practical matters

Comfort in the Arms of God: Resilience or Risk among African Americans Diagnosed with Cancer

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Introduction

She sits in a chair in an examination room with her tie-back gown on, patiently waiting for the physician to come back to the room to relay the results of her mammogram. She had a normal mammogram the previous year, so she did not expect anything different this year. When he returns, he sits in the chair next to her, reviewing her medical chart that is in his hands. He sympathetically looks in her eyes and tells her, "You have Stage 3 breast cancer." He proceeds to tell her about the aggressiveness of her cancer, known risk factors associated with breast cancer, the excess prevalence among African American women, upcoming treatment procedures to which she will need to adhere, and the recommended use of support from her family and friends. As he compassionately provides words of encouragement and support for the journey she is about to take, she tells him with the utmost confidence, "The Lord will make a way, somehow. I put my complete faith in Him to see me through." He awkwardly and uncomfortably smiles and leaves the room without engaging or addressing her profound, spiritual statement.

In the imagined example above, the physician was clearly gentle and caring, exhibiting the type of "bedside manner" most desired in health care providers. However, when it came to the outward expression of this middle-age African American woman's spiritual beliefs, it was difficult for him to understand, interpret, or even respond to what may be the most important support for his patient—her comfort in the arms of God. The physician's discomfort perhaps stems from a lack

Practical Matters, Spring 2011, Issue 4, pp. 1-12.

of training on how to integrate patients' spiritual and physical health needs. Based on his medical training, he most likely sought a traditionally measurable explanation of and ultimate "solution" to his patient's condition. He may have been concerned that her emphasis on her faith would not be sufficient for addressing her needed health behaviors as she copes and survives breast cancer. For the patient, however, her faith invoked a significant sense of spiritual healing.

These issues of spiritual and physical healing are particularly important for practitioners who provide care to African Americans, a population often diagnosed with more aggressive cancers and that is more likely than other ethnic groups to have greater cancer-related morbidity and mortality. Although African Americans are less likely to be screened for and more likely to be diagnosed later with cancer, this is not completely or simply explained by traditional social and economic factors. Spiritual beliefs may have a profound impact on how and when African Americans seek medical care after being diagnosed with a serious disease. Specifically, understanding what these beliefs are, particularly in the context of those who have been diagnosed with cancer, may help generate not only a better understanding of the comfort God brings to them but also innovative treatment strategies and procedures that are more inclusive of these beliefs.

This article provides a review of the relevant literature and suggestions for strategies for providing care that incorporates recent studies on spirituality and healing among African Americans with cancer. There is a substantial and growing body of text on religiosity and health in the health fields. Religiosity in much of these instances has typically referred to dimensions of extrinsic religiosity and religious experiences, such as organized or non-organized religious activity (e.g., church attendance, prayer, or devotional reading), invoking the social aspects of religion.[1] In some cases, dimensions of religiosity have referred to intrinsic religiosity or religious coping.[2] Spirituality, which is frequently described rather than defined,[3] may overlap with dimensions of intrinsic religiosity and religious coping, but these concepts often remain unclear in the context of healthcare delivery. Spirituality, as it will be utilized in this article, is about the "inner life or spirit of each of us as it relates to the unseen world of Spirit or of God."[4] Thus, spirituality as I define it has to do with the search for meaning and purpose in life[5] and is an inner journey toward wholeness and toward God.[6]

In the health literature, there has been an emergence, albeit limited, of studies specifically focused on spiritual beliefs and coping among African Americans diagnosed with cancer. Screening for cancers is indeed paramount to early diagnosis and treatment and ultimately can improve survival. However, by describing the factors associated with diagnosis—in the context of spiritual comfort and coping—we may garner a better understanding of approaches needed to increase screening, earlier detection, and even prevention of cancers in this population. This paper provides an overview of the burden of cancer among African Americans, followed by a brief review of the health literature on spiritual comfort (in terms of religiosity and spirituality) and coping in the presence of cancer among African Americans, with a focus on Protestant Christianity. The aim here is to describe some of the elements comprising spiritual comfort that could subsequently

impact treatment and management of cancer. Based on this review, recommendations for further integration of spiritual beliefs into healthcare practice in this population are provided.

Cancer among African Americans: A Brief Overview

Cancer is the second leading cause of death in the U.S.,[7] and African Americans generally have the highest mortality and shortest survival rate of any racial and ethnic group for most cancers.[8] As of 2005, an estimated 875,000 African Americans were living with cancer. The most common new cases of cancer for African American females are breast, lung, and colon, and for African American males they are prostate, lung, and colon. The leading cause of cancer mortality for both genders is lung cancer, followed by breast cancer for women and prostate for men. Although there has been a reported decrease in racial disparity in cancer mortality rates in the U.S., there are still disproportionately higher rates of cancer among African Americans compared to Caucasians. Rates are 16% higher for African American compared to Caucasian women and 33% higher for African American compared to Caucasian men, despite the faster decline in mortality rates for African American compared to Caucasian men in prostate, lung, and other smoking-related cancers. Most of the studies on African Americans and cancer have been in the area of breast cancer in women, who more commonly exhibit more aggressive forms than Caucasian women.[9]

Since the 1960s, the overall five-year relative survival rate for all cancers has dramatically improved. Despite this progress, African Americans remain less likely than Caucasians to survive five years at each stage of diagnosis. These racial differences are thought to be due to barriers that prevent timely and high quality medical care, resulting in a later stage of diagnoses and disparities in treatment.[10]

Risk factors believed to contribute to the racial disparities in new cancer cases and mortality that disproportionately affect African Americans are socioeconomic status, tobacco use, excessive weight, lack of physical activity, and failure to make use of screening tests.[11] Lower socioeconomic status is associated with greater amounts of new cancer cases and cancer mortality independent of race. However, those who are African American and have lower socioeconomic status are at greater risk. Smoking is the most preventable risk factor for cancer, yet it is responsible for one-third of all cancer mortality. Despite a reduction over time, a higher percentage of African American males are smokers compared to Caucasian men and to women. Obesity and lack of physical activity are associated with many types of cancers. African American women are most likely to be overweight or obese and physically inactive.[12] Screening is important for the prevention of cancer; through early detection, precancerous lesions may be treated, and cancers may be spotted while they are still curable. Despite some improvements, African Americans are much less likely to get screened, leading to a later diagnostic stage of cancer and premature mortality.[13]

Given these health disparities, numerous social, political, and medical activities have been undertaken to find ways to reach African Americans with cancer to reduce the burden, improve

quality of life, and extend years of life. What has not been discussed much in health literature is whether or how factors such as faith in God may help to improve the condition and quality of healing and life of African Americans diagnosed with cancer.

Religiosity: Coping and Cancer Among African Americans

Religion is often studied as a mechanism of social integration.[14] Religious group ties may provide emotional, cognitive, and material support, fostering the individual's perception that she is cared for and esteemed. For African Americans, this is particularly the case. The Church is the oldest and most recognized institution in African American communities.[15] More African Americans attend church than any other ethnic group in the U.S.[16] A location of worship and fellowship, the church environment can serve as a place of healing, particularly if other environments hinder wholeness and, ultimately, health.[17]

On an individual level, religion[18] has long been identified as a coping mechanism for those faced with adversity because it offers an explanation for adversity and suffering.[19] For African Americans, evidence suggests that intrinsic religious practice (in the context of coping and consolation) has a positive effect above and beyond social support. With respect to cancer, this can be essential to physical longevity as well as quality of life.

Studies of the role of faith in God in the context of coping with cancer among African Americans are extremely limited; this is even more the case for studies on the relationship of spirituality and survival. In a qualitative investigation by Hamilton et al. of twenty-eight African American breast and prostate cancer survivors' perceptions of their personal relationship with God, they found their connection with God to be very intimate, close, and real.[20] These participants, who were on average over sixty years of age, believed that God provided them with internal support that was not available through family and friends. This finding was consistent with a study by Henderson and Fogel of forty-three breast cancer survivors participating in support groups.[21] The relationships identified by Hamilton and colleagues brought a sense of hope and comfort through access to power and resources in circumstances where there was little or no control. The level of peace actively received in such a relationship was deemed very important. Additionally, they believed that God allowed them to survive and that, by receiving God's support, they were able to serve others. Serving others may mean that they are still valued as life contributors, which may be essential to improved and extended survival.

In another qualitative study of how twenty-three African Americans use spirituality in coping with cancer,[22] Schultz et al. used a model of connectedness to self, others, a higher being, and the world. Although they found that participants felt such connectedness, including that with God and others, they found that connections with others were not always positive—i.e., some who did not understand their journey with cancer did not know how best to connect with them and were detrimental to their well-being. Participants had the desire to share their story of survival with others

and, through their experience, found a new self-understanding.

There is also evidence that spirituality can generate a resilience that results in positive outcomes among African Americans with cancer. A recent study by Gullatte et al. investigated religiosity, spirituality, and fatalism among African American women delaying breast cancer diagnosis.[23] In their investigation of 129 African American women who self-reported detecting a symptom twelve months before a breast cancer diagnosis, the mean time of delay for seeking medical care was five and one-half months. Those who were less formally educated, unmarried, and those who prayed about their diagnosis instead of talking about it with someone were significantly more likely to delay seeking medical care, whereas those who told someone in their support network were more likely to seek medical care sooner. Hamilton et al. developed a new survey, the Ways of Helping Questionnaire, to understand relationships and preferred coping strategies among 385 African American cancer survivors.[24] Analysis of this eighty-one-item survey produced ten subscales: 1) others there for me; 2) physical care and treatment needs; 3) help from God; 4) church family support; 5) helping others; 6) being strong for others; 7) encouraging my healthy behaviors; 8) others distract me; 9) learning about cancer; and 10) distracting myself. Significantly, this study found that, out of all ten subscales, "help from God" was the only one associated with positive effects on physical and mental health.

Studies by Holt et al.[25] and Djuric et al.[26] represent some of the most recent work in the literature on religiosity, spirituality, and coping among African Americans diagnosed with cancer. Holt et al., in a qualitative assessment, evaluated how twenty-three African Americans use religiosity in coping with cancer. Representative themes included control over one's illness; emotional response; the importance of social support; the role of God as healer; relying on God; the importance of faith for recovery; prayer and scripture study; and making sense of the illness. Although these themes may seem to overlap, the participants clearly identified distinct actions in each that reflected some element of healing and strength. As a result of this and previous work, Holt et al. developed and validated a way to assess religious involvement and coping. Corresponding with their previous work and that of Henderson and Fogel, they found that the belief in God as a necessary source of support, independent of others, was central to gaining control during the uncertain circumstances that are present after a cancer diagnosis.

Discussion

This brief review sought to describe the current state of the literature on spiritual coping among African Americans diagnosed with cancer, with particular focus on the role that "belief in God" plays in coping with cancer diagnosis and treatment. This topic is particularly important because of the burden of cancer on the African American population in the United States. More insight into the factors that may contribute effective ways to reach the population in order to increase survival is continuously needed. As the review of this literature has noted, many African Americans with

cancer experience some type of relationship with God. More research is needed in order to understand the best ways to successfully reach this population.

That ways in which what I call "comfort in the arms of God" may contribute to resilience (survival, improved quality of life) or risk (delay in seeking treatment, pre-mature mortality) among African Americans diagnosed with cancer are complex. Although each individual's journey to the point of diagnosis and beyond is unique, what is apparent from this brief review is that there exists for many African Americans with cancer a relationship with God or a divine being that supports, protects, strengthens, and provides care. Support from God, as it was defined in the literature, in most cases was distinctly different and sometimes independent from support from family and friends. One of the reasons why cancer diagnoses evoke such serious feelings and emotions is that we cannot easily explain them. Support from family and friends is very important and can provide the basic emotional, instrumental, psychological, financial, physical, and informational resources needed for functional everyday living. However, spiritual support, like that provided through an intimate relationship with God (as described by participants in these studies), may foster a sense of control (e.g., "the Lord will make a way, somehow"). Although more research is needed, it is plausible that the concept of control in cancer diagnosis is the pivotal point when one proactively reaches out to seek the tools needed to promote survival.

Drawing on the review presented here, there was evidence that by relying on God for support and healing, communication by African American cancer survivors with those in their support network, whether through sharing their experiences or serving others, provided a sense of empowerment. This may conceivably be a teachable moment for those willing to reach out. However, there are others who internalize their experience when diagnosed, expressing sole reliance on their belief in God, without ever taking any personal action to use available adjuvant therapy, gain knowledge on alternative therapies, or call on others in their social network for some type of support. This group of survivors may be the ones at greatest risk of advanced symptoms and premature mortality, leading health providers who do not understand this type of faith to dismiss it rather than working to understand the validity of these beliefs and how to use them as a springboard for dialogue and open exchange of ideas that promote the survivor's use of treatment. Findings from this brief review imply that there are qualitative questions and measures asked of small samples of survivors that may need to be considered as tools of communication by healthcare providers delivering clinical services or even healthcare professionals implementing interventions.

Sheppard et al. recently developed a decision-support intervention for African American women with breast cancer.[27] The authors conducted in-depth interviews with thirty-four African American survivors between thirty-eight and sixty-nine years of age to understand the context of the experiences of adjuvant therapy. This information, which included comments on spiritual coping, peer survivor-sharing, and feelings of unpreparedness to ask or discuss treatment options, was used to inform intervention messages for an in-person communication skills training and decision support intervention. Materials were reviewed by both the lay health professional and patient

communities before implementation. Results indicated that survivors felt better prepared to talk to providers. This may have profound implications with survivors who may be traditionally considered "hard-to-reach."

In another intervention, Djuric et al. also extend the area of decision-support counseling through a weight-loss intervention in thirty-one African American women with cancer who are offered adjuvant therapy. The goal of the intervention was to enhance patient-provider communication through the use of an eight-step phone spiritual counseling program for deciding whether or not to use adjuvant therapy. Women were randomly selected to receive the counseling or not. Results indicated that women who reported good patient-provider communication were more satisfied with their treatment decisions and more knowledgeable about adjuvant therapy. Furthermore, those who received spiritual counseling lost slightly more weight than those who did not receive the counseling, indicating that spiritual counseling has some clinical benefit. These types of interventions are essential, particularly since providers, as in the story in the introduction, may be unwilling to talk about feelings, religion, or spirituality when patients are facing major life situations such as cancer.[28]

Recommendations

From a *health care practice perspective*, health professionals need to continue on the path of improving lines of communication to understand how African Americans posed with a clinical diagnosis of cancer practice their faith in the context of their health. Despite evidence suggesting that providers may still have a difficult time relating to African American patients' faith, there is also evidence that improving communication is possible. Considering the whole person, particularly for African Americans, requires all four dimensions of personhood: physical, psychological, social, and spiritual.

Regarding resilience and risk after being diagnosed with cancer, it is plausible that African American patients who exhibit resilience may use spiritual coping to proactively identify solutions to help them develop or improve health behaviors that promote survival (i.e., actively partnering with God to be delivered from illness), whereas those who exhibit risk may use spiritual coping to manage the increased complexity of life's post-diagnosis challenges, thereby leading to a reactive solution (i.e., waiting on God to deliver them from illness). In either instance, the willingness and ability to communicate effectively with them in the context of their daily living are essential. In the case of the physician in the introduction, although he apparently has a good rapport with the woman, he could improve his faith communication skills by respecting and fostering discussion of what she needs at the time of diagnosis—acknowledgment of the importance she places on her faith in God.

Consider another ending to the story I offered in the introduction: While reviewing his patient's current test results in his office, the physician also reviews her medical records and sees that

she is consistent in getting screened and seeking healthcare. He also notices that she is married, has two teenage children, is fairly consistent in engaging in healthy lifestyle behaviors such as good nutrition and regular exercise, and is affiliated with a local church. He is now equipped with contextual information to help him effectively communicate with her. He comes back to the exam room to tell her that she has Stage 3 breast cancer. When she says, "The Lord will make a way somehow. I put my complete faith in Him to see me through," instead of walking out of the room without addressing her statement, he remains seated next to her and says, "I see that your faith is important to you. Thank you for sharing. That means a lot to me as your physician. How can we work together to help make that way?" The physician's empathy might begin a different type of dialogue, such that the woman, who exhibits signs of resilience, feels that she has been heard and is ready to discuss options for care and solutions for treatment.

In a second imagined scenario, the physician reviews his patient's medical records and notices that she is married with two teenage children but has *not* been consistent in getting screened for breast cancer annually. Her records also do not indicate any pattern of lifestyle behaviors or any church affiliation. In this case, when he returns to the room to tell her that she has Stage 3 breast cancer and she says, "The Lord will make a way somehow. I put my complete faith in Him to see me through," his response is, "Thank you for sharing. That means a lot to me as your physician. Is there a way we can work together to see you through this?" The woman hesitates, then responds, "I came here because my church made an announcement about getting a mammogram. I put *all* my trust in God, not man. So I am not claiming this cancer." The physician, sensing reluctance on the woman's part to trust healthcare professionals and engage in treatment behaviors replies, "I completely understand. We should not have to claim any cancer. My role is to use my gifts to give you the best health information I can provide and help you get what you need in terms of healthy living. As your physician, I will do my best to give you the best health advice I can provide. Would you be willing to discuss some possible next steps with me?" The woman replies in the affirmative and is willing to listen to options and even make suggestions on how she can successfully carry out treatment behaviors. Again, through empathy the physician is able to connect with the woman who exhibited signs of risk through her initial reluctance to engage in discussions of treatment. By doing so, he demonstrates respect for her role in her own health, rather than communicating an authoritative perspective that implies less control for her in her life.

In both of these scenarios, the woman professed her faith in God in a time of cancer diagnosis. Key to the physician's communication strategy was his ability to take time to review her medical records, listen to her faith-based post-diagnosis response, reply from a stance of connectedness, and then discuss plans of action for treatment. Although more research is needed, given this literature review, it seems that these steps may be necessary to reach African Americans more effectively from a healthcare perspective.

Finally, although not referenced as often in the literature, the role of clergy in the promotion of health for African Americans faced with cancer is important to consider. Clergy, unlike healthcare

providers, often have a more contextual view of the survivors' lives, making them important in this process of communication. This relationship between clergy and patient is evident in the mental health literature.[29] Regarding cancer diagnosis, African American cancer survivors, and possibly more so African American male cancer survivors, may be more comfortable beginning discussions on cancer-related health issues within the walls of a pastor's office than within those of a provider's office. Thus, *patient-clergy-provider* communication models should be considered. Providers and clergy could partner in everyday healing practices rather than concentrating on special healing services.[30] For example, physicians can encourage patients to identify ways in which their faith support networks can provide help. They can also point a patient to those in the healthcare system that can provide resources that she can use to connect her faith with her treatment behaviors.

Reliance on God for comfort, healing, and understanding when diagnosed with cancer can be paramount. This may particularly be the case for African Americans, who overall have disproportionately higher rates of new cancers and cancer mortality compared to other ethnic groups in the U.S. The emerging, yet limited, body of literature on spirituality and comfort among African Americans diagnosed with cancer indicates that reliance on God as a source of spiritual coping has been associated with positive treatment behaviors and improved survival (resilience). However, it has also been associated with delay in seeking treatment (risk). For some, support received from God can bring a sense of sharing and serving. There is a growing need for health professionals to understand how these relationships can benefit efforts for treatment, recovery, and survival. If African Americans with cancer who have faith in God believe that they have not been understood by the healthcare system, relationships between patients and providers must be transformed through empathic methods of communication. Drawing on these healing practices can begin to transform risk to resilience, simply through practices of listening to those who find "comfort in the arms of God."

Endnotes

Acknowledgements: This work was supported by a grant from the National Cancer Institute, R01CA142081-01A1.

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