Breast cancer is the most common cancer among women in the United States. For all ages combined, African American women are diagnosed with breast cancer less frequently than Caucasian women (American Cancer Society [ACS], 2002). However, breast cancer mortality rates are substantially higher for African American women (ACS). The precise causal pathway for the disparate incidence and mortality rates between the two groups is unclear; however, African American women are diagnosed with advanced stages of breast cancer more often than Caucasian women of similar age (Newman & Alfonso, 1997). Furthermore, later stage at diagnosis was found to account for about 40% of the difference in mortality rates (Eley et al., 1994). Other possible reasons for this include biologically different cancers (Hunter, 2000), problems with access to healthcare (Lannin et al., 1998), and, of particular interest in this study, the influence of belief in God as a controlling force in one’s health.

Data indicate that religiosity and spirituality may have a greater influence on health behaviors among African Americans than among Caucasians (Bourjolly, 1998; Parks, 1998). However, few studies have explored the effects of such factors on breast cancer screening behavior among African American women, particularly those at high risk. The purpose of this exploratory, cross-sectional survey was to examine the effect of such beliefs on breast cancer screening behaviors in female members of a large African American family with a BRCA1 (breast cancer susceptibility gene 1) mutation. Relationships among belief in God as a controlling force in health and sociodemographic, psychosocial, and clinical variables as potential confounders of religious and spiritual beliefs also were explored.

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Purpose/Objectives: To examine the relationship between beliefs about God as a controlling force in health and adherence to breast cancer screening among high-risk African American women.

Design: Cross-sectional cohort.

Setting: In-person interviews in rural, southeastern Louisiana and telephone interviews conducted at the University of Utah.

Sample: 52 females who were members of a large kindred with a BRCA1 mutation; no subjects had breast cancer.

Methods: Survey through in-person or telephone interviews.

Main Research Variables: Belief in God as a controlling agent over health measured by the God Locus of Health Control (GLHC) scale; screening behaviors measured by self-report. Adherence was based on consensus-approved recommendations for BRCA1 carriers or women at risk of being carriers.

Findings: Bivariate analysis indicated that presence of a primary care provider and low GLHC scores were associated with seeking clinical breast examination (CBE) and mammography. With the variable “presence of a primary care provider” excluded, GLHC scores were inversely associated with seeking CBE and mammography.

Conclusions: African American women at increased risk for breast cancer and with high GLHC scores may have a decreased inclination to adhere to CBE and mammography recommendations.

Implications for Nursing: Assessing religious and spiritual beliefs and incorporating belief systems into education and counseling sessions may improve understanding and acceptance of presented material.

Key Points . . .

➤ In unaffected women of a large extended kindred with a BRCA1 mutation, a high level of belief in God as the source of control over one’s health was negatively associated with breast cancer screening behaviors.

➤ Including religious and spiritual beliefs in health assessments may help to identify barriers to cancer screening.

➤ Health education and counseling tailored to patients’ belief systems may increase breast cancer screening behaviors.