

# African Americans With a Family History of Colorectal Cancer: Barriers and Facilitators to Screening

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**A**frican Americans have a 20% higher rate of colorectal cancer (CRC) development and a 48% higher incidence of disease-related death compared to Caucasians (American Cancer Society [ACS], 2011), and the burden of this disease is large, with about 143,640 new cases projected to be diagnosed in the United States in 2012 (ACS, 2012). Secondary prevention is key in detecting the disease early, when it often is curable, but screening rates are particularly low in African Americans (ACS, 2011) despite improvements in the early detection of CRC (Breen, Wagener, Brown, Davis, & Ballard-Barbash, 2001). Reasons for low screening rates in African Americans are not well understood, particularly in those with a family history of the disease.

In Caucasians, family history of CRC often is associated with increased rates of screening when compared to those without a family history of the disease (Chao et al., 2004; Lemon, Zapka, Puleo, Luckmann, & Chasan-Taber, 2001; Madlensky, Esplen, Gallinger, McLaughlin, & Goel, 2003; Thrasher et al., 2002). In African Americans, however, lower rates of CRC screening have been found in first-degree family members of patients with CRC compared to those without a family history of the disease (Griffith, McGuire, Royak-Schaler, Plowden, & Steinberger, 2008). Among those with a family history of CRC, African Americans have a significantly lower endoscopy completion rate compared to Caucasians (9% versus 27%;  $p < 0.03$ ) (Espey et al., 2007). Some work suggests that African Americans at high risk for hereditary nonpolyposis CRC and familial adenomatous polyposis have significantly lower rates of knowledge about their family histories and the increased risk conferred by that fact (Kupfer, McCaffrey, & Kim, 2006).

The purpose of this study was to explore barriers and facilitators of CRC screening among African Americans with first-degree relatives diagnosed with CRC, as well as to gather suggestions for program content designed to improve CRC screening rates within this population.

**Purpose/Objectives:** To explore barriers and facilitators of screening for colorectal cancer (CRC), as well as suggestions for improving screening among African Americans with first-degree relatives with CRC.

**Research Approach:** A qualitative, descriptive approach involving focus groups.

**Setting:** A community healthcare clinic in Baltimore, MD.

**Participants:** 14 African American men and women aged 40 or older with at least one first-degree family member affected by CRC.

**Methodologic Approach:** In-depth focus groups were conducted until thematic saturation was achieved. Thematic analysis and data reduction were conducted using ATLAS.ti, version 5.0.

**Main Research Variables:** CRC screening barriers and facilitators.

**Findings:** The participants were mostly male, insured, and had a parent with CRC. Commonly reported barriers to CRC screening included fear of serious illness, mistrust of the medical establishment, potential screening discomfort, lack of information on CRC risk factors, lack of healthcare access, absence of symptoms, no knowledge of CRC screening benefits, community reticence about cancer, and CRC myths. Facilitating factors for CRC screening included a belief of personal risk for CRC, physician recommendations, and acknowledgment of age as a risk factor. Suggestions to increase screening rates included distribution of culturally appropriate and community-based efforts (e.g., mobile units, church-based interventions). Participants also suggested ways to increase motivation and provide social support for screening patients.

**Conclusions:** Additional research is needed to identify and test effective screening approaches for this underserved group at increased risk for CRC. Study results suggest that cancer risk and screening education, coupled with screening opportunities in the community, may yield increased screening rates.

**Interpretation:** Lack of knowledge about CRC and CRC screening exists in the study population. Promoting screening across generations, developing and disseminating culturally appropriate educational materials within the community, and encouraging older individuals to screen to take care of their family may be appropriate interventions.

## Methods

Four focus groups were conducted among African American men and women aged 40 years or older with at least one first-degree family member with a history of CRC. A first-degree relative was defined as a parent, sibling, or child. For this study, CRC screening was defined as any test with an "A" recommendation by the U.S. Preventive Services Task Force ([USPSTF], 2008) for the early detection of CRC and included colonoscopy, flexible sigmoidoscopy, and high-sensitivity fecal occult blood test. For those with a family history of the disease, CRC screening is recommended to begin at age 40 or 10 years prior to the age at diagnosis of that relative (USPSTF, 2008).

In the course of group discussion, participants were encouraged to reflect on (a) the factors that influenced their own decisions to have or not have CRC screenings, (b) their experiences in screening, if applicable, and (c) knowledge about the experiences or beliefs of others regarding CRC and CRC screening. Discussions were guided by research objectives but remained flexible to pursue unanticipated issues and themes.

## Participants

Eligible participants included those who were African American, were aged 40 years or older, reported at least one first-degree relative with a history of CRC, and had no personal history of CRC. Following approval of the study from the institutional review board at Johns Hopkins, participants were recruited from the community in Baltimore, MD, using flyers and announcements at church gatherings and health fairs. The total time to recruit participants was 18 months, as multiple approaches were needed to attract interested individuals from the relatively small eligibility pool of African Americans with a first-degree relative diagnosed with CRC. Each participant received \$50 for taking part in the group. Informed consent was obtained privately, immediately prior to the group discussion. No eligible participants refused participation during the consent process. Groups were conducted consecutively; eligible participants were screened on the phone and, if deemed eligible to participate, were asked to attend the next scheduled focus group.

## Data Collection and Analysis

Data were obtained from each of four focus groups; an interview guide was used to organize the discussion, which was digitally recorded and supplemented by field notes. Focus groups were conducted in an academically affiliated community health clinic, and moderators were male African American study staff members. One of the moderators was a faculty member with qualitative research expertise, and he trained the second moderator.

Data then were transcribed verbatim. The first two authors were responsible for primary analysis of the data.

Mixed inductive and deductive approaches were used for analysis and interpretation. First, analysis included a focus on those themes that emerged from participants' own perspectives and conclusions, as well as cultural or social patterns revealed during the course of focus groups. The thematic analysis was accomplished through immersion in the data set, which produced inductively identified emergent themes (Lincoln & Guba, 1985; Ulin, Robinson, & Tolley, 2005). Second, a deductive content analysis approach was used to isolate direct participant responses to the research question of barriers and facilitators of CRC screening. Although deductive analysis is less commonly used in the setting of qualitative data, its use is increasing in focus groups, particularly when a thematic framework is developed as a result of the inductive process (Pope, Ziebland, & Mays, 2000).

A codebook was constructed, and the data were coded using ATLAS.ti, version 5.0, data analysis software. At several points in the process, the data and codes were checked for consistency and objectivity; finally, findings were reviewed by members of the study team who attended focus group meetings and who have had prior experience analyzing focus group data. As recommended by Lincoln and Guba (1985), an audit trail also was carefully maintained throughout analysis to maximize reliability.

## Results

The sample consisted of 14 individuals who participated in one of four focus groups (see Table 1). The age of participants ranged from 41–70 years, and most participants were male, had health insurance, and were living with at least one other person. The majority of participants reported a parent as the family member with CRC.

Although multiple levels of analysis were conducted, the focus of the current article is on participant identification of specific barriers and facilitators, as well as their suggestions to clinicians and researchers regarding strategies to enhance screening within their communities. The key concepts identified in the content analysis, which was based on the interview guide, included (a) barriers to CRC screening, (b) facilitating factors (based on participant experience) for CRC screening, and (c) suggestions to increase CRC screening rates among the target population.

## Barriers to Colorectal Cancer Screening

Participants were asked to identify perceived barriers to CRC screening either for themselves or others in the African American community. They had little difficulty articulating ideas or observations about barriers for others. Key concepts that were articulated by participants

included fear of illness or diagnosis, mistrust of doctors or hospitals, fear of pain or discomfort from the screening procedure, lack of information in the community about CRC and the risk of CRC, lack of access to health care, absence of symptoms, lack of knowledge of the benefits of CRC screening, community reticence about cancer or illness, and myths and misinformation about CRC.

**Fear:** Participants in all four groups noted that fear of illness or diagnosis was a principal reason why people avoid CRC screening. Some expressed fear pertaining to their own experiences. Most, however, identified fear of diagnosis as a common experience.

People are afraid that they going to find something wrong. I go to the doctor—the other day I was feeling kind of bad. I don't know what that was but I'm afraid to go, afraid they going to find out what it is. I'm afraid that the doctor will tell me I ain't going to be around much longer, so if I'm going to go, let me go. . . . And I think that plays a big part in why people aren't going to go for screening or anything else.

Another participant identified cancer as a particularly frightening diagnosis. "Now you know, but at first I was thinking about going down [and] making funeral arrangements. That's the fear that I had when somebody said the word cancer—that's the first thing."

**Mistrust of the medical establishment:** Mistrust of doctors or hospitals was mentioned as a barrier to CRC screening in three of the four groups and expanded on by several participants. This barrier in particular provoked active discussion among participants. Some told stories of incompetence on the part of doctors from their own experiences, and others made more general comments, such as, "Like I say, I do have a fear of hospitals. . . . Like I said to you, if it's not broke, don't fix it. Looking for trouble . . .," and "You know they don't like doctors, they don't trust doctors."

In response to the question of why doctors or hospitals might be frightening, one participant expressed concerns that doctors might not treat African Americans and low-income patients to the best of their ability.

The men or African American—a lot of people that I know, they don't have insurance and they feel, well, they going to just brush me off and look at me and send me on home anyway, so it's no use to even going.

**Fear of pain or discomfort:** Fears of any pain or discomfort associated with the CRC screening procedure also inspired comments in three groups. As one participant explained, ". . . and then the pain associated with the camera and tube going up, and things like that, so I mean, these are little things that turned me off with the idea." Another reported being "told that the screening

**Table 1. Sample Characteristics**

Characteristic	$\bar{X}$	SD	Range
Age (years)	55	9.7	41–70
Characteristic	n		
<b>Gender</b>			
Male	8		
Female	6		
<b>First-degree relative affected</b>			
Father	5		
Mother	4		
Sibling	4		
Brother and mother	1		
<b>Previous screening for colorectal cancer</b>	3		
<b>Insurance status</b>			
Medicare	7		
Uninsured	5		
Private	2		
<b>Annual income (\$)</b>			
Less than 8,000	4		
8,000–14,999	2		
15,000–34,999	2		
35,000 or more	4		
Missing	2		
<b>Highest education attained</b>			
Less than high school	1		
High school diploma	4		
Vocational or technical degree	1		
Associate's degree	6		
Bachelor's degree	2		
<b>Marital status</b>			
Single	6		
Married	4		
Widowed	3		
Divorced or separated	1		
<b>Number of other people living in household</b>			
None	2		
1	5		
2–4	6		
5 or more	1		
N = 14			

hurts, you know, it's a painful thing." One participant "didn't really know how to take it because other people were telling me different things about it and it's going to hurt. I don't think you want to do this and do that."

**Information scarcity:** Lack of information about CRC risk emerged as another barrier during the focus groups. Initially, participants posed many questions to group moderators about CRC risk and the CRC screening procedure. Several also admitted that a desire for more information motivated them to participate in the focus group. One older man explained, "I guess I've been putting it off, too, so now I say I'm going to get some more information." Participants also talked about a lack of knowledge in the general African American community.

Like he said, that misinformation, some people don't know what colon cancer is. What the colon is, what is its function. . . . To differentiate from prostate

cancer and the other cancers that affect African Americans mostly, or some people just don't know. This room should be full, it really should be.

**Doubts about screening benefit:** Participants suggested that some members of the target population do not perceive benefits related to screening. Indeed, one participant had doubts about the ability of screening to detect disease and related, "I was a little apprehensive, you know, about getting checked. I wasn't sure it would detect cancer. That was one of the experiences." Another participant indicated that the benefits of CRC screening may be unimportant in a context of multiple ills, including poverty, drug use, and crime.

Plenty [of] free health clinics, and health care for the homeless, there's health care for men up on Pennsylvania Avenue. We have the city health department. I've got things done through this channel, so the avenue is there, but do we take it? Because we don't think we need it.

**Access to care and insurance:** Lack of access to health care was introduced as a barrier in two discussions. Participants expressed uncertainty that their insurance would pay for the procedure and one reported a lack of insurance. One man shared, "But I haven't heard anything about anything free, I haven't checked with my doctor or anything like that, you know, my insurance would cover it, you know, I'm not sure," and another participant explained, "I don't have insurance, so I know it would be an issue for me." A third added,

And like I say, I think the insurance is your main issue of a lot of African Americans [because they] don't have insurance and I think that is one of the major problems—I heard a lot of them say, "Hey, well, I can't afford to get sick, you know." That's the way they feel.

Absence of symptoms was a barrier to screening for participants in two groups. Although several participants did note that they were aware of their personal risk for CRC and had been screened, others reported that they were not motivated to do so when asymptomatic.

I found out that I did have polyps because the doctor said, "Hey, your brother's got cancer, maybe you ought to go and get treated," and they found one big one in there and they said, "This thing has been there for a lot of years, but luckily it wasn't cancerous." And then I really started thinking—that's when I really became more aware of my health, so I'm going to the doctor on a regular basis, but before that I said, "I feel good, I'm okay."

**Community reticence about cancer or illness:** In two groups, participants noted a reluctance to talk

about illness, particularly among older members of the community. As two women explained, "Nobody in my family ever talked about it. You know how old folks are—never talked about it before," and,

I was told it was something else and in the end is when I found out—even a couple years later, but he had passed, that's what it was. I don't know. I'm not sure why it was hush hush, and maybe they didn't understand it, so maybe I can learn something.

One participant observed that reticence may result from fear of the cancer diagnosis.

When we were coming up, it was like, if you heard about somebody dying from cancer, it was just cancer. Now it's broken out to different categories, right. And my family, I don't know why, my uncle had—I don't know what he actually had, but we thought it was a hernia. He never did no lifting, and then years later found out he had some form of cancer.

**Myths:** Myths and misinformation were discussed in three groups. The participants noted that they believed or heard things about CRC that acted as barriers to CRC screening. A few participants reported that they had heard that CRC screening was painful, and one related, "But hearing it from hearsay, or people that have no idea what it is, sort of frightens people away."

Two more participants had heard other myths about CRC, including that CRC is only a threat for men, that CRC is caused by an ingested virus, and that avoiding alcohol and drugs would keep them safe from disease in general. As one participant explained, "I used to think colon cancer was for men, I really did. I didn't know it was hereditary . . . the word colon, I guess, just made me think of men."

## Facilitating Factors in Screening

In the course of discussion, participants noted several facilitators for CRC screening based on their observations and beliefs about others, and suggested ways to reach the target population. Four facilitators emerged: belief in personal risk (family or friend experience with CRC or other serious illness), physician's recommendation, general knowledge of risk factors for CRC, and family responsibility were mentioned as important reasons to screen.

**Belief in or perception of colorectal cancer risk:** The four facilitators were found to be interrelated in participants' decisions to seek CRC screenings. Belief in risk of CRC was a direct motivator for having CRC screening. For example, one participant said,

Well, I think the reason why I would want to decide to take the test, to make sure I don't have it, or catch it in time if I do have it. I might can be cured. Because I understand that death starts in the colon.

However, others tied their belief of CRC risk with having a family member or friend experience CRC or another serious illness. Those personal experiences with patients with CRC were described as stronger and more emotional motivators than the more abstract realization of theoretical risk. Focus group participants who had received CRC screening in the past reported that they did so in direct response to having a family member diagnosed with CRC. Others considered family history as primary among their reasons to have CRC screening in the future. Two participants commented, "Well, I said my father had it—also has colon cancer—and he died of it. So, it would prompt me to check to see if my colon is alright at the moment," and, "Just so that I would know, since my Daddy had it, just so I would know." A third person described the family history link more generally, stating,

I don't know, like, in my family, when things run through the family, it runs through the family. So I'd like to know before it's too late. Certain things run in our family; it could be a bunch of all this just bring together colon cancer, I don't know.

For some participants, it was not the heredity nature of the disease but becoming aware of the prevalence and risk of the disease that encouraged screening. In fact, some participants were inspired to be screened by friends who had been diagnosed with CRC.

But since this is apparent, I have agreed to have a colonoscopy on July the 18th, and that's only because several of my friends have died from colon cancer and prostate cancer and I was told that it creeps up on you, it's painless, you don't even know that you have it unless you get it checked out.

**Physician recommendation for screening:** For some participants, strong physician recommendation was noted to be instrumental to their decision to be screened.

[M]y doctor determined that my brother had cancer, [and] he made me get my test. And [I] took the colonoscopy, first time I took that they found three polyps so they removed them and it hasn't any more polyps showed up since then.

**Increasing risk with age:** Knowledge of advancing age as an indicator for CRC screening was noted by participants in three groups. Age was a factor frequently found in conjunction with doctors' recommendations and family history facilitating factors.

That's the reason that I go every couple years, because, number one, I'm old, number two, if detected early it can be cured, because I can see that through my brother, because he's had it for six years, so there is a possibility.

**Family responsibility:** Responsibility to family, although noted as a barrier to CRC screening for some, was cited as a motivator for others to undergo CRC screening. For example, one participant said,

To think that knowing a member of your family or someone in your family has had it, or been detected with it, then if you have any pride in yourself, or if you have a family, it would be easier for you to say that I'm going to get tested for this, and especially if you are the source of income for the family, so you would want to leave, you know, your family when you had a chance to take care of the problem that you may have and so go through with it and it's not as bad as people think it is.

## Suggestions to Increase Screening Rates

All group participants offered ideas about how others might be encouraged to seek CRC screening. The primary ideas included ways to provide CRC education. The majority of suggestions across groups were to increase the knowledge of CRC, CRC risk, and CRC screening procedures in the African American community. For example, one participant noted the importance of knowing the positive aspects of being screened and the negative aspects of not being screened.

In those discussions, modes of communicating the CRC screening message to others generated more interest and discussion than the fact that CRC screening is important to do. Participants made many suggestions regarding distribution of screening information to the target population. Pamphlets and public service announcements were suggested as vehicles to communicate screening. Modes of outreach discussed included mobile units, church groups, door-to-door canvassing, and public schools. One participant suggested targeting younger community members.

You know what, reaching out to junior high school students, and showing them what the effects are of not being treated for it. Like in a social science class, you understand. That may work. You get a program like that going where it's taught in the schools, you know.

Another participant suggested using media.

I would think that with the public service announcements and television, radio, and newspapers to encourage African American people to take the colon screening test, like I said before, it's painless and you would do yourself good by having this testing done and do it as often as the doctor recommends and especially, especially that's what we've been talking about this afternoon.

Finally, one participant suggested the use of mobile units.

I believe that there should be more mobile units like they do for HIV testing, going out to the community and making people more aware, along with the public service announcements and other promotions, ads, and things of that nature, you know; I think [the] community has gotten an overwhelming response and [a] better understanding of what HIV is all about because they go out to the community and do the testing. I don't know how they would do it with colon cancer, probably just to sign people up for the actual test at a local hospital or a clinic or whatever. But I think that's the very viable approach to the problem.

Participants also noted that educational materials should be culturally tailored to the African American community.

You have to get into the grassroots of the people and find out, you know, what's actually going—get the pulse of the public and have something very catchy for them to respond. It's got to have a catchy phrase to get their attention and then also make it to the point where if they don't do it, then you got consequences.

A number of barriers, including fear, myths, doubts of screening benefit, community reticence, information scarcity, access, and mistrust of the medical establishment, were identified in the data analysis of the focus groups. Education was the most common suggestion for addressing barriers to screening. Because the need for education was pervasive across barriers, facilitators, and suggestions, participants' ideas are presented as a cohesive unit in Table 2. Facilitators of CRC screening also were identified, including physician recommendation, belief in risk, family responsibility, and aging.

## Discussion

Focus groups conducted with African American first-degree relatives of patients with CRC produced data about beliefs, attitudes, and behaviors regarding CRC and CRC screening, which represented three key concepts: barriers to screening, facilitators of screening, and suggestions to increase screening rates. Findings indicate that lack of knowledge about CRC and CRC screening pervades the study population. However, repeated participant suggestions that education be community-based and socially as well as culturally appropriate are important to note. Such education might be delivered in a group setting, by racially concordant healthcare professionals such as nurses or social workers, with support from lay health workers. Educational content will require development in collaboration with

community members to ensure cultural appropriateness. Such an intervention should be piloted with additional study, preferably through the use of a community-based participatory research design. Such an approach includes community stakeholders and others who assist researchers in program planning, implementation, and evaluation. Because of community reticence related to screening identified in this study, community-oriented programs are central to overcoming many of the identified barriers.

Other findings suggest that CRC screening can be an emotionally charged undertaking that is uncomfortable for a number of reasons (e.g., mistrust of medical establishment, fear of a possible cancer diagnosis, fatalism). Fatalism, a prevalent belief among African Americans, women, and people of low income (Powe, 1995; Powe & Johnson, 1995) that "death is inevitable when cancer

**Table 2. Education-Related Key Concepts**

Concept	Category	Summary
Absence of symptoms	Barrier	Participants reported that they do not seek even preventive care in the absence of symptoms. A lack of knowledge exists of the progress of CRC.
CRC risk information scarcity	Barrier	Participants reported a general lack of information in the target population about CRC and CRC screening. Several participants themselves attended groups to gain information about CRC.
Doubts about screening benefit	Barrier	Participants observed that the benefits of CRC screening are not obvious in the target population.
Myths about CRC	Barrier	Participants reported myths and misinformation about CRC and CRC screening in the target population.
CRC education	Suggestion	Participants directly suggested education as a means to increase CRC screening rates.
Belief in or perception of CRC risk	Facilitator	Those participants who had CRC screening did so as the result of greater knowledge of risk afforded by direct experience with an ill loved one.
Physician's recommendation for screening	Facilitator	Those participants who had CRC screening did so because they were informed by a doctor about their risk.
Increased risk of CRC with age	Facilitator	An awareness that age is a risk factor for CRC and other illness was a motivator for CRC screening.
CRC—colorectal cancer		

is present" (Powe & Finnie, 2003, p. 454), continues to impact cancer screening in the study population. Prior research has found associations between fear and fatalism in African Americans (Phillips, Cohen, & Moses, 1999).

Some risks are associated with CRC screening procedures, so the medical community must make a real effort to communicate such risks accurately and within the framework of screening benefits. Fear of illness and cancer, as well as the presence of fatalism, point to a resistance to diagnosis because of the belief that cancer is a death sentence. In addition, the reported mistrust of doctors and hospitals supports the idea that, at least in the target community, suspicion exists of interactions with the medical establishment, resulting in ineffective treatment or being ignored. Participants, all older members of the community, noted a reluctance to talk about illness.

Fortunately, factors were identified that may contribute to improved screening rates. In contrast to the finding of the medical establishment as a barrier to screening, provider recommendation to have CRC screening emerged as a meaningful facilitator. That finding was an important, though not surprising, factor in CRC screening in this study of relatives of patients with CRC, and other studies have supported that finding in the general African American population (Brenes & Paskett, 2000; Greiner et al., 2005; Lawsin, DuHamel, Weiss, Rakowski, & Jandorf, 2007; Taylor et al., 2003), as well as in African Americans with a family history of CRC (Griffith et al., 2008). That providers appeared as a barrier and facilitator means that the social context in which care is provided may be particularly powerful and represents possible avenues for strengthening the influence that providers have in improving screening rates. Considering the patient-provider relationship against the backdrop of general mistrust in the African American community will be important to not overlook. More research should be done to explore any relationship between mistrust of physicians and lack of personal connection to the medical establishment. In addition, the development of educational interventions for physicians and other providers of CRC screening is a ripe area for exploration, particularly because the needs of the community are so deeply entrenched in building trust and respect.

An important concept that influenced CRC screening in this study was the understanding that advancing age is associated with CRC and the need to be screened for it. Public service announcements and other free materials may have allowed this message to circulate among the community, and this general knowledge should be capitalized on, not only because it already is present but also because it is a simple message to understand and build on. Other work has shown that in patients without a provider recommendation, advancing age was found to be the only correlate of screening adherence in African Americans (Griffith, 2009).

Given the ubiquitousness of physician or medical-system influence in each category of barriers, facilitators, and suggestions for change, recognizing the importance that healthcare providers have in promoting improved CRC screening rates in African Americans who have a family history of the disease is imperative. Well-designed educational programs will allow providers to figure prominently in the intervention while simultaneously cultivating connection to the community and making efforts to reduce fears. An ideal intervention will overcome a number of identified barriers as well, including myths, community reticence, and information scarcity. Most importantly, taking into consideration the risk-to-benefit ratio this particular population perceives should be considered carefully as the next steps are planned to increase CRC screening rates. Multiple deeply entrenched barriers are present that will require careful, systematic treatment to overcome, in conjunction with community partners.

The focus groups also produced information on how screening information might be delivered. In addition to cultural appropriateness, group narratives indicated the importance of a personal connection in health care. That is apparent from suggestions for community-based education (i.e., community outreach, church-based, or mobile unit education) and social support for CRC screenings, which could be done by patient navigators or provision of peer counselors who have experienced CRC screening. Evidence of the importance of a personal connection also was found in participants' decisions to screen.

## Limitations

Focus groups, like all qualitative methods, afford detail, context, and an "insider" perspective. The limitations of qualitative methods include a tendency toward small sample size and related sample bias. Recruiting African Americans who were first-degree relatives of an individual affected by CRC was a slow, time-consuming process, both in terms of identifying potential participants and in gaining their trust. As with many studies that include African Americans, the sample was limited, likely because of low numbers of people meeting the requirements of being an African American and first-degree relative of a patient with CRC. In addition, a selection bias may have existed toward those who were not intimidated by the healthcare system, as well as those interested in learning more about CRC. Healthcare provider mistrust, identified as a barrier to CRC screening in this study, also may have been a factor in deterring participation. Such potential biases should be taken into account in any interpretations of research findings. Continued difficulty exists in achieving acceptable screening rates in African Americans, particularly those with a family history of the disease, so low recruitment rates in this study are not surprising

and highlight the need for additional work in how to best recruit study participants from this population.

## Nursing Implications

The current study adds evidence to a growing body of literature that many roadblocks exist related to achieving optimal CRC screening rates in African Americans, particularly in those at increased risk for the disease because of a family history of CRC. Suggestions made during focus groups represent an opportunity for designing educational and other nursing interventions to encourage screening for CRC. Those activities may be created in conjunction with the community, as a community-invested approach will serve to address and overcome many barriers identified during the study, leading to improved understanding of CRC, individual risk for the disease, and the irrefutable benefits of secondary prevention of CRC.

This study demonstrates that physicians are considered valuable sources of knowledge for those who

seek CRC screening, so the lack of trust for those yet to receive screening warrants additional exploration. Promoting screening across generations, developing and disseminating culturally appropriate educational materials within the community, instituting programs to enhance trust between providers and patients, and encouraging older individuals to get screened to take care of their families may be appropriate nursing interventions to develop and test in response to findings from this study.

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