Research Article

Korean Americans’ Beliefs about Colorectal Cancer Screening

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S U M M A R Y

Purpose: The purpose of this study was to assess Korean Americans’ (KAs) health and cultural beliefs about colorectal cancer (CRC) and their CRC screening utilization in order to understand how health and cultural beliefs play a role in CRC screening utilization and why KAs have a low rate of CRC screening.

Methods: Face-to-face, individual interviews with 26 Korean immigrants aged 50 and older were conducted in Korean. A semi-structured interview guide with open-ended questions was used to explore participants’ health and cultural beliefs about CRC and CRC screening. Recorded audio interviews were transcribed verbatim in Korean and coded using thematic analysis.

Results: The themes that emerged from analyzing the individual interview data were: (a) valuing their families before themselves; (b) seeing a doctor only if they have symptoms; (c) believing that they would not get CRC; (d) balancing the will to stay healthy and fatalism; and (e) refusing health information.

Conclusion: Results show the critical need for in-depth understanding of unique health and cultural beliefs about CRC screening in KAs. These beliefs could be useful for future intervention strategies to change health and cultural beliefs in order to increase CRC screening participation in KAs.

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Introduction

Colorectal cancer (CRC) was the most commonly diagnosed cancer (14.4%) for KA men and the second most commonly diagnosed cancer (12.9%) for KA women from 1999 to 2003 (The North American Association of Central Cancer Registries, 2006). CRC incidence has been increasing among KAs in the recent past: from 31.7 per 100,000 for KA men and 21.9 per 100,000 for KA women between 1988 and 1992 (Bernstein & Wu, 1998) to 55.9 per 100,000 for KA men and 35.9 per 100,000 for KA women between 1998 and 2002 (Miller, Chu, Hankey, & Ries, 2008).

CRC screening can detect CRC early and may reduce the incidence of CRC because it leads to the removal of precancerous polyps (McCacken et al., 2007). However, current literature shows that KAs underutilize CRC screening (Jo, Maxwell, Wong, & Bastani, 2008; Maxwell & Crespi, 2009; Wong, Gildengorin, Nguyen, & Mock, 2005). Furthermore, researchers consistently report declining CRC screening rates among KAs (Maxwell & Crespi; Maxwell, Crespi, Antonio, & Lu, 2010). The California Health Interview Survey found that CRC screening utilization among KAs decreased from 2001 to 2005 (Maxwell & Crespi; Maxwell et al., 2010). KAs who reported having had a fecal occult blood test (FOBT) within 1 year of the survey declined from 14% in 2001 to 7% in 2003 and to 2% in 2005 (Maxwell & Crespi). KAs who reported having had an endoscopy during the 5 years preceding the survey went from 30% in 2001 to 31% in 2003 and to 28% in 2005 (Maxwell & Crespi). Up-to-date CRC screening rates (either having an FOBT in the previous year or endoscopy in the previous 5 years) in KAs decreased from 39% in 2001 to 34% in 2003 and to 29% in 2005. In comparison, up-to-date CRC screening rates in non-Hispanic Whites went from 56% in 2001 to 55% in 2003 and back up to 59% in 2005 (Maxwell & Crespi).

The literature indicates that low CRC screening utilization rates in KAs are associated with sociodemographic factors including not having had a checkup, inability to afford testing, lower percentage of lifetime spent in the US, language barriers, and limited access to health care including low rates of physician recommendations and lack of health insurance (Jo, Maxwell, Rick, Cha, & Bastani, 2008; Jo et al., 2008; Juon, Han, Shin, Kim, & Kim, 2003a). However, only a few studies have identified determinants of suboptimal CRC screening utilization among KAs. Most of them identified socio-demographic factors and limited access to health care but barely examined beliefs about CRC and CRC screening (Jo et al., 2008; Jo et al., 2008; Juon, 2003a), although beliefs are an important factor influencing cancer screening behaviors across diverse populations as shown by studies (Eun, Lee, Kim, & Fogg, 2009; Lee, Fogg, & Menon, 2008; Lee, Eun, Lee, & Nandy, 2012; Rawl et al., 2005).
Beliefs, especially Korean culture-specific beliefs, might be an important factor associated with CRC screening in KAs as suggested by three pieces of empirical evidence in the literature. First, high proportions of KAs are foreign-born and have low English proficiency. In 2000, 77% of KAs in the US were foreign-born, 52% did not speak English well or at all, and 35% were linguistically isolated (United States Census Bureau, 2001). Foreign-born Asians including Koreans have been found to be less likely to have had CRC screening than US-born Asians (Goel et al., 2003). The single most important self-reported reason for not getting screening was because they had not experienced problems or symptoms, whereas US-born Asians were more likely to report pain/embarrassment, the lack of a doctor or insurance, or that screening was too expensive as reasons for they did not get screening (Kandula, Wen, Jacobs, & Lauderdale, 2006). Second, many studies of breast and cervical cancer screening behaviors among KAs have shown that there were culture-specific beliefs associated with some kinds of cancer screening including not having symptoms (Juon, Seung-Lee, & Klassen, 2003b; Kim, Lee, Lee, & Kim, 2004), misconceptions (Juon et al., 2003b; Kim et al.; Lee, 2000), a belief in destiny or fatalism (Lee; Lee, Tripp-Reimer, Miller, Sadler, & Lee, 2007), and lack of a preventive health orientation (Juon et al., 2003b). These beliefs, which have been shown to be correlates of breast and cervical cancer screening in KA women, might play a significant role in low CRC screening rates in KAs as well. Lastly, among the few studies on CRC screening among KAs (Jo et al., 2009; Jo et al., 2008; Juon et al., 2003a; Ma et al., 2009), one used the health belief model and social cognitive theory and found that a culturally acceptable CRC screening intervention that addressed accessibility, psychosocial barriers, and navigation assistance increased screening rates (Ma et al.). In that study, the researchers conducted two focus groups in order to develop culturally acceptable instruments and interventions. They found that focus group participants had strong cultural beliefs including self-care and fatalism. However, that study includes little detailed information about specific health and cultural beliefs about CRC screening that KAs hold or about how health and cultural beliefs affect KAs' CRC screening behaviors. This suggests that more in-depth investigation regarding KAs' health and cultural beliefs about CRC screening is needed.

The purpose of this study was to assess KAs' health and cultural beliefs about CRC and CRC screening utilization. Because little research has been done on this topic to date, a qualitative approach was chosen in this study to understand the participants' beliefs about CRC screening more deeply by identifying concepts and themes emerging from open-ended interviews. This qualitative study will contribute to the understanding of how health and cultural beliefs play a role in CRC screening utilization and why KAs have low CRC screening rates.

**Methods**

**Study Design**

A descriptive qualitative approach using face-to-face individual interviews was used.

**Setting and samples**

The sample for this study was KAs who were (a) born in Korea and immigrated to the US, (b) aged 50 and older, and (c) at average risk for CRC (i.e., no history of Crohn's disease or ulcerative colitis, no history of CRC, and no first-degree relative with CRC) based on the American Cancer Society's guidelines (American Cancer Society, 2011).

After obtaining institutional review board approval from the University of Illinois at Chicago, KAs were recruited using chain referral sampling in the Chicago metropolitan area to find KAs who were eligible for this study. The principal investigator (PI) contacted one KA man who was eligible for this study as an initial contact person through the PI's personal networks. He referred several other eligible KAs as possible participants for this study. A series of participant referrals to other eligible KAs for the study occurred. Also, quota sampling was used to recruit approximately equal numbers of males and females and equal numbers of persons in the age groups 50–64 and 65 and over in order to understand gender and age differences in beliefs about CRC screening. The PI told participants whether males or females were needed and which age group was needed when she asked them to recommend other KAs. Recruitment continued as long as new themes continued emerging from the interviews, and data saturation was reached at a sample of 26 (Lincoln & Guba, 1985).

**Ethical consideration**

After the research protocol has been approved by the Institutional Review Board at the University of Illinois at Chicago, participants were recruited in the Chicago metropolitan area. Participants were informed that they could decline to answer any questions that make them uncomfortable. Translated Korean version of informed consent including information on protection of privacy and confidentiality were given to participants in either verbal or written form. All materials including the audiotapes and signed consent forms were stored in a locked file cabinet in the PI's office at the College of Nursing at the University of Illinois at Chicago to ensure the protection of confidential participant information.

**Data collection**

The individual interviews were conducted from January 2010 to February 2010 at places the participants chose. Fifteen interviews took place at participants' homes (57.7%), and 11 at participants' work places (42.3%). After signing a consent form, participants were asked about their experiences and perceptions regarding CRC and CRC screening, their opinions on health, and their cultural beliefs. Individual interview questions were:

- When you hear the words colorectal cancer, what comes to mind?
- When you hear CRC screening test, what comes to your mind? How much do you know about it? How do people talk about their experiences of getting a CRC screening test?
- Have you had a CRC screening test? If you have had a CRC screening test, what would you say about your experience? If you have never received a CRC screening test, could you share the reasons?

After the participant answered the above questions, if necessary, the PI asked a follow-up question to elicit specific information relevant to the participant's answers. Also, cross-member validation of the findings was conducted during the individual interviews. For example, after an interview, information from the previous interview was validated by asking the second interviewee whether that information reflected the second interviewee's experience or thoughts, and the same procedure was continued until the end of the individual interviews.

The individual interview questions were developed in English and translated into Korean by three bilingual translators who were fluent in both Korean and English using a committee translation method of reaching consensus by reconciling differences among their respective versions (Vijver & Leung, 1997). The individual
interviews were conducted in Korean and were recorded on audiotape. The PI moderated the individual interviews using a semi-structured interview guide and took notes on the participants' comments while the interview was being recorded. Each individual interview lasted approximately 60–90 minutes. After the interview, participants were asked to fill out a brief background questionnaire about their gender, age, time spent in the US, marital status, education, income level, and health insurance. Respondents received a $20 gift certificate for their participation after completing the individual interview.

Data analysis

Data analysis was initiated as soon as each interview was collected. The recorded individual interviews were fully transcribed in Korean by four Korean research assistants. The data were coded by concepts and beliefs and sorted using a computer-assisted text analysis software program, NVivo 7 (Qualitative solutions and research international Inc., Cambridge, MA, USA). Representative phrases and words that the participants mentioned during individual interviews were marked for use as themes (Boyatzis, 1998). Analysis reflected the researcher’s internal cognitive processes and reflexive thinking using an inductive and deductive cognitive process (Boyatzis; Koch & Harrington, 1998). Codings and themes were developed in Korean, then after deductive cognitive processes and re-examining the data, the results were translated into English. Using a committee translation method (Vijver & Leung, 1997), the translated codes, themes, and important texts in transcription from Korean into English. An expert who is fluent in both Korean and English and has over 10 years of experience in conducting qualitative studies on cancer screening research with KAs reviewed the procedure, data analysis, and results of the study. Descriptive statistics were calculated for background information on participants’ characteristics and CRC screening utilization.

Rigor of study

The rigor of this study was established in terms of determining whether the findings are accurate from the standpoint of the researcher and the study participants as Creswell and Miller (2000) suggested. First, researcher reflexivity was used by writing a journal for ongoing self-critique and self-appraisal during the process, as Koch and Harrington (1998) recommended. The reflexive journal included facts that participants mentioned during interviews, findings from related literature, and the researcher’s interpretations in order to self-disclose the researcher’s beliefs, values, and biases as the study proceeded. Second, cross-member checking (Creswell, 2003) was used to determine the accuracy of the qualitative findings through asking successive participants about emergent themes as explained above (Boyatzis, 1998).

Results

Themes revealed during individual interviews

Sample characteristics of the participants are displayed in Table 1. During the individual interviews, 12 of the 26 participants (46.2%) indicated that they had heard a lot about endoscopy for CRC screening but had not heard about FOBT. Findings from individual interviews revealed emergent themes describing Korean health and cultural beliefs about CRC screening that are different from those in western cultures. There were no gender or age differences in these themes except for family concerns in different age groups, which are described below.

### Table 1 General Characteristics of Participants (N = 26)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n (%)</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age [yr]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50–64</td>
<td>13 (50.0)</td>
<td>64.69</td>
<td>9.75</td>
<td>50–88</td>
</tr>
<tr>
<td>≥ 65</td>
<td>13 (50.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11 (42.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>15 (57.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in US</td>
<td>24.08</td>
<td>8.75</td>
<td>8–38</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently married</td>
<td>19 (73.1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>2 (7.7)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Divorced</td>
<td>5 (19.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school diploma or lower</td>
<td>17 (65.4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher than high school diploma</td>
<td>9 (34.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>10 (38.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time</td>
<td>3 (11.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>13 (50.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18 (69.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>8 (30.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual household income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ $50,000</td>
<td>16 (61.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; $50,000</td>
<td>9 (34.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1 (3.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRC screening in lifetime</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18 (69.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>8 (30.8)</td>
<td></td>
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</tbody>
</table>

Note. CRC = colorectal cancer.

Valuing their families before themselves

Many participants felt fear when they thought about CRC because cancer was directly related to death. They became worried about themselves as well as their families because CRC would negatively affect them and their families’ lives in two ways: (a) by breaking life patterns in their family because they would not be able to play their parental role and (b) by causing psychological or emotional difficulties. Regarding life patterns broken in the family, if participants developed CRC, they believed that their family would face financial difficulties in the areas of finances, housework, family relationships, and that they would be exhausted by life. As for family relationships, participants said that they would feel guilty and cause discomfort to their family by burdening family members who would need to do their own work and that of the sick person’s too. In addition, they were concerned that their family members would feel tired, fatigued and stressed because of them if they were sick with CRC. One man said the following:

> When I hear of cancer, death comes to my mind. [If I had CRC] I would be having a hard time and my family would also. Cancer is a hard word itself. . . .CRC would cause complicated problems. My life and finances would be a mess [if I were diagnosed with CRC]. I would worry about my family more than myself. My family’s way of life would be broken financially and emotionally. If I had cancer, I could die in years. I think I should give it up [living] because everyone knows that cancer patients do not live for a long time. This way of thinking gives me comfort.

Another woman worried about financial problems, housework, and family relationships. She said the following:

> [If I had CRC] financial difficulties would be a problem without making money for our family, and if I didn’t cook or do laundry, my husband would have a hard time. . . . Also, I am a go-
between for my husband and my children, so if I were sick and did not play the role of go-between, my family would not do well. I would really worry about them.

Because of family obligations, middle-aged KAs aged 50 to 64 worried a lot that CRC could affect their family because of the difficulties that other family members would experience if they developed CRC. Meanwhile, KAs aged 65 and older mentioned that they would not be much concerned about their family because they did not have many family obligations anymore, and they had already lived long enough and would accept death if they developed CRC.

All participants said that if they had CRC, their family would have psychological or emotional difficulties due to worrying about the sick family member and fear of loss. They thought that their family would experience pain, pity, sadness, heartbreak, or depression. One man indicated that “if a family member, especially a mother, was sick, the whole family would feel pain, which is what family is... There would be no pleasure at all in the family.”

If they were diagnosed with CRC, KA participants said they would be very worried about their families. They would fear being a burden to their families, but this would not keep most of them from getting CRC screening. Only 2 out of 26 (8%) stated that they would not get CRC screening because they were afraid they would burden their family if diagnosed with CRC. Also, 17 KA participants (65.4%) mentioned that they would get screening if their family wanted them to because they understood that CRC screening might enable them to reduce the financial and emotional burdens on their family and/or that they could take care of their family by finding CRC early. However, 9 participants (34.6%) said that they would not get CRC screening despite their families’ encouragement because their families are not experts on health and could not be trusted about these matters.

Seeing a doctor only if they have symptoms

Participants indicated that healthy food, regular exercise, and/or positive thinking are good for health, and they tried to do these things to maintain health and prevent cancer. Also, all participants agreed that finding health problems early is important. However, many KAs have crisis-oriented ideas in which not having symptoms means they are healthy and that they do not need to see a doctor unless they are sick. They said that there was no reason to spend money and time if they were not sick and had no symptoms. Almost everyone mentioned that not having symptoms was a main and direct reason why they have not had CRC screening. One man said the following:

I am living healthy without symptoms, why I should get CRC screening?... I am interested in my health, but doesn’t it [the CRC screening test] require collecting stools and other things [tests]? It would be good to get tests when people don’t have symptoms. But, I am not sure if I have time to get tests [when I don’t have symptoms]... I am pretty busy making a living.

Some said that only the sick need to go to see a doctor, and healthy people do not need to see a doctor. They indicated that ideally they need to see a doctor although they do not have symptoms. Also, they knew that they might have a diagnosis of late-stage CRC if they go to see a doctor after symptoms occur. However, in practice, they said that it was difficult for them to see a doctor when they were not sick due to reasons of money, health insurance, time, and a busy life.

Believing that they would not get CRC

The thoughts, “I will not get CRC” and “I will be okay” were common reasons for not having CRC screening. KA participants said that people including themselves had self-confidence and complacency about their health because they thought that their chances of developing CRC were low, they were healthy, or misfortunes had nothing to do with them. The following statement of one man suggests that KAs may have an unrealistic optimism regarding their chances of getting CRC:

People think that “I will not get CRC.” Everyone thinks like this: “No, not me.”... They live in ease and are ignorant of their health. They do not make efforts [to maintain health] and just think that “misfortune [developing cancer] has nothing to do with me.”

Many of the respondent’s beliefs that they would not get CRC were based on family history, health habits (e.g., eating healthy food such as vegetables and fruits, not eating red meat, exercising), and lack of symptoms related to bowels (e.g., constipation). For example, when they had no family history of CRC, chose vegetables and fruits more often than red meat, engaged in exercise regularly, or did not have constipation, they thought they would not have CRC either in a few years or in their lifetime. One woman said the following:

I don’t think I will get CRC... because I eat a lot of vegetables and fruits and have more fish than red meat... I don’t exercise, but I walk all day long due to my work... I don’t have a family history of cancer, which is one reason [why I don’t think I will get CRC].

Many KA participants ate healthy food and exercised for their health, but they were not familiar with having cancer screening at hospitals or other health care institutions. Some participants said that this was because Koreans are not familiar with taking tests at hospitals and do not want to go to clinics or hospitals.

Balancing the will to stay healthy and fatalism

Both internal and external controls over health behavior explain CRC screening behaviors in KAs. People believed that things happen due to their own behavior (i.e., internal control) and due to the control of powerful others, fate, or luck (i.e., external control). Regarding internal control, many KAs said that finding health problems early was their own rather than others’ responsibility. KAs thought that they would get cancer or diseases if they did not take care of their health. Regarding external control, among powerful others (e.g., doctors, family, or friends), all participants said that they would complete tests if doctors recommended the tests because doctors are experts in health.

Among the 26 individual interviewees, 17 (65.4%) believed in destiny, fate, or predeterminism (Unmyung or Palja in Korean). A common expression among Koreans, and one many of the participants had heard, is “In-myeong-eun Je-cheon-i-da,” which means that humans cannot control life and death; only God or an unknown supernatural power decides whether we live or die. They felt that life is predetermined when persons are born and that a relationship exists from birth between destiny and diseases, including cancer. Some said that God controls everything, so destiny (whether person develops a disease like cancer and lives or dies) is determined by God. One man said the following:

I believe that “In-myeong-eun Je-cheon-i-da.” God decides everything. Why should I get cancer screening to extend my life? I do not believe in prevention. Death is already pre-determined. It’s just that I don’t know when it will be.

Among participants who believed in destiny or predeterminism, almost all of them mentioned that they would try to do whatever they could for their health as long as they live, although life was
predetermined by God or an unknown supernatural power. How long they will live has been predetermined, but this was not important to them. For them, it was important to live in good health. So, although life is predetermined, they would do what they need to do to maintain health and find cancer early. For example, one man said the following:

There is nothing we can do about living or dying... We should believe in destiny... The Korean saying is that “In-myeon-eun je-cheon-i-da.” We are going to follow destiny even if we would like to live a long life. But I need to do what I can do for good health like exercising and eating healthy food. And I should live with acceptance of my destiny that God has decided... God makes decisions about whether we are healthy or sick or live or die.

Another man said the following:

God makes the decision whether we are healthy or sick. I believe that God gave us our body to take care of, but if I don’t take good care of my body and drink alcohol, smoke cigarettes, eat unhealthy food, and don’t exercise, then I am going to be at high risk of getting CRC. That would be my fault... God decides destiny like getting CRC, so we should let God decide but we should do what we need to do. If I was diagnosed with early-stage CRC, God would decide my destiny, but I would do things to take care of my CRC like managing my diet, taking medications, or getting chemotherapy, which is what I would need to make my effort for my health. It is not all right to just let God decide all of my destiny and for me not to take chemo and medications, not to exercise. This would be wrong.

These statements show that both internal control (the will to stay healthy) and external control (fatalism) existed in participants’ minds, because for them it was important to take an active lead in their health behaviors and early detection efforts although they had fatalistic views on health and believed in destiny or predeterminism. Furthermore, 4 of the 17 (23.5%) who believed in destiny, fate, or predeterminism said their own efforts in life could change destiny or fate, indicating a very active attitude towards fatalism. They indicated that people could choose to do good things or bad things in life, for example, following doctors’ recommendations. Depending on their own efforts and behaviors, they believed that destiny could be changed.

Regarding luck, many participants pointed out that people could have good luck in finding cancer early by chance. If they found early-stage CRC, the treatment would be easy and they would recover from the cancer.

Some explained why they came to believe in destiny. They indicated that there are things that they cannot control no matter how hard they make an effort to change things in positive directions. One man said the following:

Even if people were extremely careful about their health, they could die from unexpected car accidents, earthquakes, and so on. Even if I had lots of health examinations, I will have cancer and die if that is my destiny. Getting cancer would be a destiny because life is predetermined. We cannot predict anything. Thinking and accepting this way makes people comfortable.

Refusing health information

Some KAs agreed that having health information would help them improve their health. In contrast, one barrier to cancer screening including CRC screening was a proverb, “Knowledge can be a disease (A-neun-ge Byeong-i-da in Korean); ignorance can be medicine (Mo-i-neun-ge Yak-i-da in Korean).” This indicates that having health information on the symptoms of disease or health checkups could be harmful, and it is better not to know about this because it makes people worry. For example, one KA man said the following:

I knew a KA man who was 62 years old... His wife got cancer, so they went to Korea for her treatment. He was in Korea, so [due to the low cost of checkups] he decided to get a checkup, and cancer was found. He suffered at a hospital in Korea for a year and died of an infection, not of cancer. This case made me think “A-neun-ge Byeong-i-da; Mo-i-neun-ge Yak-i-da [traditional Korean saying]” because he was so healthy... and liked exercising... if he had not known about his health problem from checkups, he could have lived a healthy life for many years until he was 80 years old. From this point of view, I think knowing too much is not good.

Another man said the following:

It is had to get CRC screening, I said “A-neun-ge Byeong-i-da.” I might have CRC now, and it’s good that I don’t know about it. Because if I knew that I had CRC... People would get stressed because they would think that they would die [of CRC] soon. So, it’s better not to know whether I will die sooner or later.

Some KA participants indicated that people would respond to health information differently depending on their personalities. They indicated that if timid people heard about their health status, they would be abnormally obsessed with health. This would hurt their health by worrying too much even if they were healthy.

Discussion

The purpose of this study was to assess KA’s health and cultural beliefs about CRC and CRC screening utilization. This study revealed five themes describing KAs’ health and cultural beliefs regarding CRC and CRC screening. This is unique given that previous studies on CRC screening in KAs focused on sociodemographic and health care access factors. The themes that emerged from the individual interview data present important concepts as described in the findings: (a) valuing their families before themselves (familism); (b) seeking a doctor only if they have symptoms (crisis health orientation); (c) believing that they would not get CRC (unrealistic optimism); (d) balancing the will to stay healthy and fatalism (balance between internal and external control); and (e) refusing health information (health information refusal). Compared to previous studies, this study offers two unique findings (Korean health fatalism and health information refusal) and three similar findings (familism, crisis health orientation, and unrealistic optimism) regarding health and cultural beliefs about CRC screening in KAs.

Regarding unique findings in this study, first, participants exhibited both internal control (the will to stay healthy) and external control (fatalism). While locus of control theory conceptualizes a person’s locus as either internal (event is contingent upon one’s own behavior) or external (event is contingent upon fate, luck, or powerful others) (Rotter, 1966), some KA participants in this study believed that both internal and external controls (the will to stay healthy and fatalism respectively) were determinants that affected their CRC screening utilization and health. Previous studies have reported similar findings among different ethnic groups. For KA women and Latino participants in qualitative studies (Florez et al., 2009; Lee, 2000), internal (will to change) and external forces (God) were not completely separate but merged comfortably into a single locus of control over breast and cervical cancer detection. Furthermore, to our surprise in this study, some KAs believed that human’s own efforts in life could change destiny or fate. This may
be related to traditional philosophies including Confucianism, Buddhism, and Taoism. Korean traditional fatalism—the belief that one’s entire life is predetermined from birth—is one dimension of these philosophies that also emphasizes humans’ current active efforts for positive change of their destiny (Sim, 2003). In Confucianism, Mencius insisted on an active attitude toward fatalism, suggesting that people actively do what they need to do before passively accepting their fate (Sim). Many Buddhists also believe that fate is not absolutely predetermined and that humans can change fate through good behaviors because current good action causes good things in the future (Kim, 1992; Sim). In Taoism, harmonizing with nature is an important virtue, and humans need to make active efforts to be a part of nature and accept the natural order (Lee, 1982; Sim). These philosophies emphasize both fatalistic views and humans’ active efforts in life, which is consistent with the answers given by participants in this study. Korean health fatalism may be unique in that it is a very active attitude towards fatalism (i.e., human’s efforts can change destiny).

One of our significant findings is that fatalism played a positive role as a coping strategy by allowing interpretation of difficult-to-understand events or acceptance of uncontrolled events, including developing cancer. This is counter to many of the findings in studies of breast, cervical, and CRC screening in different ethnic groups including African Americans, Hispanics, and KAs, which view fatalism as a barrier to cancer screening from a pessimistic perspective (Fernandez, Palmer, Leong-Wu, 2005; Powe & Finnie, 2003; Suh, 2008). This suggests that future research needs to investigate how health fatalism can contribute to positive health outcomes.

Second, this study presents new information on health information refusal. Based on a traditional Korean proverb, health information refusal is a barrier to CRC screening. Some respondents believe that if they knew about the symptoms of a disease, they would obsess over the idea that they might get that disease, and they would go to a doctor for checkups although they were healthy. Thus, to avoid wasting their time and money, they might not want this health information. It is the case that partial knowledge may be harmful because it causes more worrying. However, providing people with specific, exact health information should reduce the amount of worrying because it removes uncertainties about their health.

Lastly, our findings are similar to previous studies that report familism (i.e., valuing their families before themselves), unrealistic optimism (i.e., believing that they would not get CRC), and crisis health orientation (i.e., seeing a doctor only if they have symptoms). As consistent with past studies (Cummings & Quintela, 2007; Hurh, 1998; Kang & Crogan, 2008), participants in this study put family interest before individual interest, which is influenced by Confucianism (Kang, 2004). KAs live in the US where western cultural values (e.g., individualism, equality, freedom, self-assertion, and self-reliance) dominate, and acculturation may influence KAs’ beliefs and values, but many Asian immigrants including Koreans keep their traditional cultural values somewhat intact while adopting selected dimensions of American values and social attitudes (Chun, Chesla, & Kwan, 2011; Hurh). In this study, the mean number of years living in the US for participants was more than 24 years (range 8–38 years; Table 1). Regardless of the length of residence in the US, many participants valued their families more than themselves, which suggests that their attachment to Korean cultural values such as family interest over individual interest seems unaffected by length of residence in the US.

While a past study (Jo et al., 2008) found that fear of being a burden to the family if diagnosed with cancer was a cultural barrier to CRC screening, this study found that the fear of being a burden to the family if diagnosed with cancer would not deter or discourage KAs from getting CRC screening, even though most disliked burdening their family. They indicated that their families should know about any health problems they might have including CRC. This might be due to the Korean culture-specific value that family is the basic unit for dealing with health problems of family members, as past studies have indicated (Chang, Lee, & Kim, 2008; Cummings & Quintela, 2007).

This study found that family encouragement for CRC screening would be effective for many KAs, which is consistent with past research (Han, Williams, & Harrison, 2000). For those who would not comply with their family’s encouragement to get CRC screening, the reason was that family members were not experts in health. Since all participants said they would follow doctor’s recommendations, encouragement from both doctors as experts and family may be a better intervention strategy to increase CRC screening in KAs rather than family encouragement alone.

As with past cancer screening studies with KAs (Juon, Kim, Shankar, & Han, 2004; Kim et al., 2004; Lee, 2000; Maxwell et al., 2010) and other Asian groups (Choe, Tu, Lim, Burke, Acorda, & Taylor, 2006; Nguyen, Barg, Armstrong, Holmes, & Hornik, 2007), this study found that KAs’ use of the health care system is crisis-oriented: being symptom-free is an indicator of good health, and symptoms are a cue to seek health care. KAs in this study focused on healthy food, regular exercise, and positive thinking to maintain health and prevent cancer, which is consistent with findings of previous breast and CRC screening studies with Chinese Americans and KAs (Choe et al.; Domi Le et al., 2011; Suh, 2008). These findings suggest that KAs support primary prevention (engaging in healthy lifestyle to maintain health and for cancer prevention) but not secondary prevention (having cancer screening).

Regarding unrealistic optimism, based on self-judgment, KAs thought they would be okay because they were eating healthy food, exercising, or had no family history of CRC. KAs did not have an awareness of their vulnerability to CRC. They were overconfident that their chances of developing CRC were lower than that of others, which is different from Americans who had greater sensitivity to and awareness of their vulnerability to illness compared to that of other groups (Dein, 2006). Similar findings have been reported in other studies on cervical and CRC screening among different ethnic groups including Hispanics and KAs that these cancers would not happen to them (Brouse, Basch, Wolf, Shmukler, Neugut, & Shea, 2003; Kim et al., 2004).

Crisis health orientation and unrealistic optimism seem to stem from following traditional values and beliefs including (a) the concepts of Taoism and its methods for cultivating mind and body and harmonizing with nature (Kim, 1999) and (b) Korean traditional medicine including principles of yin-yang (Hong & Heo, 1990). Koreans and some other groups in Asia traditionally believe that disease is caused by an imbalance between two interdependent energies in the body (yin and yang, sometimes characterized respectively as dark/passive/downward/cold and light/active/upward/hot) and that to maintain health and prevent disease, a balance needs to be achieved such as by eating healthy foods or cultivating the mind (Kendall, 1988; Kim). Because of these Korean cultural patterns, beliefs and behavior, KAs are more likely to be familiar with primary prevention than with secondary prevention.

This qualitative study had limitations. Generalizability may be limited because this study used a voluntary, convenience sampling method with KAs in Chicago. Therefore, the findings are limited to the specific time and place—January to February 2010 in Chicago—and should not be considered representative of the entire population.

Despite this limitation, practical suggestions can be made. The findings could be used for health care professionals to (a) deliver
messages with accurate health information about CRC, (b) consider KAs’ beliefs about family and doctors’ influence on their beliefs and on behavioral change, (c) educate KAs in order to increase awareness of CRC to change their crisis health orientation and unrealistic optimism, and (d) familiarize KAs with secondary prevention including CRC screening. Also, all five themes describing health and cultural beliefs in this study seem to stem from traditional philosophies (Confucianism, Buddhism, and Taoism) or proverbs. Future research should focus on further investigation of culture-specific beliefs about CRC screening in KAs, because it is essential to examine these beliefs and CRC screening behaviors in order to develop culturally appropriate interventions for KAs. Also, future research could examine beliefs and cancer screening behaviors in populations with similar cultural contexts that were influenced by Confucianism, Buddhism, and Taoism (e.g., Chinese Americans) since they may have similar beliefs as the people in this study.

Conclusion

All five themes emerged in the current study are health and cultural beliefs about CRC and CRC screening that are grounded in traditional oriental philosophies or proverbs. Specific beliefs embedded in traditional Korean culture play a significant role in preventive health behavior including CRC screening in KAs. These unique culture-specific beliefs should be considered in developing culturally appropriate educational interventions to increase CRC screening in KAs.

Conflict of interest

There is no conflict of interest.

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Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese ethnicities.


