Womanism, Spirituality, and Self-Health Management Behaviors of African American Older Women

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Abstract

Many older African American women perceive spirituality as an important resource in facilitating the self-management process of their chronic disease conditions. Research designs, which are congruent with theoretical frameworks of African American women, are important. However, many researchers remain unfamiliar with womanist thought or are unsure of how that framework can be used to understand specific aspects of self-management practices. The purpose of this exploratory study is to explicate a womanist epistemological framework that can support the development of self-management intervention designs aimed at assisting older African American women in health-promoting behaviors. Data from a sample of twenty-one African American women were collected from semistructured interviews and analyzed for common themes through narrative analysis. Four themes emerged from the linkage of womanism, spirituality, and self-management. Spiritual- and womanist-based strategies may provide a foundation for innovative self-management programs that target this older African American female population. Healthcare workers and public health professionals can assist in the co-creation of programs that focus on the collective personal responsibility of health promotion practices.

Introduction

Of the 90 million Americans living with a chronic illness, minority women, especially African American women, are disproportionately affected (CDC 2007). Furthermore, older African American women have experienced earlier onset of chronic illness, as well as more frequent ailments and severe impairments from chronic ill health, than any other older adult group (Federal Interagency Forum on Aging-Related Statistics 2008).
African American women are more likely to have higher rates of hypertension and are more liable to die from cardiovascular disease than Latina and non-Hispanic white women (Clark 2005). In addition, African Americans are 1.8 times more apt to develop type-2 diabetes than non-Hispanic whites. Twenty-five percent of African American women, who are 55 years of age and older, are diagnosed with type-2 diabetes (ADA 2012). Finally, older African American women are more likely to be diagnosed with knee osteoarthritis and have a higher burden of large-joint osteoarthritis, such as hip and spine, compared to non-Hispanic whites.

Living with a chronic and debilitating condition is a balancing act because individuals often make daily decisions concerning the management of their illness. For older African American women with chronic conditions, the self-management process becomes even more complicated. For many older persons, the changes imposed by chronic illness signal a diminished quality of life and the need to utilize adaptive behaviors (Baldree, Murphy, and Powers 1982). As their illnesses progress, this population is faced with the challenge of loss of function, episodic pain, the rising cost of long-term medical treatment, and the constant threat of more serious medical problems.

The womanist theory provides insight into the life experiences and health of aging African American women. Because “womanism” contextualizes the intersection of race, gender, and class among African American women, the concept contributes to the discourse of culturally relevant theoretical frameworks. Those frameworks shape our knowledge of aging African American women’s lives, which can guide the development of self-management and health care programs. Health and well-being are a concern for most women, but, for African American women, the art of self-healing through spirituality plays a major role in the recovery of both their physical and mental health. Accordingly, spirituality is often used as a base on which African American women stand to negotiate and transcend adverse conditions that cause stress. Likewise, spirituality serves as a personal and communal source of solace and hope, and it is used as a strategy for coping with chronic illnesses or conditions (Lewis et al. 2007).

The use of spirituality in health-related research has gained renewed interest, particularly focusing on older adults (Taylor, Chatters, and Joe 2011). However, several limitations have arisen regarding the scientific study of the relationship among aging populations, spirituality, health, and well-being outcomes. For example, most studies primarily use quantitative methods, but they lack heterogeneity among gender and racial/ethnic groups in examining the experiences of research participants (Unson et al. 2008).
Hence, the purpose of this research is to examine the role of spirituality as a self-managing coping practice among aging African American women, using the womanist conceptual framework. This paper will offer an understanding about spirituality and its influence on self-management behaviors for chronic illness as spirituality specifically relates to the life experiences of older African American women.

Religion, Spirituality, and Health

In recent years, interest in the religion, spirituality, and health connection has grown significantly. In the past, the study of this subject was greeted with skepticism and not openly highlighted as a legitimate area of health research. However, in fields such as psychology, sociology, gerontology, and medicine, the use of religion or spirituality as a focus of health-related research has increased tremendously (White, Peters, and Schim 2011). A growing body of research has recognized the centrality of religion in the lives of many people and its relevance to health and well-being, including health promotion and health recovery (Taylor et al. 2011; White, Peters, and Schim 2011). Similarly, previous research supports a relationship between religion and a wide range of health behaviors, including (1) reduction of smoking, drinking, and drug use; (2) difference in sexual activity; (3) better dietary habits; and (4) increase in exercise (Koenig, McCullough, and Larson 2001). For example, in studies examining the association between church attendance and health behaviors, participants who spoke about being more religious were more likely to report regular exercise or repeated preventive health care measures (Aaron, Levine, and Burstin 2003; Benjamins and Brown 2004; Idler and Kasl 1997; Levin and Schiller 1987). Similarly, participants who reported being more religious were less likely to report smoking cigarettes or drinking alcohol (Arredondo et al. 2005, Hill et al. 2005, Idler and Kasl 1997, Levin and Schiller 1987). Among these studies, health behaviors were also found to differ by denomination, with more conservative and strict denominations, such as Mormons and Seventh-Day Adventists, generally having lower levels of smoking and drinking (Koenig et al. 2001).

Religion and Spirituality Practice among Older African Americans

African Americans reported higher levels of religious practices and spiritual experience compared to non-Hispanic whites (Taylor, Chatters, and Jackson 2007). Likewise, African-Americans reported being religious (79 percent), attending at least one religious service a week (53 percent), and praying
more frequently (76 percent), compared with other racial and ethnic groups (56 percent, 39 percent, and 58 percent, respectively). As noted in previous research (Taylor, Chatters, and Jackson 2004; Underwood and Teresi 2002), women and older participants reported significantly higher levels of religious participation and spiritual experience. African American women were more likely than African American men to be affiliated with a Protestant religion (82 percent of women versus 72 percent of men). African American women reported the highest percentage, as it related to being religious (84 percent) and attending at least one religious service a week (59 percent), compared to men or women from any other racial or ethnic background (Pew Research Center 2009). This trend continues with current studies showing African Americans with the highest levels of religious participation compared to black Caribbeans and non-Hispanic whites (Chatters, Taylor, Bullard, and Jackson 2009).

Religion and spirituality have often been used interchangeably, yet these two terms are distinct, and, in some cases, they are overlapping concepts (Lewis et al. 2007). Religion conveys the practice and conformity of religious rituals, beliefs, and procedures (Miller and Thoresen 2003, Thoresen and Har-ris 2002). Accordingly, religion, as defined by its boundaries, is an inclusive concept and narrow in scope. Spirituality, on the other hand, can be defined as a relationship with God or whatever is held to be the ultimate Higher Power that fosters a sense of meaning, purpose, and mission in life. In turn, this relationship produces fruit (such as altruism, love, or forgiveness) that has a discernable effect on an individual’s relationship to self, nature, others, and the ultimate (Sermabeikian 1994, Spero 1990). As it relates to influencing overall health outcomes, spirituality has been characterized as a high level of faith, hope, and commitment in relation to a well-defined worldview or belief system that provides a sense of meaning and purpose to existence in general. Spirituality has also been described as offering an ethical path to personal fulfillment, which includes connectedness with self, others, and a Higher Power or larger reality (Hawks 1994).

It is important to establish a working definition of spirituality that the authors can systematically use to describe their research findings and facilitate interdisciplinary dialogue, as well as provide a source of wholeness. Hence, spirituality is understood in this paper in the most expansive form. Spirituality is the total way of being in the world, including the processes of coming to belief systems, naming core values, and acting on those beliefs. Spirituality, in this sense, does not consist only of those components that are bound by a given denomination or religion. Spirituality can include struc-
tures of organized religion in addition to going outside those parameters, and, more importantly, spirituality framed in this manner gives room to explore the existent framework of faith beliefs (Mitchem 2004). Womanist scholars have described spirituality as the ability to outgrow the constraints of customary and inert philosophies of religiosity (Frederick 2003). Spirituality for African Americans is described as an intimate relationship between self and God (Mattis 2000) and interpersonal relationships that are built on a personal belief and faith in God (Newlin, Knafl, and Melkus 2002; Shambley-Ebron and Boyle 2006). Since spirituality is influenced by sociocultural orientation that combines social and cultural factors (White et al. 2011), spirituality is considered an important cultural strength within the African American community. Many studies support the strong presence of spirituality among African Americans (Banks-Wallace and Parks 2004; Newlin, Knafl, and Melkus 2002; Polzer and Miles 2005). This wider view gives new ground on which to recognize and define African American women’s spirituality and health realities.

Womanist Theory

Womanist is a term coined by Alice Walker, which means being committed to the survival and wholesomeness of African Americans (Walker 1983). The term womanist reflects Walker’s view that the experiences of African American women are unique and significantly divergent from those of European women (Brown 1989). The womanist theory is a conceptual framework developed by black women for black women and is specific in articulating personal insight from the black female perspective. This theory advances the unique experiences of black women as they relate to the intersection of race, gender, and class, with the aim of eradicating oppressive and subordinate conditions through empowerment (Banks-Wallace 2000, Collins 2000). Collins (2000) classified two crucial relationships for black women: (1) relationships with one another and (2) relationships with formal and public spaces, such as black churches or black women’s organizations. In this framework, Collins suggested—within black women’s circles—that mentoring empowers black women “by passing on the everyday knowledge essential to survival as African-American women” (102). Likewise, the womanist theory focuses on African American women’s experiences. The theory also enables black women scholars to engage in issues of race, class, and gender in ways that provide an understanding of African American women’s social, cultural, and historical experiences.
Grounded in many sources, such as theological, social, anthropological, economic, and material, the womanist theory contributes to the process of African American women clarifying their connection and commitment to understanding their cultural realities as women (Rodriguez 1996). Appropriately, Williams (2006) proclaimed that womanism is female centered and culturally important as it relates to the values of African Americans’ experiences and traditions. Thus, the womanist theory adds a unique aspect to conducting health research. The use of the womanist theory is critical in assessing how aging African American women manage chronic illness. The womanist paradigm embodies the art of participatory witnessing, that is, African American women telling their stories, as well as possessing an ethic of caring (that is, the validation of their individual experiences). This ethic is grounded in the realization that “one’s well-being is connected with the well-being of others” (Banks-Wallace 2000, 41). The womanist theory illuminates the understanding that African American women’s concept of health and well-being involves a relationship between mind, body, and spirit and that their social and cultural contexts are not separate from that relationship (Townes 1998). Hence, the womanist theory values aging African American women as “possessors of knowledge and recognizes their experiences as valid sources of information” (Shambley-Ebron and Boyle 2004, 16).

**Womanist Spirituality**

Spirituality takes place in many forms of expression and is present throughout the life course of African American women as a way of giving meaning to their lives. Hence, the womanist theory is particularly valuable when studying spirituality because it gives African American women meaning to life, as well as to their existence (Jackson 2002, Swimme and Berry 1994). Historically, African American women’s experiences are grounded in a background of healing traditions and practices that include spirituality (Williams, Frame, and Green 1999). Through years of coping with racial discrimination and socioeconomic challenges, African American women use spirituality to maintain their health while dealing with the stressors, which are embedded in the cultural realities of their lives (Lee and Sharpe 2007, Parham 1999).

Values and practices, like prayer and regular church attendance, have become routine support mechanisms in dealing with adversity, such as racism and poverty (Lee and Sharpe 2007). Likewise, African American women’s “belief in an ever-present divine power capable of delivering them from any measure of trouble has been a traditional characteristic of their faith” (Paris 1995, 15). This belief or ethos of spiritual praxis of resistance instills in African
American women a power of determination and optimism, while maintaining personal dignity and an unwavering love of God (Stewart 1999). Hence, the womanist spirituality enables African American women the ability to possess a will to survive, as well as a desire to confront threats to their mental and physical being, while providing adaptive mechanisms that reinforce their sanity and affirm their wholeness (Stewart 1999).

**Self-Management**

Clement (1995) defined *self-management* as the knowledge attained and skills required in taking care of oneself, being able to manage crises, and changing one’s lifestyle successfully. Clark et al. (1991) described three sets of tasks individuals must master to ensure successful self-management of chronic illness. First, the individual must be knowledgeable about the condition to determine the required care. Second, the individual must be able to perform activities to manage the condition. Third, the individual must apply skills essential to sustain adequate psychosocial functioning. In other words, self-management of chronic illness refers to day-to-day activities that individuals must adopt to keep the illness under control, to reduce its impact on their physical health status, and to cope with the psychosocial consequence of the illness. Such activities often include, but are not limited to, medication management, physical activity, and dietary compliance.

**Self-Management and Spirituality**

Spiritual practices and religion have been found to help older adults cope with chronic conditions (Chin et al. 2000). More researchers are identifying the importance of spirituality for African Americans in maintaining health and managing illness (Davis 1998; Loeb 2006; Mansfield, Mitchell, and King 2002; Samuel-Hodge et al. 2000). Davis (1998) indicated that African American women believe God is in control of illness and health. Other researchers reported the ultimate healer (that is, God) was able to alleviate illness and protect one from harm through prayer and faith (McAuley, Pecchioni, and Grant 2000; Potts 1996). Mansfield et al. (2002) stated that African Americans have described God working through their doctors to help care for their conditions. Leach and Schoenberg (2008) interviewed individuals to examine how disadvantaged middle- and late-life adults with multiple morbidities employ self-management strategies for their chronic conditions. The participants in the study gave an account of the use of cognitive structure techniques, self-care regimens, and faith-oriented strategies.
Although both races were consistent in self-care and cognitive structuring techniques, African Americans were more likely than non-Hispanic whites to mention prayer and receive support from God and church members as a strategy for self-management. In addition, Loeb (2006) reported participants using a variety of coping strategies for their chronic conditions; the specific coping mechanisms included relating with health care providers, medicating, exercising, changing dietary patterns, seeking information, relying on spirituality and/or religion, and engaging in life. Loeb's study identified attitudinal strategies as coping strategies among older African Americans: “dealing with the issue” used to manage chronic illness, engaging in life, exercising, seeking information, relying on God, changing dietary patterns, medicating, self-monitoring, and self-advocating. Participants in both studies indicated the importance of religion and God (Loeb 2006).

A number of studies among African Americans with chronic conditions relate spirituality and/or religious activities, such as prayer, church attendance, and divine intervention, as valuable components within disease management. For example, Mansfield et al (2002) found that African Americans more commonly spoke about praying for guidance, help, or healing for self and others compared to whites. Accordingly, research supports that African Americans use prayer as an aspect of coping with chronic conditions such as (1) cancer (Hamilton and Sandelowski 2004, Henderson et al. 2003), (2) diabetes (Polzer and Miles 2007, Popoola 2005), (3) HIV (Woodard and Sowell 2001), and (4) osteoarthritis (Jones et al. 2008). Studies indicate that spiritual practices may enhance self-management of chronic conditions in African Americans. Utz et al. (2006) and Jones et al. (2008), with sample sizes of 68 and 73 patients, respectively, conducted focus group interviews among African Americans with type-2 diabetes to identify both barriers and facilitators to self-management. Participants reported that faith in the Bible helped them to decide which foods to eat. Furthermore, Samuel-Hodge et al. (2000) found that God played a central supportive role in the management of chronic conditions among African American women.

African Americans and non-Hispanic whites viewed prayer as a major component of their self-management of chronic disease (Loeb 2006). Forms of spirituality, such as praying or meditating, may help individuals cope with chronic illness, serving as an internal agency to perform behavioral changes to mediate the chronic condition. Although a number of authors have explored the importance of spirituality with chronically ill individuals (Ai et al. 2007; Chen and Koenig 2006; Dilworth-Anderson, Boswell,
and Cohen 2007; Gall et al. 2005; Loeb 2006), the use of spirituality and womanism in self-management practices has not been researched.

**Methods**

This study used a commonly employed qualitative method, thematic analysis, for identifying, analyzing, and reporting patterns within the data (Braun and Clarke 2006). Additionally, the study utilized deductive or “theoretical” thematic analysis appropriate for investigating womanism and the range of experiences within the womanist epistemology (Braun and Clarke 2006, Boyatzis 1998). The analysis focused primarily on understanding the meaning of womanism and spirituality, as these terms relate to self-management practices among aging African American women in an urbanized city.

**The Parent Study**

Participants in the present study were enrolled in a larger, four-year longitudinal study funded by the National Institute on Aging (R01-AG 18308). This larger study was titled “Process of Self-Care: Comparison of Older African Americans and Whites,” also labeled the “parent study.” The study examined the process of self-care for hip or knee osteoarthritis (OA) and ischemic heart disease (IHD) in a community sample of older African Americans and non-Hispanic white Americans in Allegheny County, Pennsylvania. The parent study’s sampling frame was the Medicare Enrollment File for Allegheny County in April 2001. African Americans were overrepresented in the parent study to achieve an adequate sample size for statistical analyses. The sample was stratified by gender and race to assure a more effective comparison when using these indicators. Disease eligibility criteria were based on a series of self-report questions, which were derived from the National Health and Nutrition Survey, and self-report disease markers for cardiac conditions and treatments. Additional eligibility criteria included community-dwelling residents of Allegheny County aged 65 and older and who were able to give consent.

**The Present Study: Data Collection**

Before the third interview of the parent study, the primary author conducted a pilot test with a purposive sample of ten individuals, aged 69 to 79, that aimed to determine the appropriate questions for the present study. The Institutional Review Board of the University of Pittsburgh (IRB-UP)
approved a pilot study in which respondents were asked to define spirituality and explain how spirituality or spiritual beliefs helped them manage their illness. Persons refusing to participate in the pilot study remained eligible for participation in the parent study. After completing the pilot test, the spirituality questions were added to the parent study questionnaire, which was approved by the IRB-UP. By the third wave of the parent study, 959 participants were actively enrolled, but 414 of the enrolled participants had not been interviewed. Approximately 20 percent of the 414 participants (N = 81) in the parent study were selected through quota sampling and then stratified by gender and race for participation in the present study. This study will focus only on the African American women interviewed (N = 21). Data collection began in November 2003 and ended in February 2004. By adopting the voice-centered qualitative methodology of seeing the older African American women as the experts in self-management practices, the female interviewers were trained to be sympathetic listeners and to pay attention for multiple viewpoints in their narratives of self. The interviewers used open-ended questionnaires to elicit the participants’ subjective views: (1) on being spiritual, (2) their definition of spirituality, (3) how spirituality or spiritual beliefs helped them to manage their most important health problems, and (4) how they used spirituality or spiritual beliefs in managing their illness. The interviewers opened with a general statement on the lack of research from the perspectives of older African American women on spirituality. They then said they were seeking the participants’ assistance to gain insight into the lived experiences and actual perspectives of African American women managing chronic conditions. The trained female interviewers conducted 21 in-depth interviews in the women’s homes that were audio-recorded and later transcribed.

Participants

Participants of the present study (N = 21) ranged in age from 66 to 85 years, with an average age of 72.4 years (SD = 4.9). Most participants were married (42.9 percent) or divorced (23.8 percent). Many of the participants had some form of postsecondary education (38.0 percent), while 19.1 percent had at least a bachelor’s degree. Among the participants’ ailments, cardiovascular disease (47.6 percent) was the most prevalent chronic condition, followed by arthritis (14.3 percent), diabetes and complications due to diabetes (23.8 percent), and other illnesses (14.3 percent). An overwhelming majority of women, who identified themselves as Protestant (80.9 percent), reported being either very religious or moderately religious (95.2 percent), and they
considered themselves as having either very high levels or moderate levels of spirituality (90.5 percent).

**Data Analysis**

Each interview was audio-recorded and professionally transcribed verbatim. Particular attention was paid to retaining the individual voice of each participant by writing excerpts in the participants’ own words. The transcribed data were then read and reread several times. This process of “repeated reading” (Braun and Clarke 2006) was used to help the researchers become immersed in the interview. The next steps involved systematically generating initial codes from the transcription by using line-by-line coding of the transcripts. Initial descriptive coding, using the words or phrases of the participants, involved looking for repetition within and across the transcripts. The identified codes were considered pertinent to the research question and theoretical concepts.

The researchers compared units of text and sorted them into categories and subthemes, which were assumed to represent womanism and self-management—the chosen phenomena (Aronson 1994). For the purpose of this inquiry, themes were identified as categories that connected elements of the narratives identified in the individual and collective transcripts. Themes were attributed to the group, rather than to individuals, as the unit of analysis. After the coding process was completed for each transcript, the authors searched for subthemes to identify common concepts that illustrated the core categories of womanism. All initial codes relevant to the research question and theoretical concepts were incorporated into a subtheme. The identification of the subthemes and aspects in the narratives told the researcher how older urbanized African American women use the precepts of “womanism” and “spirituality” to manage their chronic conditions.

**Findings**

Womanism assumes a holistic perspective that recognizes the uniqueness and complexity of African American women’s experiences. Because womanism places issues that are relevant to African Americans at the center of analysis, this theoretical concept has facilitated a meaningful examination and interpretation of the experiences of this population. The five emergent themes based on the womanist paradigm are (1) Learning the “Plan,” (2) Spiritual Conversation, (3) Reflection in the Role of Suffering, (4) Community, and (5) Personal Responsibility. The recurrent themes of the data show the complexity in which aging African American women’s lives are affected.
by chronic disease and how womanist spirituality allows these women to manage their conditions.

**Learning the “Plan”**

As previously stated, religiosity and spirituality are not mutually exclusive. However, in this section, African American female respondents discussed the role of the Bible as a guiding force for helping them understand their faith and how scriptures facilitate that growth in their faith. The female respondents aligned their beliefs and the events in their lives with what they read in the Bible. Because both boundless joy and immense suffering are contained in the Bible, the focus group respondents understood that ordinary worries (that is, chronic disease) and extraordinary uncertainties (that is, deaths and other traumatic events) are part of God’s larger “Plan.” For example, a sixty-eight-year-old woman, married and college educated, who has cardiovascular disease, stated,

Yeah. Now hopefulness is that all people, all of humanity, has problems—mental, physical, and emotional to some degree at some point in time. But my hopefulness is that my Christianity and spirituality can lead me through this. . . . Nobody wants to go through death, but we will ultimately find death as a part of our life. And it is meant to be.

Another divorced woman on dialysis described her struggles with dialysis over the years, but she spoke enthusiastically about a sudden change in course during the past few years. What was once a difficult procedure (that is, tri-weekly dialysis treatments) has become easier for her, as she has become stronger in the faith and has more fully accepted the “Plan”:

And He’s with me all the way. And I don’t give up. I don’t care how [much] pain I get or whatever, or whatever they say to me at dialysis. I don’t ever give up. I have too much faith and belief. That’s my true Savior. And when He’s ready for me, He’ll call me. I don’t have time to be complaining about that. And when I come in and I kiss—that’s one of my pictures of my Lord and Savior right there. At the stand over there. That’s my Lord and Savior. And I pray and thank Him each and every morning and night with the love He has in His eyes and a smile on His face. God is with me. He’s busy, but He’s with me. And I believe when He said you’re all of my children. And it’s so important to love one another.

From a womanist perspective, the authors found that these women were able to transcend their personal struggles to observe larger community issues.
A female respondent continued the interview by describing the crime and violence within her community and in the world around her. Her chronic disease and this suffering are part of what she sees as the work of Satan. However, she also understands that, in the midst of everything else, God is still working in the background. Moreover, the blessings of her improved health and her continued ability to wake up each morning and fulfill the mandate to love her brothers and sisters overshadow much of her suffering. Therefore, she is able to give back to the community and transcend her personal suffering in order to keep with the “Plan.”

**Spiritual Conversation**

The authors indicated that spiritual conversations with God demonstrated the importance of spiritual dialogue as an integral part of several respondents’ faith, as well as an effort to manage their day-to-day chronic illness. One African American female participant discussed how she kissed the face of her Savior (for example, Jesus’s picture on the wall in her apartment) and talked with him every day about her health condition. These conversations became more poignant preceding her dialysis appointments. Her “spiritual conversations” were frequent and could be characterized as “praying.” In these spiritual conversations with the divine, discussions about their health care providers (for example, prayers for them in their work, prayers to find the “right” fit), and treatment choices frequently resulted in self-empowering the respondents in their decision-making process. Consequently, after their spiritual conversation, these African American women were able to go confidently to their appointment knowing that God was “guiding the hand” of the health care practitioner.

Within these kinds of conversations, the African American women contemplated their roles in the “Plan” and offered a haven to speak about their fear. For example, a widowed eighty-five-year-old woman with emphysema said,

I’m in prayer continuously, yeah. Praying for strength and praying for the doctors who help you. I’m glad we have them. It would be terrible if we didn’t have the doctors. Be thankful that God gave them knowledge to be able to treat us. I pray that this is the medicine [that] is going to help, and I pray that—and thankful that medicines help do away with most of the pain, sometimes all of it. Nothing’s worse than being in pain. So the medicines help that a lot, make life more pleasant. . . . Well, pain in the back, you know, that back pain, that will really make you pray.
While the spiritual conversations have deep and abiding meaning, they required no religious formality: “I just talked to him like I would talk to you. He’s my friend.”

Reflection in the Role of Suffering

The role of suffering represented how the African American respondents reflected on the events in their lives within a historical perspective through the examination of their upbringing and personal adult choices. The African American respondents’ past experiences were both a source of inspiration for their chronic conditions or an explanation for their current suffering (that is, “getting too far away from God” results in suffering or a feeling of loss). In reflecting on their journey of health and illness, the female respondents acknowledge that their past experiences were manifested through their current health status. Many of the female respondents used this time of reflection to consider this question: “Where has God brought me from?” The female respondents mentioned that they were able to manage chronic disease when they were on a righteous path of their life journey.

The primary way the African American women were able to highlight their current life—even if it is riddled with illness and misfortune—was to focus on the positive consequences of growth through the act of “witnessing.” Participant witnessing in womanist research occurred when the researcher needed to listen or “bear witness” to the respondents’ lived experiences in a way that encouraged both self-representation and an accurate “other-representation” during the data collection process. A married sixty-six-year-old woman with arthritis saw her participation in the study as part of this reflective witnessing. She “witnessed” to the interviewer to teach her that, by sharing her health issues, she was in essence helping other women deal with their health concerns:

That’s what it means. And you strive each and every day to be his witness, which means you are a servant and you are a volunteer servant because that’s what—that’s what you want to do. That’s what you want to be. . . . This is a witness. I am witnessing to you. And I’m taking this time to witness to you. And I’m taking this time to answer your questions because the old Leila would say, no, I don’t want to be bothered, you know, and say, I’m not even on any of this program. That would be the old Leila. But the new Leila is a person that wants to strive to—if anything that I can do to help somebody else to understand their arthritis or understand their situation or understand their problems, and then maybe this interview would help somebody else.
In a world full of darkness and suffering, this particular female respondent hoped her story of failure and redemption would prove to be a beacon of hope to others. She was proud of her continued growth and imagined that her life was an example to others, especially within her personal social networks. This private reflection also appeared when these African American women described their relationships with others. They were suffering, but what is their pain in comparison to others? As a result of reflecting on the afflictions of others, the female respondents found ways in which they could give to others through their support and prayers. By focusing on the suffering of others and then reflecting on—and attempting to alleviate—the pain of others, this process allowed the female respondents to grow in grace and gratitude regarding their own chronic conditions. This process was lengthy and arduous, as evidenced by a statement from a divorced woman with type-2 diabetes: “And accepting the fact that, you know, this is what I [reference to God] want for you. That’s the biggest hurdle I [reference to self] had to get over.”

Furthermore, the reflection in the role of suffering was illustrated by a married sixty-eight-year-old woman with cardiovascular disease who, when focusing on others around her, was able to distract herself from her own illness:

I think it has caused me to look to other avenues of involvement in my life and thereby cause this serious distraction from the heart problem itself. In addition, it has assuaged some of the symptoms that I felt directly. And that has—that has a definite impact on my part as far as I’m concerned, and it helps me to deal with it. It redirects your attention and your focus to other things. Because I do believe that the work that I do, I don’t think that I would have chosen all of these things or as many of the things as I do for myself I am doing. I think they have been really spiritually allocated to me for me to do. And in this way, it has become a total diversion from—almost a complete diversion from my physical problems with my heart. Because I’m so absorbed in the duties that I need to do to get through some of the functions that it has helped me to deal with it.

The reflection on their chronic conditions focused on the respondents looking at the suffering of others to help them understand their own pain. Their medical distress was seen as a gift that allowed them to physically do a little more than others and to use that extra strength to help the less fortunate:

I look at other people that can’t move and get around and I thank God for this whatever. The little ailment I have in my knees, I can get around. I can
get up and do for myself. I have a halfway good mind, so I’m thankful for that. And when you look at—when I give—we give. . . . You go in these hospitals and things and see people and you just thank God your condition is no worse than what it is. Something to be thankful for and don’t complain and just go on with just my knees.

Community

As seen from the “reflection in the role of suffering,” the women in this study focused on others in their personal networks, but this theme also concentrated on communion with others. This communion is seen in volunteering and prayer groups. Through community relations, the female respondents became closer to a Higher Power (that is, God) and embraced the “Plan.” The other side of reflection was learning from their mistakes and focusing on others. Prayer became a community activity that heals and connects the respondents in their social networks. A married woman with a high-school degree spoke about the role prayer and community played as a part of her health and medical care:

You can’t do it by yourself. You have to have their prayers, and I found that out when I had my aneurysm, you know. And I do believe he brought me through. I had everybody praying for me, prayer partners, and things like that.

The respondent was able to show the power of her faith (for example, by believing that prayer would work) and the strength of her personal networks (for example, a ready-made group of supporters she trusted during times of crisis). Another female respondent shared that she believed her community’s prayers brought her back to the “world of the living”:

Well, my husband prays for me and my church prays for me. . . . Yes, in times past. I haven’t lately because I haven’t been that sick, you know. But whenever I do need it, I certainly ask . . . because I believe I can pray for you and help you, and I believe you can pray for me, if you believe in God, and help me. . . . Yes. And I wouldn’t be here today I don’t think if they didn’t. I would be gone. . . . Yes, that’s what they were praying for me for, my health . . . and I stopped breathing. That’s why I was on that ventilator twenty-four days or however many days. . . . But anyway, I was on that ventilator all that time. I stopped breathing. I actually stopped breathing. And like I said, I believe it was nothing but God brought me back. Of course, they put me on the ventilator, you know.
While the example of the suffering of others could be a source of discouragement for some dealing with chronic disease, these women used their community as a source of support and strength. By being a witness to the power of prayer and community, they were encouraged to move ahead in their chronic disease experiences. The presence of the community was a testament to the rightness of their faith.

**Personal Responsibility**

While the previous themes placed great emphasis on a Higher Power, as well as health care providers and community, all of which are forces outside an individual’s domain, the participants focused on the personal responsibility that they affirmed in their narratives. Faith required taking responsibility for their health (that is, taking care of one’s health business). To call oneself “faithful” was to read the Bible, to accept and understand the degrees of sickness and suffering, and to follow the instructions of health promotion. Medical adherence and setting health limits were all considered important parameters in taking personal responsibility of one’s self-management practices. In accordance with the role of spiritual beliefs, several women spoke of their body as a vehicle for their faith or as being a “temple.” For example, a married woman, diagnosed with cardiovascular disease, described the role of healthy dietary habits in her cardiovascular health outcomes. She was aware that a healthy diet could positively influence her heart, and she was also keenly aware of the deleterious impact of the “wrong” eating choices:

> And so I am not to eat or drink in excess anything that’s going to harm it [heart]. I know that too much of certain foods would cause flack in my body, salt to retain fluid, and—not that I don’t sometimes eat pretzels and stuff. . . .

> But in general, that I am to take care of—this is what all—this is how God can use me through a healthy body better than an unhealthy body.

Personal responsibility also required experiencing suffering in order to participate in health-promoting behaviors, such as being compliant with the health care provider’s instructions. One female participant with arthritis stated that, when she spoke to God, he told her what she needed to do: “I just take it for granted, get up, and go with it. And I’m going to see a doctor about it, but I know that some way, somehow, God will help me until I get to that doctor.”

> It was her personal responsibility to become proactive in her health care. Based on the themes stated previously, the women in this study found that
the “Plan” sometimes revealed itself through their spiritual conversations with God or through reflection on their health journey. Reflection and community helped the female respondents to understand their role in life, as well as distracted them from pain while focusing on others. The “Plan” may be for one to live through the pain with no relief, or it may guide their health care worker to alleviate the symptoms.

**Discussion**

Womanist theory was used to provide understanding and unique insight into self-management practices among older African American women. This analysis attempted to elicit the relationship between the womanist theory and spiritual beliefs among older women in this study. The goal of the study was to understand the complexity of African American women’s lives as they manage and understand their chronic conditions through their spiritual beliefs. These findings were based on a womanist paradigm that produced positive behavioral change, as well as providing a pathway for their spiritual faith (Boyd-Franklin 1989, Collins 2000, Williams 1993). Womanism assumes a holistic perspective that recognizes the uniqueness and complexity of African American women’s experiences. The womanist paradigm helped understand the subtle complexities of spirituality and self-management strategies, as demonstrated by a group of older African American women diagnosed with a myriad of chronic conditions. When given a voice, the African American respondents stated that their spiritual beliefs helped them with their self-management practices.

For the older women in this study, spirituality represented a personal belief and faith and/or a relationship with a Higher Power, identified as God or Jesus. The respondents’ journey with self-management always begins with an intimate relationship with God. The women stated that their faith provided the strength to make critical health behavioral changes to manage their chronic conditions. Self-management practices from the respondents drew strength based on womanist concepts, such as spiritual beliefs and community connections. The older women’s experiences, as heard in their testimonies and in the application of biblical narratives, suggest a consciousness that enabled the women to maintain and sustain their health behavior changes (Polzer-Casarez, Engebretson, and Ostwald 2010). Each of the women in this study told “her story” of spiritual growth that transcended her current life experiences. Similar to Abrums (2004), the authors found that spiritual beliefs offer insight based on the respondents’ personal experiences.
The practice of the “worship” experience allows for oral communication in the form of testimony, which is conducive to the edification of those who are present and who are the listeners and witnesses to the testimony (Hall 1999). As in Smitherman’s (1994) work, the respondents bore “witness” to the women’s narratives by the illustrations of the main themes. The older female respondents may have perceived the interviews as an act of testifying and giving voice for those who could not testify (Taylor 1998).

Because the women considered themselves to be their “sisters’ keepers,” they refused to let their physical limitations prevent them from helping others. In addition, the women’s spiritual beliefs provided meaning and purpose, which helped them to transcend their illness. In other words, helping others often made it easier to forget their own aches and pains. Several of the study participants believed that their illness served a purpose in their lives in that their ailments set an example of how to handle pain for those close to them. Similar to other researchers, the authors found that supportive relationships, particularly caring women-kin relationships, were another source from which older respondents were able to draw strength and make or sustain behavioral changes. This collective support system of African American women is consistent with the communality that was the social essence of traditional African societies (King and Ferguson 1996). African American women’s spirituality groups have focused on valuing personal experiences and interpersonal relationships and establishing community (Cervantes and Parham 2005, Daly et al. 1995). A crucial belief is that knowledge sharing among individuals can be used to build or nurture behavioral change (Olphen et al. 2003). The womanist concepts include community building, self-determination, and empowering the female respondents through their interpersonal connection (Williams 1993) to make behavioral changes. These concepts can be used to guide the development of future self-management interventions with African American women clients (Dodani and Fields 2010; Peterson et al. 2005; Peterson, Yates, and Hertzog 2008; Samuel-Hodge et al. 2009). Although the interventions (Peterson et al. 2005; Peterson, Yates, and Hertzog 2008) do not use womanism within the study design, they draw on the tenants of womanism by incorporating spiritual beliefs and practices, extended family network support systems, and a shared tradition of strength—all of which may serve to promote, maintain, and sustain health (Samuel-Hodge et al. 2009). Self-management programs should include identification of cultural values associated with practices that are health promoting for African American women because these programs employ personal experiences as a basis for program development.
Paradoxically, recent black feminists (Beauboeuf-Lafontant 2008) have argued that the strength received from African American women’s religious or spirituality beliefs may create an inner conflict by focusing on the self-sacrificing notion of strength—modeled by the expectation of the black community. Theoretically, the discourse of “the strong black woman” allocates insufficient opportunity for acknowledging the emotional needs because it takes the “suffering discourse” of self to focus on others (Beauboeuf-Lafontant 2009). As a result, this discourse can create rigid social boundaries and expectations among a population that may be struggling to achieve social refuge in their lives (Beauboeuf-Lafontant 2003). Consistent in this stereotype is the idea of the African American woman as a “long suffering, religious, maternal figure,” loved for “her self-sacrificing self-denial for those she loves” (hooks 1981, 10).

Regardless of previous limitation, it is worth noting that this study expands the knowledge regarding African American women’s lived experiences, which is inspired by their spiritual beliefs and a way of identifying their commitment to the community (Carlton-LaNey et al. 2001). The seminal work of McCray (1980) characterized this “extended caring” depiction. This role included the following components: (1) a heritage exclusively connected within the culturally African American, (2) strong spiritual beliefs, and (3) the desire to aid in the collective group survival (McCray 1980). The present research study valued these African American women’s comments and reflections regarding the existing literature paradigm of the womanist theory. This information is grounded in the consciousness that “one’s well-being is connected with the well-being of others” (Banks-Wallace, 2000, 41).

Additional limitations to the study included the small sample size and single geographic location. As in most qualitative studies, the sample was not statistically representative of the target population. However, it should be kept in mind that the goal of qualitative research is to uncover and delineate new perspectives for research and practice rather than make generalized statements. This investigation’s sample predominantly represented Christian African American women. Nevertheless, the findings add to the limited research using the womanist paradigm among older adults with chronic illness. Research is also needed to explore how other models can work in tandem with traditional medical and health behavior theories. While this research study was limited to a small number of older adults and is, therefore, exploratory in nature, it is considered groundbreaking and provides the first step of inquiry, linking womanism, spirituality, and self-management of chronic illness. Unlike the “medically prescribed” methods of self-management, many older African American women have adopted self-management
practices that are consistent with their culture. In conclusion, although self-management has emerged as an important component of health maintenance, prevention, and illness management in recent decades, the cultural components of self-management and their relevance for illness management have been underemphasized.

References


Mansfield, Christopher J., Jim Mitchell, and Dana E. King. “The Doctor as God’s Mechanic?


