *descuido* (carelessness), and (3) heredity.

The majority of participants ($N = 17$, 68%) agreed with the statement, "Having breast cancer is like a death sentence" [8, 9]. However, several narratives on this theme revealed references to cases of late-stage diagnosis, as in Anabel's comments that "cancer is silent, slow and sometimes [detection] comes when it is already too late". Quiqui corroborated this idea, "[Breast cancer] can be a death sentence...but if it's detected early it can be

resolved". Therefore, participants did not consider breast cancer to be a death sentence per se, but a tangible possibility due to other specific factors, most notably late diagnosis.

The notion of "*descuido*" or carelessness also permeated participants' reasons for agreeing that breast cancer is like a death sentence. Berta's comments exemplified themes related to *descuido*: "I would say that [cancer] could be a death sentence if a person is careless and does not receive timely treatment". Participants explained that *descuido* leads to less screening, which in turn, reduces the likelihood of early diagnosis. For example, Alma stated that "of course [cancer is like a death sentence] because if you do not take care of yourself you can die, but if you take care of yourself you can [live] for many years".

Slightly over half of the sample ($N = 14$, 56%) also agreed with another "fatalistic" statement, "if a woman is destined to get breast cancer, she will get it no matter what she does" (Powe Fatalism Inventory) [12]. In many of these cases, respondents such as Erika explained that family history predisposed women to breast cancer: "For me…[breast cancer] often depends on your own family [history], on the family you are associated with, if there's a history in a family of dying from [breast cancer]". Valeria also agreed, but offered an optimistic outlook, "Yes, [I agree]. [Breast cancer] is determined by heredity although there are many advances in medicine". For these participants, although there were ways in which women could avert breast cancer, heredity or genetic predisposition presented strong forces outside of their individual control. In this sense, themes of destiny or predetermination were interwoven in women's narratives. We turn to this notion of *destino* next.

Constructing One's Own Destino (Destiny): Above and Beyond Fatalism

The concept of *destino* (destiny) was central to women's conceptions of fate and breast cancer. Some participants described destiny not as a supernatural process devoid of personal control but as genetically determined *and* responsive to personal agency. Among participants who opposed the statement "if a woman is destined to get breast cancer, she will get it no matter what she does," responses centered on heredity but also highlighted the important role of early diagnosis, treatment efficacy, and personal determination, as Carlota noted:

> Strongly disagree…that is why I get checkups because *una herencia* [heredity] comes because it comes. Like diabetes, a family continues to be affected by it because it is hereditary....I do not believe in destiny. You make your own destiny. There is a destiny...[the kind] that you are born with. But sometimes there is [the kind] of destiny that you yourself look for...

As Quiqui further explained, "I think that [a woman] can be destined to have [breast cancer], but if she gets regular checkups [she can] reduce her chances of dying". For these participants, the idea of breast cancer as predetermined by fate and nonresponsive to personal action ran counter to their beliefs. If breast cancer was unavoidable, according to respondents, they could take measures to manage the disease and avoid dying from it. Yolanda's comments illustrated this perspective:

> [Y]ou make your own destiny. Because if [the mammography] shows a lump in my breast, and I react "oh, I am meant to have cancer and will die, because that is my destiny," No! I will look for my doctor and my medication first. My doctor must tell me what to do....You cannot let destiny influence you, allow destiny to do that to you. You must help destiny, you cannot allow yourself to be controlled by it.

Many participants perceived their destiny as a confluence of their own actions and the effects of external forces beyond their control, such as family history of disease or genetics. To these participants, personal initiative and responsibility were key to early detection and favorable treatment outcomes. However, they also believed that genetics played a role in defining their destiny. When Carlota stated "there is a destiny...[the kind] that you are born with," she alluded to an inevitable risk for disease due to a genetic predisposition. In her view, a woman can be destined to develop breast cancer if she is born with a genetic susceptibility to the disease. However, for many who held this view, knowledge of family history or genetic predispositions for diseases like breast cancer led them to take additional precautionary measures (e.g., recommended biannual mammographies). Consequently, rather than surrendering their agency to the risk of disease, they presided over their health by taking an active lead in their preventive health behaviors and early detection efforts.

Women's breast cancer narratives also highlight the need for a finer distinction among and departure from traditional conceptualizations of "fate" and "fatal" in the cancer fatalism literature. Specifically, the literature conceptualizes "cancer fatalism" as both "fate", that is, as a predetermined outcome, and "fatal", or as certain to cause death following a cancer diagnosis. Our results indicate that participants conceived of cancer as fate (i.e., predetermined) or potentially fatal *only* when external factors influenced the likelihood of developing or dying from cancer. For example, cancer could be fateful (i.e.,

predetermined) in cases where family history predisposed women to developing cancer. Breast cancer could be fatal (i.e., result in death) if women lacked timely treatment, as in cases of advanced-stage breast cancer diagnoses. Importantly, even when viewed as a fateful event, participants did not endorse a passive stance nor did they equate cancer with unavoidable death. Rather, they responded to a family history of cancer, for example, by obtaining annual mammograms, and stated that they would exhaust all medical treatment options prior to conceding to terminal cancer. Women adamantly believed that cancer was responsive to their own initiated primary and secondary prevention efforts, and viewed death from cancer as avoidable given appropriate medical attention. Contrary to the characterization of Latinas in the cancer fatalism literature, therefore, breast cancer narratives in this study revealed women as assertive actors in their health processes and outcomes, as well as in the subjective meaning of their health experiences.

"God Helps Those Who Help Themselves": Faith and Its Importance to Health

Overall, the theme of *destino* illustrated not only the critical need to understand Latinas' concepts of breast cancer and screening, but also to broaden culturally-based frameworks of health and disease. Narratives about destiny were not characterized by feelings of doom or resignation as depicted often in the fatalism literature, but rather by active participation in cancer screening. As a result, the *destino* framework allowed participants to comfortably engage in screening while understanding that total avoidance of breast cancer was never truly possible. Noting external issues such as genetics that can work in tandem with individual action, participants rarely described situations regarding their health (or life in general) as completely hopeless or bleak. Indeed, *destino* narratives described a phenomenon that mostly *combined* individual agency and external forces, often through God's intervention. Much like other adversities in their lives, the majority of respondents (84%, $N = 21$) did not consider breast cancer to be a punishment from God for having lived a bad life:

> God has the power to send us many things but to speak of disease – I don't think that God [would do that], because God forgives those who have sinned, the good, the entire world. That's why I don't think God sends disease. I don't think so. People pick up diseases from the life they lead... (Laura)
>
> God has nothing to do with [people getting diseases]. God would not punish a person in that way. He loves all his children and no father would want to harm his children. (Daniela)
>
> I don't think God has anything to do with this disease. I don't believe [breast cancer] is from God's hands. It's something that we eat, I don't know, or something in the environment. (Hortensia)

Women felt that some circumstances in their lives (including disease) were a direct result of their own actions and God's will. Nevertheless, given the hermetic nature of God's plans, participants recognized that it is not possible to discern (in advance) their chances of surviving a life-threatening condition. Discussions about illness or life in general highlighted a deep connection with God or spiritual elements. For example, Fátima discussed God in the context of destiny:

> I will tell you that one has the power to change things...aspects of our destiny like things in our everyday lives. We can change in order to become better people...like me going [back] to school. There are many little things that can be changed. God gives you that strength and a brain [to think].

God's presence often complemented rather than obscured women's own efforts. This intimate aspect of religiosity highlighted a complex relationship where participants viewed God as a companion. God was an active member in women's lives and they often had complex and active strategies for contributing to the relationship, as Rosa noted:

> If you do not have faith in good things...you cannot attain good things, you will never see them because you have to have faith in God, He is the one that helps us...God always puts in our path good things when we confide in Him, when we speak to Him.

Faith, praying and staying positive all were active ways in which participants talked about life and their health. Citing the almighty power of God and the dictum, "God helps those who help themselves", Quiqui commented:

> You can pray and ask for help from God...but you cannot be [negligent]. It is when He sees that you are doing what you are [supposed] to be doing that God gives you a hand...that is why I think you cannot leave it all up to our Lord.

Interestingly, because of these religious beliefs, some participants had reservations about using the word "*destino*", yet they shared the overarching belief that individual action as well as fate could shape life events. For these women, who often characterized themselves as devout Christians, *destino* held a pagan connotation, perhaps associated with practices meant to elicit answers to the

unknown and the future (e.g., tarot cards readings). Despite their rejection of the word, these participants alluded to a similar partnership dynamic with the divine. That is, they believed that their own actions as well as external forces constantly shaped their lives. These "powerful others" often included God and medical doctors. Often described as a power ordained by God, Rosa's description exemplified narratives on physicians and destiny:

> Destiny...I do not know [how to make sense] of this word. Destiny is what most people call a [forecast/prediction]. I do not believe this. [I believe in] the objective that each person has for herself...this is because if you ask God and you pray concerning a [health] problem...I know that then doctors can become very powerful...God has given [doctors] that power to deal with health problems.

Regarded as a catalyst in their lives rather than a source of their adversity, participants held themselves accountable to the divine in line with the maxim, *"Ayudate que Dios te ayudara"* (God helps those who help themselves). Convinced of God's generosity and power, women actively pursued solutions to their troubles certain that God would approve of and aid their efforts. As such, participants held medical science not in opposition to but as enabled by God. For these participants, the belief in God as the enabling agent behind a physician's ability to detect and cure cancer formed the foundation for their trust in medical science, including their beliefs about the efficacy of mammograms and breast cancer treatments.

Lucha: Overcoming Life's Obstacles

Although participants had faith in God's intervention, they took responsibility for their own life outcomes via the cultural framework of *luchar* (to persevere). Norma's position exemplified this perspective, "When we are experiencing difficult times...we must continue to trust in God and you know one must try to *luchar* [persevere], as long as one is living." Rooted in positive thinking, self-initiative, and empowerment, the mind set of *luchar* centers on the belief in one's ability to fight and defeat adversity. As an active coping process, *luchar* runs counter to the passive beliefs and attitudes dictated by fatalism theory. Women's potential ability to handle adverse cancer outcomes was fixed in this cultural framework, in which they saw themselves as proactive agents in their healthcare, thereby influencing their illness destiny. This cultural world view anchored not only women's *destino* frameworks on breast cancer but their overall outlook on life. Conscious of their daily challenges, participants in this study represented *la lucha* as a self-commitment to persevere against and overcome adversity by maximizing available resources and opportunities, as illustrated in the following quotes:

> [With breast cancer] *hay que hacerle la lucha* (you must persevere), it is never too late. There is no worse struggle lost than the one you do not try. (Valeria)
>
> There are people...[who say] "that is my destiny [to have cancer], I do not care to live" but I do not agree. No, no, no! As long as there is science you must *luchar* (persevere). (Laura)

Discussion

In spite of the growing popularity of the proposition that *fatalismo* deters Latinos from cancer screening, there is also evidence that Latinos hold positive beliefs about screening and the likelihood of surviving cancer [10, 11, 20]. Our findings support this body of work and provide an alternative interpretative framework that departs from the deficiency model characteristic of the fatalism literature. Supported by the multidimensional concept of *destino* (destiny), women's emic perspectives of health and disease were devoid of the hopelessness and bleak resignation inherent in the fatalism construct. Instead, our results indicate that positive views on breast cancer and screening are produced and maintained through a complex framework of inner will and external forces that allow for the possibility of both survival *and* death from breast cancer.

For the majority of participants in this sample, the notion of agency (will to change) and external determinants (e.g., genetics, God) merge comfortably into a single locus of control. Instead of creating a dichotomy between internal and external forces, a double determination of agency and external forces characterize women's narratives concerning their beliefs about cancer detection and survival. Furthermore, participants avoid any dissonance between internal and external forces after accessing the range of means within their reach (e.g., using modern screening technology, engaging in regular check-ups, praying to God for assistance). Therefore, rather than a fixed, static and predetermined trait, *destino* represents a complicated notion fundamentally shaped by both self-determination and various external forces.

Destino, as related to breast cancer detection and survival, also elucidates an important distinction between "fatal" and "fate" that is often obscured in the cancer fatalism literature [13]. Women's interpretative frameworks distinguish between breast cancer as fate (i.e., a predetermined event that engenders resignation in those affected) and fatal (i.e., certain to cause death). Participants equated breast cancer with death only in certain cases (e.g.,

late detection of cancer or inadequate treatment). Further challenging simplistic notions of fatalism, women's complex understanding of "*destino*" represents their concept of "fate" through the combination of inner and external forces that determine cancer outcomes. Therefore, these findings suggest that, counter to the cancer fatalism literature, beliefs in predestination do not necessarily translate into pessimistic views about certainty of death from breast cancer.

Women's call for prioritizing their health through regular breast cancer screening highlights the importance of individual agency in maintaining health. Indeed, because women who fail to obtain regular mammographies are more likely to receive a late-stage cancer diagnosis compared with those who prioritize their health, respondents describe the notion of "*descuido*" or carelessness as a kind of risk factor for poor health. Participants, in fact, offered *descuido* as a potential reason why breast cancer could become a death sentence for some women. Interestingly, other studies of Dominican women also report that *descuido* is a salient theme and barrier to screening [19, 25].

Other crucial findings concerned beliefs in God as both an external force and a mechanism for coping. It is interesting to note that spirituality or religious beliefs are also linked with fatalism in several other studies [17, 30]. To better understand Latinos' beliefs in predetermination, religious beliefs should be considered and contextualized. For example the item, "God gives people cancer because they have lived a bad life" [8], denotes an antagonistic perspective that may not fully capture religious beliefs in the context of destiny. Our findings illustrate that participants viewed God as an all-loving fatherly figure that restrained from punishing his own children. Therefore, fatalism, as rooted in religious beliefs, may be better represented with themes related to acceptance, as in "what God sends, one has to accept" [18, p. 441], or to frameworks for interpreting events in terms of a greater purpose or "grander plan" [31, p. 55]. The connection between religiosity and fatalism may be particularly salient among some Latino groups, for whom religiosity is embedded in an overarching belief system that helps individuals to cope with stressful events, and promotes physical and psychological well-being [32–36]. Religious beliefs centering on God as a "partner"[37] may actually counteract fatalistic tendencies by increasing Latinos' sense of mastery and ability to cope with disease by providing hope in their lives, and by strengthening self-esteem and social support networks. If considered from the vantage point that religious-oriented fatalistic beliefs reflect acceptance of and provide meaning for difficult life circumstances *when there is little else that can be done*, then this particular aspect of fatalism may actually serve an adaptive coping function. It is not clear if Latinos engage in this kind of coping strategy when faced with insurmountable difficulties because their everyday contexts may be fraught with hardships (e.g., poverty, dislocation, immigration angst). Interestingly, there is some evidence that cognitive adaptations characterized by acceptance seem to diminish some of the stress that Latinas experience when faced with a difficult health decision (e.g., amniocentesis) [38]. These conceptual issues warrant further exploration.

The findings from our study illustrate that the notion of "*la lucha*", an optimistic outlook on life that participants embrace as an active coping skill, endorses women's agency and speaks to the importance of self-reliance in women's health seeking behaviors. Although the concept of "*la lucha*" has been studied before, particularly regarding the role of religiosity and spirituality in gaining strength in the face of adversity [39, 40], little research focuses on its importance in empowering women to deal with negative health diagnoses and outcomes. According to Zavala-Martinez [39], "*estar en la lucha*" (to be in the struggle) reflects both historical constraints and Latinas' daily struggles to survive and overcome everyday hurdles that impinge upon their lives. In this study, "*en la lucha*" refers to an ongoing process of persevering, dealing with, and fighting against adverse health and other events in which willpower and self-reliance to overcome hardships are expected. Interestingly, research on other Caribbean Latinos shows that self-reliance can be a positive coping mechanism in the face of minor health problems, but a deterrent to seeking needed professional healthcare for more severe health issues [41].

A few additional issues warrant mention. Importantly, our data raise issues that force rethinking assumptions about fatalism. Nevertheless, just as some caution should be exercised in drawing conclusions from the existing fatalism literature—based almost exclusively on Mexican Americans in the western and southwestern sections of the United States—our results should be interpreted within the socio-cultural context of Dominican women living in New York City. Further exploration of fatalism as a complex cultural belief among additional Latino subgroups is necessary to understand critically how this world view may impact Latino health and health behaviors. Furthermore, other sociodemographic and contextual issues must be explored. Our data, for example, do not directly address issues of age, social class, or transnationalism. Our findings that fatalism is a complex construct, rather than a simple belief system, and that agency plays a major role in beliefs about *destino* may be rooted in specific class-based, developmental, or sociopolitical histories and trajectories. Nevertheless, we believe that our results raise issues concerning the concept of fatalism that may be relevant to other Latino groups.

In conclusion, the results of our study suggest that there is a great deal of misunderstanding in the scientific literature concerning the concept of fatalism among Latinos. Our exploration of participants' responses to fatalism items suggests that these measures tap superficial aspects of the fatalism construct. Our data show that while participants agreed with several fatalism items (e.g., "Cancer is like a death sentence"), these beliefs were rooted in salient, specific situations (e.g., cases of late-state diagnosis). Their ideas surrounding predetermination were couched within a much more complex belief system that included individual agency as an element of change. These construct validity issues regarding cancer fatalism call into question prior assumptions on the impact of fatalism on Latino health. In contrast to the deficit model of Latino culture embodied in the concept of fatalism, our data support a multidimensional concept of *destino* ("destiny"). By better accommodating issues of agency, destiny more accurately reflects the Latino cultural value that is labeled "fatalism" in the literature.

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