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Religion, spirituality, coping, and resilience among African Americans with diabetes

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Abstract

Study aims were to explore how religion and spirituality impacted attitudes about self-management practices among African Americans with homelessness histories and to understand resilience in diabetes care practices. Qualitative semi-structured face-to-face interviews were conducted with 42 African Americans older than 18 years. All audio-taped interviews lasted between 1–1.5 hr, transcribed verbatim, and analyzed using ATLAS.ti (version 7.0). Five resilience themes emerged. While participants recognized diabetes as an illness requiring professional treatment, the context of balancing treatment with religion and spiritual practices mattered. The study findings highlight the importance of spirituality, religious beliefs, and coping strategies in diabetes self-care activities.

Keywords

diabetes; African Americans; religion; spirituality; coping; resilience; qualitative research

Type 2 diabetes represents a chronic disease that heavily relies on individual self-management behaviors which might be influenced by an individual's determination, cultural factors (Collins-McNeil et al., 2012), socioeconomic status, environmental issues, and familial problems (Hill-Briggs, Gary, Hill, Bone, & Brancati, 2002; Hill-Briggs et al., 2011). Managing diabetes is burdensome due to the complexity of maintaining and monitoring daily activities, such as exercise, diet modification, and medication adherence (American Diabetes Association, 2015). While it is important "to individualize self-management practices based on relevant medical history, age, cultural influences, and diabetes knowledge," it is equally important to support an individual's attitude, life context, and health beliefs in order to achieve lasting improved health outcomes (Funnell et al., 2012, p. 91).

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One life circumstance practitioners do not anticipate when developing and intervening with people diagnosed with Type 2 diabetes is past experience with homelessness. Individuals who have experienced homelessness are more likely to be diagnosed with multiple chronic illnesses (Hwang et al., 2011; National Health Care for The Homeless Council, 2011). According to the National Alliance to End Homelessness (2018), an estimated 553,742 people in the United States experienced homelessness on any given night in 2017 where many lived in some form of transitional housing (360,867 people; p. 1). By extension, many people served in the social service system will likely have had experience with unstable housing. Studies have reported that when housing is stable for people who were homeless, health outcomes improved (Bonin et al., 2010; Fitzpatrick-Lewis et al., 2011; Henwood, Cabassa, Craig, & Padgett, 2013; Hwang et al., 2011; National Health Care for The Homeless Council, 2011). For example, California implemented the largest increase in permanent supportive housing capacity since 2007 with 33,049 beds (National Alliance to End Homelessness, 2018). No specific statistics were offered in the report to distinguish those diagnosed with diabetes from any other health condition. However, the National Health Care for the Homeless Council claimed, “Housing and health care work together [as each] are essential components to preventing and ending homelessness. Health care services work better when a patient is housed,” (National Health Care for the Homeless Council, 2011, p. 3).

Although studies repeatedly show that housing improves health outcomes among homeless people, clear explorations on culturally relevant factors that can affect health-related perceptions and self-care behaviors among African Americans who are in transition from homelessness to permanent supportive housing remain lacking in the literature (Henwood et al., 2013). Religion and spirituality may serve as two connections that deserve more scientific exploration because of their cultural importance and potential relevance to support Type 2 diabetes symptom management (Unantenne, Warren, Canaway, & Manderson, 2013). Dhanani (2011) argued that little is known about religious faith and the impact on treatment among homeless individuals as well as those who find shelter. The role of religion and spirituality could help in diabetes self-management practice education given the generally accepted cultural aspects of the African American experience and past research studies have not explored their relevance among this vulnerable population.

Purpose of the study

In the present qualitative study, responses to semistructured interview questions were analyzed in order to explore how religion and spirituality impacted attitudes about diabetic self-management practices among African Americans with homelessness histories and to understand resilience in diabetes self-care practices. We were especially interested in advancing a theoretical understanding of how the impact of performing new responsibilities in being housed would affect perceptions of self-management behaviors. The expectation is that study findings will inform intervention programs and enhance well-being among this population. It is also hoped that the study findings will inform practitioners about the importance of culture and culturally informed practice behaviors so that Type 2 diabetes self-management activities among this population might achieve greater adherence. This study fills a gap in knowledge because little is known about how spiritual and religious

beliefs and practices affect diabetes self-management among African American adults who have had histories of long-term homelessness.

Theoretical framework: coping and resilience in managing health outcomes

The study uses the theory of stress and coping as one of its theoretical foundations (Aneshensel, 1992; Lazarus & Folkman, 1984; Neff, 1985; Neighbors, 1986; Pearlin, 1999; Thoits, 1995; Turner, Wheaton, & Lloyd, 1995). Stress arises when individuals perceive a difference between the physical or psychological demands of a situation and the resources (coping) of his or her biological, psychological or social systems. Diabetes is a critical and ongoing life stressor for people in general, but it is hypothesized to be more stressful for people relearning life management and healthy behavior skills (Shah, Gupchup, Borrego, Raisch, & Knapp, 2012). The U.S. Interagency Council of Homelessness states that when formerly homeless people transition into new housing, many experience difficulties due to a lack of social and self-management skills ("Critical Time Intervention," n.d.). Moreover, these individuals experience many personal and medical barriers. Davachi and Ferrari (2012) report that newly housed diabetic individuals with homelessness histories typically experience barriers such as making diet choices, limited access to medication and glucose monitoring supplies, and seeking care from a primary care physician. Other studies suggest a strong correlation between one's negative appraisal of diabetes and diabetes-related self-management stress (Carey et al., 1991; Fisher, Glasgow, Mullan, Skaff, & Polonsky, 2008) where coping psychologically and behaviorally become deeply embedded in past experience with the larger health system access points (Folkman, 2010). Folkman (2010) argued, "Hope in turn can sustain coping …" (p. 907). The present study argues that religious faith represents a significant cultural factor that promotes hope, a positive emotion-focused response, which can be useful to practitioners and African Americans that have had homelessness histories, newly housed, and are diabetic, in improving health behaviors.

Diabetes self-management standards

It is unclear if the standard self-management protocol for Type 2 diabetes is useful to African Americans who are newly housed after more than 1 year of homelessness.

Diabetes self-management education remains a critical element for care to promote healthier outcomes (Center for Disease and Prevention, 2014). Quality diabetes self-management includes knowledge, skills, and abilities necessary for improved health and quality of life. The evidence-based standards incorporate the needs, goals, and life experiences of the person with diabetes; however, the transition in demands of survival from being homeless to being housed are never considered in the guidelines. Embedded in the standards is the assumption that all people have similar experience and connection with the health care system. The standards support informed decision making, self-care behaviors, enhance problem solving, and collaboration with health care professionals (Funnell et al., 2012; Rovner, Casten, & Harris, 2013).

Theoretically, the seven domains thought to predict good health outcomes and support sustained diabetes self-management behaviors include: (a) healthy eating, (b) being active, (c) monitoring blood glucose, (d) taking medications, (e) good problem solving skills, (f)

healthy risk-reduction behaviors, and (g) healthy coping skills (Collins-McNeil et al., 2012; Funnell et al., 2012; Shrivastava, Shrivastave, & Ramasamy, 2013). Religion and spirituality do not appear among the important diabetes self-management behaviors which might enhance balance, awareness, and mindfulness toward wellness. The present study sought to explore how religion and spirituality impacted attitudes about self-management practices taking into account culture.

African Americans, type 2 diabetes, and spirituality/religion

African Americans are disproportionately affected by diabetes, when compared to other racial groups (Chlebowy, Hood, & Lajoie, 2013; Collins-McNeil et al., 2012; Namageyo-Funa, Muilenburg, & Wilson, 2013) and hold lower adherence to Type 2 diabetes self-management recommendations especially when low socioeconomic status is taken into account (Hill-Briggs et al., 2011). Lower adherence to Type 2 diabetes self-management recommendations typically leads to higher morbidity and often for African Americans, lower life expectancy. The literature shows that although African Americans have made significant gains in life expectancy, and the mortality gap between Whites and African Americans has been cut in half since 1999, life expectancies remain lower for African American men (72.3 years) and women (78.5 years) compared to White men (76.7 years) and women (81.5 years; USA Life Expectancy, 2016).

Religion often refers to “an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent and to foster an understanding of one’s relationship and responsibility to others,” while spirituality is defined as “the personal quest for understanding answers to ultimate questions about life, meaning, and relationship to the sacred or transcendent,” (Lundberg & Thrakul, 2013, p. 1908). Religion and spirituality are often used as distinct but overlapping concepts in many studies (Dancy II, 2010; Lundberg & Tharkul, 2013). In the spirituality and health literature, spirituality is broadly defined with concepts of “transcendence, meaning, hope, and connectiveness,” (Unantenne et al., 2013). Based on these broad concepts of spirituality, researchers have sought to explore the role of religion and spirituality among diverse populations with chronic illnesses and life struggles. Religion and spirituality are deeply embedded in African American culture and tradition (Moore-Thomas & Day-Vines, 2008).

Spirituality and religion play important roles in many African Americans lives as they regard their health. Researchers have used multiple approaches to measure the role of spirituality and religion on health outcomes. In addition, researchers have studied the amount and type of influence spirituality and religion play on the association between coping and Type 2 diabetes; spirituality and religiosity emerged as important factors in maintaining general health and coping with disease (Samuel-Hodge et al., 2000). Spirituality and spiritual practices also have been found to positively influence Type 2 diabetes management, follow-up care, general health, and overall well-being (Unantenne et al., 2013), as well as indicate a positive association with improved health outcomes (Gupta & Anandarajah, 2014; Namageyo-Funa et al., 2013; Quinn, Cook, Nash, & Chin, 2001; Unantenne et al., 2013; Utz, Steeves, Wenzel, Jones, & Mupby, 2006). It appears that religious faith, meditation, prayer, and religious service are used by many African Americans as mechanisms to cope

with stressors caused by diabetes (Belcher, 2003; Jones et al., 2006; Shuler, Gelberg, & Brown, 1994). Moreover, many African Americans believe God plays a significant role in diabetes treatment, and supports individual self-management practices (Polzer & Miles, 2007). Spirituality, therefore, helps maintain hope, motivation, and cope with stigma associated with psychological well-being (Belcher, 2003; Snodgrass, 2014).

Resilience and type 2 diabetes

Resilience can also serve as an important personality characteristic for African Americans living with diabetes. It represents an emotional strength and capacity to respond to life challenging circumstances in an effective way (Wagnild, 2010). Since resilience is a multifaceted and multidimensional concept, there is no consensus among researchers on one definition (Manning, 2013). Broadly, resilience is defined as one's capacity to successfully adjust and adapt to adversity (DeNisco, 2011; Manning, 2013). DeNisco (2011) defined resilience as "the ability to achieve, retain, or regain a level of physical or emotional health after devastating illness or loss" (p. 105). Wagnild and Young (1990) reported that resilient older women were more capable of integrating life difficulties, maintaining balance after a major loss to their lives, and continuing to enjoy their life purposes. Although not studied specifically, the Wagnild and Young (1990) findings can be projected to serve as a personal strength for men and African Americans given abilities to stay positive, hopeful, and willing to enhance personal control in handling life adversities (Steinhardt et al., 2015). Both religion and spirituality represent significant resilience factors for people living with life difficulties (Pargament & Cummings, 2010). By extension, several studies reported that resilient individuals had better diabetes control (DeNisco, 2011), higher levels of positivity, and lower levels of depression (Steinhardt et al., 2015).

Five themes of resilience emerged from Wagnild and Young's (1990) study which can serve as a theoretical foundation to explore the role of religion and spirituality in Type 2 diabetes self-management practices in the present study. The substantial literature on resiliency has progressed to the point where applications to unique populations are possible. Because there are multiple pathways to understand resiliency, the themes must be explored in the context of culture, life experience, and life integration. In the absence of clear guidance in the literature for African American individuals with homelessness histories, utilizing the following listed themes to understand which components will be important in detecting resiliency among a unique vulnerable population.

(1) Equanimity: A balanced perspective of one's life experiences.

(2) Self-reliance: A belief in one's self and one's capabilities and finding the inner resources and confidence to manage life despite adversity.

(3) Existential aloneness: The realization that each person's life path is unique; a source of creativity, comfort, self-acceptance, and sense of uniqueness.

(4) Perseverance: The act of persistence despite adversity or discouragement.

(5) Meaningfulness: The realization that life has purpose and to value one's own contribution (Wagnild & Young, 1990, pp. 253–254).

In sum, it can be argued that both coping and resilience may be most useful as a singular framework for guiding inquiry and understanding the cultural use of religion and spirituality in diabetes self-management activities. Few studies have explored the relationship between resilience and diabetes self-management among African Americans, in general, and we have discovered no study which has explored religion and/or spirituality as a resilient factor to improve self-management behaviors specifically among diabetic African Americans with homeless histories.

Methods

Participants and data collection site

Participants were recruited from an urban integrated medical and psychiatric services clinic in California that specializes in providing treatment to low income and vulnerable populations. The study researchers did not plan to recruit participants who were newly housed, had homelessness histories, or not enrolled in health insurance. Data collection began at a time in United States history that presented a unique opportunity that cannot be replicated due to the timing of the implementation of health insurance enrollment as mandated by the Affordable Care Act. Study participants included 42 African American adults older than 18 years receiving services for diabetes management. Self-reporting as African American or Caribbean Black, being a current clinic client and receiving a Type 2 diabetes diagnosis represented the inclusion criteria. The case management team member assigned to this study corroborated each participants' inclusion criteria and informed the researchers that participants had previously been homeless. Individuals were excluded from study participation if his or her age was below 18 years, self-identified racially beyond the scope of the study, and actively used illegal substances that impaired decision making. The research study was reviewed and approved by the University at Albany Institutional Review Board.

Procedures and materials

Design—Semistructured face-to-face interviews were conducted to explore the role of religion, spirituality, and resilience in coping with diabetes among African American adults. Face-to-face interviewing allowed participants to offer depth, richness, and cultural interpretations of health behaviors (Creswell, 2013).

Data collection procedures—Convenience sampling was used for data collection. Flyers publicized the study in the clinic to solicit volunteers. After a potential participant indicated interest, the research team screened for inclusion criteria and an interview session was scheduled. Semistructured face-to-face interviews were conducted in a room with few distractions in order to maintain control over the interview, increase confidentiality, offer the participant the ability to concentrate, and increase communication between the research interviewer and participant. The interview questions were standardized, worded to elicit a narrative-style responses, and the interviewer was instructed to probe or clarify responses when appropriate. Participants were asked to verbally share his or her thoughts about demographic background characteristics, physical health, personal experiences with

diabetes, depression or the comorbidity, his or her cultural beliefs about illness, religion and spirituality. Specifically, participants were asked:

1. Describe the role religion or spirituality plays in your life
2. How has your health affected your experience of religion or spirituality?
3. After diagnosis, how has your connection to spirituality or religion changed?
4. Describe ways your faith have helped you manage your illness?
5. What beliefs or practices help you manage your illness?

Data analyses

All semistructured interviews were audio-taped and transcribed verbatim. Collected data were divided into two data analysis programs to represent both quantitative and qualitative responses. The descriptive demographic data was entered into STATA (version 13) for univariate and bivariate analysis. The transcribed interview data were imported into ATLAS.ti (version 7. 0) for qualitative data analysis to develop themes. The text was reduced to major themes or concepts that had meaning to the study topic. Analysis of the transcripts focused on themes resulting from discussions of illness, cultural ideation of illness, and medical health management. Items were developed and organized based on prior research findings in the literature review and the Manual of Spirituality Assessment Tools by Boyds (1998). Certain questions implied predetermined categories such as religious/spiritual practices and beliefs that help them manage health. Most codes were largely developed from the raw data.

Prior to formal analysis, two researchers independently read the verbatim transcribed transcripts several times to identify the significant topics discussed. The researchers then met and discussed the identified and constructed single list of topic codes, and reconciled any differences in the codes discovered by each researcher. Again, they independently evaluated the created codes and agreed on a final code list by creating a revised codebook. They applied the codebook to the full set of verbatim transcripts by using the ATLAS. ti (version 7.0). Codes were scrutinized, expanded, altered, or discarded to develop the most comprehensive and accurate analysis before being categorized into higher-order themes and subsequent subthemes. After discussing whether textual evidence supported each theme properly, the researchers finalized themes with agreement. To ensure consistency, raters re-examined the established hierarchies for reliability and concluded that all relevant data had been well represented. The research team additionally sought consultation from the assigned case manager to learn if conclusions were representative of the participants' experience. Asking for the case manager's opinion represented an attempt to reduce inaccurate interpretations, and increase validity to the analysis process.

Results

Descriptives

The sample demographic information is presented in Table 1. Forty-two African American adults ranged in age between 28 and 71 years (mean age = 53.5 years). Women represented

the majority of the sample (n = 23; 55%) compared to men (n = 19; 45%). The majority of the participants were never married (n = 25; 59%). Few participants were divorced or separated (n = 15; 36%) and two participants were widowed. On average, reported annual incomes were less than $9,400 and more than half were high school graduates (55%). The majority of the participants indicated being permanently disabled and not employed (55%).

Themes

The significance of religion/spirituality in health management

Religious upbringing.: When the interviewers asked the participants about the role of religion and spirituality, statements were commonly initiated with memories of religious upbringing and descriptions of the significance of their religion and spirituality in life. Religious upbringing included any participant statements about when they grew up or experienced any form of organized religion in their early ages. In addition, religious identification included any reference to a religious affiliation or denomination such as Catholic (n = 2), Christian (n = 10), Baptist (n = 6), a combination of Methodist and Baptist (n = 1), Buddhist (n = 2), and atheist (n = 2). The remaining 19 (45%) people did not mention any specific type of religious affiliation. Among the identified religious categories, protestant Christians were the most dominant in the group. There were two African Americans who identified themselves as Buddhists and engaged in Buddhist practice such as zazen or silencing the mind. Only two instances revealed that participants were not committed to any religion. Many participants were fairly familiar with one form of a structured religious community due to being raised in the church. The following comment offers an example of how participants described their religious/spiritual background and identity:

> I had a strong Catholic background growing up. I was in private school up until the 8th grade. My grandparents were very religious. My mom kind of trailed off with it, but still exposed me to everything. I would say that at this point it's definitely more of a spiritual being that I have a lot of metaphysical beliefs, alternative medicine beliefs, that type of thing. And I think that that all goes into my spirituality, just my own church, you know. And that keeps me grounded, something inspirational reading-wise or even whatever, it may be meditation, that type of thing. (43, female)

Religion/spirituality as a source for health and mutually connectedness—Study participants viewed religion and spirituality as an important component of life. Half of the participants (n = 21) reported that religion and spirituality played a significant role in their lives. Four participants described religion/spirituality as a life priority. For example, a 56-year-old female stated, "Religion/spirituality should be at the forefront [of her life]." Religion and spirituality were viewed as significant sources for health because of inherent understandings about the reciprocal relationship between religion/spirituality and their physical and mental health. The health effects religion and spirituality provided were also understood. Half of the participants (n = 21) stated that their current health affected their experience of religion and spirituality after diagnosis. Participants shared that after diagnosis they became "more spiritual" and felt "closer to God." Nine participants reported that

diabetes and other comorbid conditions increased their faith in God. The following statement is an example of the connectedness participants' related as religion/spiritualty and health effects.

> That's the most important thing to me no matter what. That's all I ever wanted, because I want to serve God and be right with Him… . He [God] is the most important. He is the first. I think the lack of religion and spirituality made my health bad. But the more religion and spirituality I become, the better my health become. But I'm glad I'm not like I used to. I used to drink all the time going through that, but now I don't desire for that … It [diabetes] made me more spiritual because I had to pray thing off of me. (49, male)

In sum, the participants' religion/spirituality was anchored in understanding that God resided in him or her. Embracing religion and spirituality made it possible for study participants to feel connected with everyday living. Participants viewed religion/spirituality as an important component for living a healthy life, and believed that a positive connection between religion/spirituality and health promoted growth in a reciprocal manner.

Interconnectedness and interdependence of coping, hope, and faith

Coping, hope, and faith were found to be interrelated and interdependent in the data analysis. Participants understood his or her religious faith and hope as a spiritual coping strategy. The participants' hopeful and positive mindsets were derived from their religious/spiritual faith. The religious/spiritual faith in which each person believed that God would heal them, increased hope for better health outcomes. The following comments exemplify how faith and spiritual coping are mutually connected.

> It's given me faith. In the beginning the doctors weren't giving me, I think, a complete diagnosis of my illness. I don't even know if they knew, but I believed that I would get through it. I have faith. I have faith that the Almighty wouldn't let me down now. (61, male)

> Well, I just keep faith in that I will get better, or that I don't get worse. I just have faith. And it has gotten better. I'm still here. (59, female)

The following statement illustrates how spiritually helps participants cope with their illness based on hope. "Just being positive, you know, having hope, having faith in whatever it is that it's going to get better, that I can get better, that I can do better and that I have control over it" (42, female).

In sum, faith in God sustained each participants' hope for healing and supported their expectations for better health outcomes. Religion and spirituality enabled the participants to maintain and promote their willingness to cope with diabetes despite hardships in treatments and self-management practices.

Resilience

Study participants strongly emphasized that their religion/spirituality enhanced their resilience to cope with their Type 2 diabetes and to effectively respond to their chronic disease with a positive mind and hopeful attitude. Resilience represented an emotional

strength and capacity to reinterpret and respond to challenging life circumstances. The five resilience themes developed by Wagnild and Young (1990) were applied to the data. Transitioning from being homeless to being housed required a whole collection of individual decisions that were based in resilience. The data offered insight into the study participants' inner strengths for wanting to live healthier with Type 2 diabetes based on the role of religion and or spirituality.

Equanimity—Religion/spiritualty helped the participants to maintain a balanced perspective of their life experiences in spite of adversity. Since Type 2 diabetes is a chronic disease that requires consistent care and adherence to treatment plans, the sense of equanimity represents an emotional strength that supports a strengths-based mindset in order to respond to diabetes related stressors. The following quotation offers a brief depiction of how one's religious and spiritual belief enhances a sense of equanimity.

> … Yes, I give thanks to God for every day, especially when I was homeless. I got my little place what I have now and I just thank God for this every day. I look at the people out there and I used to be that way and I thank God for that. (60, male)

The 60-year-old male participant recalled his life in the street as a homeless man and expressed being grateful to God for the apartment and daily life existence. Although the participant must continually manage diabetes, he maintained a positive and balanced perspective on daily life beyond his homelessness experience and his faith in God. The following quote also serves as an example of how religion and spirituality affects one's sense of equanimity.

> He [God]'s the most important, He's first. Then the family, then being able to take care of one, you know what I mean? However you want to take care. But that's the order. And I'm happy. My happiness would be within Him. I want to walk into a doorway, everybody loves me and I love everybody. And when I'm at peace, then my body is at peace. I start doing things, I start going to church or wherever I need to go to worship, exercise, time for this and that. There's order in my life. And I wanted that, and I said that I … but it didn't go. That's first. Sorry, I don't know what I want. I do what I want. Just it's going to take some time. But, in the meantime, I don't want to spend my time just feeling sad and hurt all the time. You know what I mean? I don't like that. I want to be happy. (49, male)

Despite facing adversity due to diabetes, this participant declared that he will not passively remain in the difficult circumstances diabetes brought into his life. Rather, he claimed that he had an ability to make himself happy. By remaining spiritual, the participant previously quoted, appeared to hold a healthier sense of self. Although resilience did not directly provide practical skills to manage his diabetes, equanimity served as a great emotional asset to effectively deal with the burdens associated with chronic illness.

Another example of how spirituality affirms healthier behaviors comes from a 33-year-old male participant. Equanimity in coping and resilience is shown.

> Just knowing that with prayer and help from God that I can get over this. I think you receive blessings in many different forms, monetary, also with you might wake

> up one morning and be so happy. That's from above, you just get that feeling. I always feel so good when I leave church … Yeah, almost kind of like a new person when I walk out of there, because I remember one day I woke up feeling so terrible. I was like I don't want to get up. I don't even want to wake up. I just want to stay in bed all day and just turn my phone off and don't do nothing. I […] go to church. I got up. I went to church, and the preacher started preaching. I just started crying. Oh, my God, this is what I needed to hear. Oh my Lord. By the time church was over, I felt like a million dollars … I can't repeat yesterday, so I have to worry about today. When the day gets here, worry about this day. (33, male)

The previous quotation shows how one person describes coping with diabetes and diabetes-related life stressors through spiritual practices and help from God. It was following spiritual/religious practices that helped restore a positive mindset toward diabetes self-management. Exercising and maintaining a positive mood was directly connected to emotional strength and a willingness to effectively deal with diabetes.

Self-reliance—It is important to note that religious/spiritual beliefs and practices influenced a sense of self-reliance. The following quotation from the previous 49-year old male offers an example:

> I want to hear God speak to me, and I don't want to be high or loaded or drunk enough because I'm trying to re-listen and pay attention, and I don't want to be under the influence of nothing that's going to be messing with my prayer and listening. I'm trying to be helped out of this one. I'm trying to hear which way I should go. Like He's the guide, and you know what I need and what do I need to do to be comforted. Sorry, I don't know what I want. I do what I want. Just it's going to take some time. But, in the meantime, I don't want to spend my time just feeling sad and hurt all the time. You know what I mean? I don't like that. I want to be happy. (49, male)

He showed a sense of self-reliance, which was anchored in religious faith in God. His self-reliance was related to the religious practice of prayer to ask God for strength to overcome diabetes. Self-reliance represented a form of resilience promoting the participant's capacity to continue diabetes self-management practices and daily self-care. Another example of self-reliance was offered by a 64-year-old female. She offered her thoughts about God's ability to support her ability to manage her diet and health. She stated, "Just believing in God's hands, and try to take care of myself, eat the best food I can to try to help whatever food beneficial to my health you know" (64, female).

Meaningfulness—Lasting positive health behaviors were associated with the meaning attached to human activity. Finding and supporting a renewed life purpose and spiritual meaning remained a vital component of diabetes self-management. Meaningfulness was dynamic and guided life choices that changed based on what was deemed influential (Frankl, 1963). While the participants may not have gained practical skills from finding meaning in diabetes self-management, the underling sense of benefit from making choices that were desired rather than imposed often support healthier behaviors. Many study participants shared a new perspective about health that was supported by spirituality. Some

participants were able to express how reinterpreting and reconstructing life circumstances was meaningful to his or her overall physical and mental well-being. Several participants reconsidered his or her health status as a new opportunity to connect with God and to develop spiritual connections, instead of blaming or resenting God. “I think I got closer to God. I fell off and then I started talking to Him spiritual-wise, you know? And, there is a reason for everything” (66, female).

The woman’s statement implied that she sought to find spiritual meaning and reasons for being ill; her health problem involved making her faith stronger. The following statement exemplified how religion/spiritualty can promote meaningfulness and perseverance.

> You have to add more cracks […] stress, then it isn’t the board you’re looking for. Throw that board away and make yourself another board. So whatever He got for me, maybe He wants me to be able to hold up something and be strong for His glory, I guess, so He got to put some stress on me. I read Job. Job was like a hero to me recently. I’m not fooled in. I went in there and I said, God, no matter what they put on in me, He held me… . Yes, I am enduring. And, I want to be strong. There have been times when I feel I like that was not strong. And, I used to put myself in a position. I say, “just help me be strong.” (49, male)

This 49-year-old male respondent reinterpreted his circumstance with diabetes in order to find a spiritual purpose and meaning in his life. Seeking spiritual meaning through his health problem motivated him to be stronger and more resilient.

Perseverance—In the statement previously quoted, the 49-year-old male mentioned a specific biblical figure, named “Job.” His comment illustrated how religion/spirituality promotes one’s perseverance to deal with diabetes via a biblical figure showing strength. The participant was encouraged by the story of Job, who had many hardships in the Bible. He reinterpreted his life circumstance with diabetes by finding the similarities from Job’s story.

A 67-year-old male also commented that his faith in God not only helped him persevere, but also helped him stay healthy.

> I think that it has helped me in my quest to stay healthy. So, yes, I think that grounding myself has allowed me to not be consumed by some of the health issues that I face […] not be consumed, but to continue to persevere and endure. That’s what I would say… . Yes. It [my faith] helped me—I mean I figured that by resourcing myself it would allow me to endure and […]. Yes, so that, I mean so check that, I mean, yes, it’s allowed me to endure. (67, male)

Both quotes on religion/spirituality described resilience and positive coping with diabetes. The 67-year-old male participant also stated that religion/spirituality helped him endure the hardship caused by his diabetes.

Existential aloneness—Only one participant mentioned existential aloneness. Existential aloneness represents a source of creativity, comfort, self-acceptance, and a sense of uniqueness (Wagnild & Young, 1990). The following quote demonstrated how spirituality

was connected to existential aloneness as a form of resilience. "…It was funny because I wanted to go somewhere by myself and I went to a park, and I couldn't get […] one park, and I went to church… . I was listening to Him" (49, male).

Being in a place to listen to God meant seeking a source of strength. Existential aloneness, here, implied his realization about his uniqueness as an individual before God. His action to be alone and spiritually connected with God represented resilience in dealing with disease.

Religious/spiritual practices promoting diabetes self-management practice

Religious/spiritual practices were utilized for coping and resilience mechanisms for African Americans with diabetes. The code for religious and spiritual practice is combined with church attendance, reading the Bible, praying for health, studying the Bible, and using electronic media.

Participation in religious services—The majority of participants (n = 25, 61%) reported attendance to religious services. Twenty-four participants (57%) participated in religious services in a house of worship, whereas, 15 participants (36%) participated in religious and spiritual activities when they were available. Eleven participants (26%) reported church attendance on Sundays, and five (12%) reported participation in religious and spiritual services during the week in addition to Sunday. Using media services was also reported as a type of religious activity. Ten participants (24%) used Christian television shows, online programs, and smart phone applications to support spiritual and religious practices in managing health.

Prayers—Prayer represented one of the most significant religious and spiritual activities used for physical, psychological, and spiritual well-being. Twenty-two participants (52%) prayed for strength to cope with their health. A 33-year-old male commented that prayer was a powerful healing method, and a 67-year-old male stated that he prayed for controlling his blood glucose when his blood glucose level dropped below acceptable levels.

Reading the Bible—The Bible represented a spiritual coping method. Twelve (29%) participants read and studied the Bible or incorporated religious readings in daily activities as a health management behavior strategy. An illustration appears as follows.

> Sometimes when things get hard, I'll read my Bible. I don't believe everything that's really in the Bible because I believe a lot of—some stuff man has put in there because that's His word, but you can easily detect what's man's word and what's God's word. If it agrees with your own common sense, then just sometimes reading certain verses, going to Bible study on Wednesday to have a better understanding of what's in the Bible so I am able to use it to … not just my daily life but just kind of also understanding … I always carry my Bible with me in my purse. (28, female)

Religious and spiritual beliefs promoting diabetes self-management

The positive image of God—The participants revealed that they understood God as a positive image rather than a negative image. Sixteen participants (38%) described God as a

supportive actor who helped in the midst of life difficulties. The participants also viewed God as the one whose presence was very close and had a personal relationship.

> I do. I trust enough that he's going to make it all right, because so many times before, he's always been there for me, and he's been near through all of this. It's just that I wouldn't open up and let Him in more because I had … I had this in my life that was really just bad and I didn't give it up. (49, male)

> I think God keeps me strong enough to come and fight and come to my doctors' appointment. (44, female)

Positive images of God appeared to increase their willingness to cope with disease and hope to overcome adversity using spiritual and religious methods.

God plays an active role in health management.: A 44-year-old female respondent described God's role as fairly supportive and active in her health management. She believed that God made her keep her medical appointments.

> I think God keeps me strong enough to come and fight and come to my doctor's appointment … I still thank God for saving my life because He just keeps on keeping me coming to these doctor's appointments because I wouldn't go. And, I won't have the energy to come. But I get a taxi and I'll come to the doctor, so. If I hadn't had that, I would not come. (44, female)

Meditation is an alternative medicine.

> A 65-year-old Buddhist woman understood that meditation was a natural alternative to medicine.

> In the sense that I understand that before modern medicine was around, human beings used everything that was here. And so there is a connection to the earth in that regard, and to the force that gives rise to everything that comes up out of this earth. Let's see. Maybe this will be better. When I meditate, I feel better. Maybe that will help. (65, female)

Discussion

The study's results indicate that the participants reported being spiritual and or religious and utilized his or her faith to cope with diabetes. Most participants engaged in religious practices that supported his or her diabetes self-care. Our findings show support for the theory of stress and coping as well as the application of theoretical framework of resilience, which has not been previously interpreted among African Americans with homelessness histories and diagnosed with diabetes. The findings show consistency with the literature on the role of religion and spirituality in health behaviors with African Americans (Gupta & Anandarajah, 2014; Namageyo-Funa et al., 2013; Quinn et al., 2001; Unantenne et al., 2013). The study results appear to be among the early research to report religion/spirituality as important components for diabetes self-management among formally homeless, but newly housed African Americans. Connecting religion and or spirituality, in a cultural sense, to diabetes self-management practices suggests another important lever that may attenuate poor

health habits (Bernstein, Meurer, Plumb, & Jackson, 2015; Dhanani, 2011; Unantenne et al., 2013).

Our participants described religion/spirituality as a foundation for maintaining diabetes care practices. For many, reporting good physical health meant that his or her connection to religion/spirituality was strong. As such, completing diabetes self-management activities such as blood glucose testing and eating a healthier diet were more consistent. The five types of resilience—equanimity, self-reliance, meaningfulness, perseverance, and existential aloneness—emerged from the data analysis. Culture plays a unique role in the development of resilience; and this is especially true for people of many professionals who do not attribute a spiritual sense of self or formal religious practice. The themes of coping, faith, and hope were interrelated and interdependent for the African American participants most likely because these participants reported having faith in God and by extension, they maintained hope to be “healed” and “get better.” The positive mindset captured in this study served as a support for spiritual coping. Spiritual coping represented beliefs and practices that supported how a person felt he or she derived meaning of life. Positive and hopeful beliefs were interrelated with the positive images of God. Participants described his or her relationship with God as being a supportive, secure, and close figure that helps throughout the journey to health improvements. Few participants blamed religion or his or her specific connection to spirituality on times when diabetes self-management practices faltered. Many supported the notion that it was their belief in a forgiving God that helped him or her make corrections in health habits. Prayer and reading the Bible were the frequently mentioned spiritual coping methods.

Limitations and strengths

The research results should be interpreted in light of certain limitations. One limitation of this study is the lack of generalizability because of the nature of face-to-face interviews. Another known limitation is the memory inconsistency associated with self-reported data. The reinterpretation of the resilience theoretical framework may also signal a limitation. Although the resilience theoretical interpretation is widely used, it was originally developed to theorize about the behaviors of widowed, White women (Wagnild & Young, 1990). Our research sample were African Americans and thus, the framework may have culturally and racially inappropriate elements. Lastly, selection bias might influence the findings on religious/spiritual beliefs as suggested by Chatters and colleagues (2008).

Notwithstanding the study limitations mentioned, this study includes several strengths. The participants provided a very rich set of qualitative themes and narratives, which significantly enhance current understanding of how formerly homeless, but newly housed African Americans use religion and spiritualty to cope with diabetes management. The present research contributes significantly beyond existing work on the supportive role of spirituality and religion in several ways. First, this research focuses on a population in need of support to achieve independent living and acquire the personal assets to live productively with chronic illness. Second, this research produced more specific information about the role of religion in diabetes self-management practices than known previously. Knowledge about spirituality and religion, a cultural foundation among African Americans, can only enhance

what is known about diabetes self-management standards. Practitioners may gain much needed insight into building stronger connections with potential intervention participants often needing additional support. Lastly, the data reported here point to clear possibilities for future interventions with people who are making important strides in transforming his or her life to one focused on health. In planning intervention content, the findings can assist program planners to focus on elements that decrease threats to physical health while creating opportunities for practicing consistent healthier behaviors. Further, programs might focus on creating social support networks in order to maintain diabetes self-management habits. Future interventions may include specific elements that help African Americans to continue to engage in the health enhancement process by recognizing the cognitive strength needed to live differently with diabetes using the supportive foundation of spirituality and religion. Moxley, Washington, and McElhaney (2012) research findings suggest creating programs incorporating practical daily living skills such as paying bills, grocery shopping, and medication management scheduling in the church community. The practical ways to help were directly related to church communities, however, much can be gained by social work interventions incorporating these practical skills focused on formerly homeless people to help remain in stabilized housing and improve health outcomes. Moxley and colleagues (2012) offer a powerful purpose to social services by building individual social capital and resources via spirituality and religious anchors. The applications for theory development also might result from this work.

Implications

Religion and spirituality play an important role in the lives of many African Americans. Although Taylor and Chatters (1986) state that African Americans are generally more religiously involved than other groups, it was quite interesting to report that people who held histories of homelessness kept a “spiritual” sense of self and support for the ability to cope with stressful life events. Future studies in this area should examine the specific role of religion and spirituality in supporting diabetes management not only from the social determinant of low socioeconomic position, but also from frames of reference that combine the complexity of life rebuilding and quality of life enhancements. It is likely that multiple strategies to improve diabetes self-management practices can be developed for similar “hard-to-serve” populations.

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Table 1.

Demographics.

Variable		
Age	Ranged between 28 to 71	Mean: 53.5 years
Gender	Female	n = 23 (55%)
	Male	n = 19 (45%)
Marital status	Never married	n = 25 (59%)
	Divorced/Separate	n = 15 (36%)
	Widowed	n = 2 (5%)
Average annual income	$9,400	
Education	More than 50% high school graduates	
Employment	55% permanently disabled and unemploye	