Journal of Social Work Practice and Education
An open access journal
eSciRes
SWPE-1-101
Research Article

"If It Had Not Been for the Mighty One Who Was on Our Side" Diabetes, Depression, Fatalism and Spirituality among African Americans: An Afrocentric Qualitative Interpretive Meta-Synthesis (QIMS)

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Abstract

There is existing literature on the blood glucose dysregulating condition of type 2 diabetes, as it co-occurs with the mood disorder of depression. However, a comprehensive empirical and theoretical knowledge base pertaining to these co-occurring conditions among African Americans and the positive impact of spirituality is lacking. This article furthers the knowledge base related to diabetes, depression, and fatalism, and the protective factor of spirituality among African Americans and demonstrates a unique method of qualitative data analysis that has been used in social work – qualitative interpretive meta-synthesis (QIMS). This author conducted an Afrocentric QIMS of eight qualitative studies. This method was specifically developed for social work, as it is focused on human behavior in the social environment. Grounded in traditional qualitative methodology, it draws from other disciplines that have used qualitative meta-synthesis as common practice. A new, synergistic understanding of the topic under study emerges from the QIMS process of synthesizing the results of multiple qualitative studies on a topic. This Afrocentric QIMS generated four themes: "Betrayal by (My) Body" (Diabetes); "Keep the Bully Out" (Depression); "What Will Be, Will Be" (Fatalism); and "If It Had Not been for the Mighty One on Our Side" (Spirituality). The findings demonstrated implications for three areas that relate to social work services with African Americans who are living with type 2 diabetes and/or depression and fatalism: culturally sensitive and gender specific programs should be developed for African Americans who are living with diabetes and/or at risk of depression; spirituality should be infused in psychotherapeutic interventions and diabetes education; and community based health care programs should endeavor to have culturally specific providers, whenever possible. Furthermore, extensive triangulation and broadening of extrapolation possibilities were identified as two major strengths in using QIMS.

Keywords: African American(s); Afrocentric QIMS; Type 2 diabetes; Depression; Fatalism; Spirituality

Introduction

Research indicated that the rates of type 2 diabetes and clinical depression are higher in African American communities than in the Non-Hispanic White (NHW) population [1]. These higher rates of diabetes and depression may be due to increased income disparities, community isolation, decreased health and social services [2]. Additionally, African Americans have the highest prevalence rate of obesity among all other racial and ethnic groups, especially among persons living with diabetes (Centers for Disease Control & Prevention [3]. All of this is coupled with the biopsychosocial-cultural and spiritual issues in many African American communities, where there are the highest homicide rates, the lowest high school completion rates, the highest unemployment rates, and shorter life expectancies, as compared to White Americans and other racial and ethnic groups [3,4].

These statistics regarding health disparities and inequities, coupled with the historical context of dehumanizing enslavement, posttraumatic slave syndrome [5] economic impoverishment and disenfranchisement, make the unhealthy state of Black America very apparent. However, as noted in the scriptural/biblical verse says in Psalm 124:2, "if it had not been for the Mighty One who was on our side" [6], where would the Black/African American community be, in the face of racism, sexism, classism, elitism, ageism, violence, poverty, unemployment, diabetes, depression and fatalism. Spirituality and faith in a Power greater than ourselves, along with other protective factors have helped/are helping the Black/African American community to "keep on keepin' on…one day at a time".

The Black/ African American Community

According to the Centers for Disease Control and Prevention, Blacks/African Americans have a long history in

the United States (U.S.), with individuals, families and communities that have been in this country for many generations or others who are immigrants from Africa, the Caribbean or other geographic regions [3]. Furthermore, the U.S. Census Bureau identifies Blacks or African Americans as people having origins in any of the Black racial groups of African descent. The Black or African American population includes people who self-identify as "Black, African American or Negro", or as sub-Saharan Africans, such as, Kenyans, Nigerians, Ethiopians, et al., or as Afro-Caribbean, e.g., Haitians, Jamaicans, Cubans, et al. [7].

The 2012 population of Blacks/African Americans in the United States, in combination with other races/ethnicities, was estimated at 44.5 million and constituted 14.2% of the total population [7]. Those who self-identified as only Black or African American made up 13.1% of the U.S. population or 39 million people [7]. By the year 2060, it is projected that there will be 77.4 million African Americans in the U.S. including those of more than one race, making up 18.4% of the total U.S. population [7]. Although African Americans geographically lived throughout the U.S. in 2011, the largest geographic concentration of African Americans was in the southern states. About 55% of those persons who self-reported in the 2010 U.S. Census as Black or African American, alone or in combination, lived in a southern state: Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Delaware, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, and Texas.

The Unhealthy State of Black America

In its second consolidated assessment report, the CDC's 2013 Health Disparities and Inequalities Report (HDIR) - United States highlighted health disparities and inequalities across a wide range of diseases, behavioral risk factors, environmental exposures, social determinants of health and health care access by sex/gender, race, ethnicity, income, education, disability status and other social characteristics. This CDC's2013 HDIR and other research included the following biopsychosocial-cultural factors regarding African Americans [3,8,9]. In 2011, of the total 25.8 million children and adults in the United States diagnosed and undiagnosed with diabetes, 12.6% of non-Hispanic Blacks aged 20 years or older were diagnosed with diabetes [8]. From 2007-2010, the prevalence of obesity among adults was the largest among African American women compared to white and Mexican American women and men. The obesity prevalence among African-American adults was the largest, as compared to other races and ethnicities [3]. In 2009, African Americans had the largest death rates from the cardiovascular disease of heart disease and stroke, the leading causes of mortality and morbidity in persons with diabetes, as compared with other racial and ethnic populations. This disparity was also found across all African-American age groups younger than 85 years of age [8]. In 2009, African Americans had the largest death rates from homicide among all racial and ethnic populations. Homicide rates among African-American males were the largest across all male age groups [3]. In 2011, similar to other racial and ethnic adults ages 25 years or older, African-American adults had a larger percentage that did not complete high school than white adults. African-American adults also have a larger percentage that lived below the poverty level. Also, more African-American adults aged 18-64 were unemployed compared to the same age white adults.

"The Unhealthy State of Black America" is dismal. Contributing factors to these poor health outcomes among African Americans include discrimination, mistrust and history of maltreatment by health care providers, as exemplified by the U. S. Public Health Service Syphilis Study at Tuskegee, along with socio-economic and socio-cultural challenges (CDC/HCIR, 2013). In 2011, although the gap is narrowing, the average African-American could only expect to live 75.3 years compared to 78.8 years for white Americans (NVSR, 2011).

Fatalism, Nihilism, and Spirituality among African Americans

Given the aforementioned poor health outcomes, it appears that the cultural barriers, and the lack of health care access, and other psychosocial factors have adversely impacted African Americans [3]. The negative "belief systems" of racism, sexism, classism, elitism, ageism, white (skin) privilege should be added to this list, along with the role of fatalism, "a complex psychological cycle characterized by perceptions of hopelessness, worthlessness, meaninglessness, powerlessness, and social despair" [10]. Powe and Johnson [11] developed and conceptualized a culturally specific perspective on fatalism and contextualized this within the African American experience in the United States. They ascribed the origins of this fatalism to an existential angst and nihilism [11]. This existential angst was defined as "the universal experience of dread and despair that stemmed from the history of enslavement, economic impoverishment, and disenfranchisement" [11, pp: 119]. Nihilism is defined as "the experience of coping with a life of meaninglessness and hopelessness" [11, pp: 119].

For African Americans, spirituality has ontological significance, as it pertains to the very questions of existence or being and relates to connecting with a Power greater than oneself. Spirituality is central in the lives of African Americans and is of paramount importance when providing health care within this community [12,13]. The African American world view of spirituality has profound implications, particularly as this affects diabetes self-care management [13]. As influenced by our African heritage, as well as, by racism and the historic power relations between the "privileged" and "oppressed" racial groups in the United States, many African Americans believe that the most vital aspect of being is spirituality. Given this ontological significance, spirituality is often fully intertwined in all aspects of life [13], with no distinction between the religious and the nonreligious, between the secular or the sacred, or between the spiritual and material areas of life [12,13]. So, even in the face of diabetes, depression, fatalism, and spirituality, in the scriptural/biblical words of Psalm 124:2 – "if it had not been for (the Mighty One) who was on our side…." [6, pp: 718] where would African-Americans be. Because of a paucity of existing knowledge about diabetes,

depression, fatalism, and spirituality among African Americans, it is imperative for practitioners, researchers and educators to have a greater depth and breadth of understanding about these life experiences. Consequently, further research about diabetes, depression, fatalism and spirituality was conducted.

Given the aforementioned biopsychosocial-cultural and spiritual complexities, there is meager research and gaps in the literature on the impacts of diabetes, depression, fatalism and the mediating role of spirituality among Black/African Americans, but there is a vast body of general literature. The literature indicates that diabetes and depression are significant issues in the Black/African American community [1].

For our research purposes, Bell's critical race theory [14], which is widely used in the social sciences, was chosen as a theoretical framework and lens for understanding diabetes, depression, fatalism and spirituality. Critical race theory (CRT) recognizes that racism is engrained in the fabric and system of the American society. The individual racist need not exist to note that institutional racism is pervasive in the dominant culture. This is the analytical lens that CRT used in examining existing power structures. CRT identifies that these power structures are based on white privilege and white supremacy, which perpetuates the marginalization of people of color [14].

Elements of institutional racism and mistrust have been felt by many African Americans as a major barrier in their relationships with their health care providers and health care institutions, as indicated by some of the participants; responses in this qualitative research. As a result of all of these factors, it is imperative that practitioners, researchers and educators understand the implications of an Afrocentric/African centered spirituality on diabetes, depression and fatalism.

Health Disparities in the Black/African American Community

In these southern states and throughout the U.S., African Americans face significant health disparities and health care differences. Striking health disparities and comparative health care differences between African Americans and other racial and ethnic groups are apparent in death rates, life expectancy rates, risk conditions, health behaviors and other measures of health status [3]. Among the top ten leading causes of death for African Americans are heart disease (#1), diabetes (#4) and homicide (#8) [4].

Diabetes and Depression among Black/African Americans

Specifically, the Black/African American community is disproportionately impacted by the blood glucose dysregulating condition of diabetes (U.S. Department of Health and Human Services – Office of Minority Health [USDHHS-OMH], 2008), as well as, the brain chemical imbalance, mood disorder of depression – profound sadness [15].

Diabetes: Research has indicated that African Americans are twice as likely to be affected by diabetes mellitus, particularly type 2 (hereafter, type 2 diabetes), a metabolic condition of blood glucose dysregulation, as compared to Non-Hispanic Whites. African Americans comprise 3.25 million of the 25.8 million persons who are living with diabetes [8]. Type 2, insulin resistant diabetes is the most common form of diabetes affecting 90 to 95% of Americans with diabetes. Type 1, insulin dependent diabetes, occurs when the body's own immune system destroys the insulin producing cells of the pancreas [8].

Depression: Further studies have shown that people with diabetes have a greater risk of clinical depression than people without diabetes [16]. This sadness may be due to the daily stress of diabetes self-management, feelings of loneliness and isolation, or diabetes complications [16]. Consequently, the mental, emotional and behavioral health condition of depression, that is, profound sadness and dysphoric moods, has been found to be twice as prevalent among persons living with diabetes, as compared to people without diabetes [17]. Available data suggests that African Americans with diabetes experience higher rates of elevated depressive symptoms as compared to Whites. Depression is also an independent risk factor in cardiovascular disease [18-20]. Depression is associated with poorer diabetes self-care management, poor glycemic control and decreased health-related quality of life, especially among women [21].

Using qualitative methodology, the goal of this Afrocentric QIMS was to explore the life experiences of African American adults who were at risk for depression and fatalism, while living with diabetes, and to describe the relevance of spirituality in their lives. The purposes of this present study were to use an Afrocentric qualitative interpretive meta-synthesis (QIMS) to better understand the interconnections of diabetes, depression and fatalism and the mediating role of spirituality among African Americans, as identified in individual qualitative studies.

Regarding diabetes, depression, fatalism, and spirituality among African Americans, the research questions of this QIMS included: (1) what is the essence of the experiences of African Americans who are living with diabetes and/or depression; (2) what is the role of fatalism with African Americans; and (3) how does spirituality/higher consciousness, religion, belief, and/or worship serve as protective factors for African Americans.

Method

Afrocentric Qualitative Interpretive Meta-Analysis (QIMS)

In this cross study analysis, Aguirre and Bolton's [22] qualitative interpretive meta-synthesis (QIMS) was used, as it is tailored to social work research to synthesize the findings of previous qualitative studies concerning relevant factors. QIMS is conceptualized "as a means to synthesize a group of studies on a related topic into an enhanced understanding of the topic of study" [22, pp: 329). Herein, "the position of each individual study is changed from an individual pocket of knowledge of a phenomenon into part of a web of knowledge about the topic" [22, pp: 329). The synergistic interconnections among these studies creates "a new, deeper and broader understanding" [22, pp: 329). QIMS begins with

identifying the sample of studies to be synthesized, extracting the original themes from the studies, and then synthesizing these themes across studies using constant comparative methods where extracted themes are compared with one another continuously, thus evolving into an inductive process [22]. Nonprobability samples, called purposive samples, have been generated to "yield the most comprehensive understanding of the subject of study, based on the intuitive feel for the subject that comes from extended observation and reflection" [23: pp: 448).

The goal of this QIMS and other types of qualitative research is to collect and synthesize the possible data over a relatively prolonged period of time through prolonged immersion in some social location or circumstance [24]. Regarding human behavior in the social environment, according to Rubin and Babbie [22]:

qualitative research is especially effective for studying subtle nuances in attitudes and behaviors and for examining social processes over time…the chief strength of this method lies in the depth of the understanding it permits.

Like other social and behavioral science researchers who utilize qualitative methods, the flexibility, relatively low cost, and unusually in-depth, comprehensive understanding of this type of research is appreciated [22]. In order to appraise the rigor of qualitative research, it is necessary to understand the key criterion of *trustworthiness* i.e., the extent to which objectivity is maximized and bias is minimized. [22].

An Afrocentric approach was incorporated into this study to explore culturally specific phenomena, allowing observations of empirical data from the point of view and life meaning of a particular cultural group [25].

Sampling

Purposive sampling was used to select studies relevant to our topic of interest for inclusion in the QIMS (Figure 1: Quorum Chart). For study selection and decision making, we discussed inclusion criteria until decisions were reached. To increased transferability, qualitative synthesis literature searches are often limited in relation to the temporal, time-sensitive relevance of topics. However, because topical importance, our qualitative synthesis literature searches were not limited by publication year. Thus, studies relevant to the topics prior to 2010 were considered for inclusion.

The resources related to the research topics were compiled and after the resources were exhausted, the list of studies was narrowed in terms of topic relevance and fatal flaws. Fatal flaws, such as, lack of triangulation, researcher bias, lack of theoretical tradition in data collection and analysis, or questionable trustworthiness was eliminated from the sample [26].

A total of eight original studies (n=8) published between 1997 and 2010 were included in this Afrocentric meta-synthesis, as they provided the greatest breadth and depth of information, including two gender specific studies with 17 African American women and 16 African American men, These eight studies yielded the perspectives of 372 African American adult participants. These participants were between the ages of 18 and 80, were male or female, and all were facing health challenges. These eight studies were from a larger sample of sixty potentially relevant studies screened in sixty articles (N=60). One of the eight studies utilized grounded theory (the Individuals, Symbols, Audience, and Situation [ISAS] Paradigm - a social psychology theory), five studies used phenomenology, one used illness narrative, and one used literature review. The lived experiences of the African American participants were utilized to extract themes regarding diabetes, depression, fatalism, and spirituality.

The literature review article on "Spirituality and Self-Management of Diabetes in African Americans" by Polzer and Miles [13] was exemplary and had sufficient qualitative rigor to include in the data extraction and analysis process of this Afrocentric meta-synthesis, because of its findings about African American spirituality, health, and self-management of type 2 diabetes, a complex chronic disease.

Inclusion and exclusion criteria: Peer-reviewed journal articles, books, theses or dissertations, published in English, and conducted using a qualitative paradigm, were considered for inclusion. The main topic-related criteria included the following: type 2 diabetes, depression, healthy coping, fatalism, and spirituality. Studies that examined problem solving in diabetes self-management and diabetes primary care were excluded. The inclusion/exclusion criteria are found in the Quorum Chart (Table 1) and identified the studies and the characteristics of the participants.

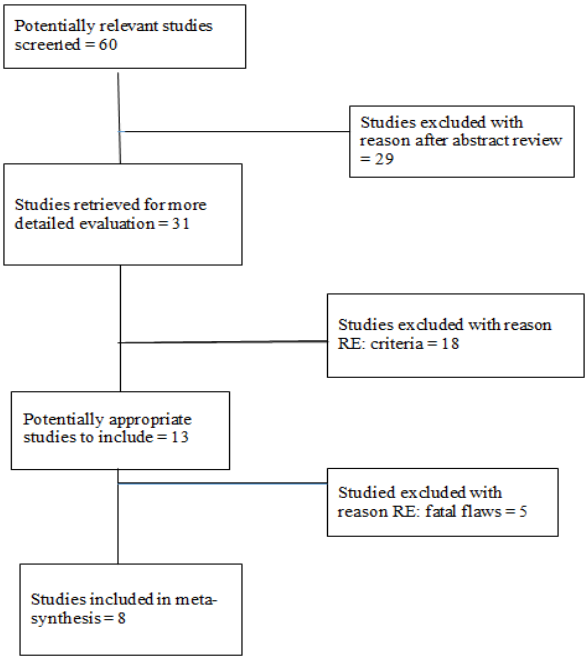

Figure 1: Quorum chart.

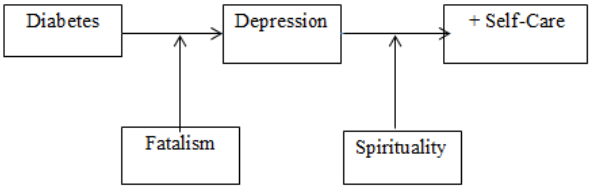

Figure 2: Path analysis.

Article	Type	# Participants	Age	Geography	Facility Type
Cooper-Patrick, Powe, et al. (1997) Journal of General Internal Medicine	Phenomenology/ 2 patient focus groups – stratified by race (w/audiotapes and transcribed verbatims) Regarding help-seeking behaviors and patient preferences in depression treatment	8 African American/ Black patients All with depression diagnosis	Black patients: 5 women & 3 men, avg. age 42 yrs.; 5 currently being treated for depression White patients: 5 women & 3 men, avg. age 47 yrs.; 6 currently being treated for depression	South eastern United States	Out patient clinic-urban medical center
Egede & Bonadonna (2003) The Diabetes Educator	Phenomenology/ grounded theory (ISAS paradigm social psychology theory) & 7 focus groups Regarding role of diabetes self-management and role of fatalism	39 African American/ Black patients All with type 2 diabetes	17 women & 22 men: avg. age 48 yrs.; avg. duration of diabetes 13 yrs.	South eastern United States	Out patient clinic-large urban medical center
Liburd, Namageyo-Funa & Jack (2007) Journal of the National Medical Association	Ethnographic study, interviews, illness narratives Regarding gender identity, black manhood, masculinity, diabetes self- management	16 African-American/ Black men All with type 2 diabetes	Avg. age 54 yrs.; avg. duration of diabetes 10 yrs.	Southern United States	Community diabetes project
Peek, Odoms-Young, et al. (2010) Social Science & Medicine	Phenomenology/ interviews & focus groups Regarding race and shared decision making, perspectives of African Americans with diabetes	51 African American/ Black women & men All with type 2 diabetes Semi-structured individual interviews = 24 Focus groups=27	Avg. age 66 yrs. (interviews) Avg. age 59 (focus groups)	Chicago, IL	Urban academic medical center
Penckofer, Ferrans, et al. (2007) The Diabetes Educator	Phenomenology/ focus groups Regarding the psychological impact of diabetes: women's daily experiences	17 African-American/ Black patients with type 2 diabetes	Avg. age 55.6 yrs.; avg. duration of diabetes 8.7 yrs.	Chicago, IL	Large midwestern university medical center and surrounding community
Polzer & Miles (2005) Journal of Holistic Nursing	Literature review regarding African American spirituality & diabetes self-management	4 studies: w/185 total African American participants	Avg. age 60 yrs.; included men & women- with diabetes (96% type 2 & 4% type 1)	South eastern United States	Academic center
Shellman, Mokel & Wright (2007) Journal of the American Psychiatric Nurse Association	Survey regarding beliefs and attitudes of older African Americans about depression	51 older (than 60 yrs.) African Americans	Avg. age 71.3 yrs. 36 women & 15 men Avg. number of years had attended church 51 yrs.	North eastern United States	Large university medical center
Wenzel, Utz, et. al (2005) The Diabetes Educator	Phenomenological/ focus groups - barriers to type 2 diabetes self-care for rural African Americans	3 African American women & 2 men	African Americans age 21 and older	South eastern United States	Rural community center

Table 1: Demographics from Culturally Sensitive Articles including in QIMS.

Data collection

We conducted a purposive sampling of qualitative studies via title searches using a large number of computer databases and reference lists in English-language literature of medicine, holistic and psychiatric nursing, sociology, and diabetes education. Databases searches included: Academic Search Complete, PsycINFO, MEDLINE, Dissertation Abstracts, and Google Scholar. Search terms included: African American(s) qualitative, diabetes, depression, self-

management, fatalism, spirituality, phenomenology, ethnography and critical race theory. The initial relevant studies were identified and were scanned to further judge topic relevance and relevant references. Studies in these studies and references were relevant were obtained and reviewed for inclusion.

Data analysis

Each of the eight articles were analyzed consistent with the QIMS methodology to determine the themes identified by the original researchers/authors and for theme extraction. The data analysis (Table 2) includes twenty-nine original themes extracted from the included qualitative studies, as identified by the original researchers/authors. Cognizant of the data analysis processes outlined by Aguirre and Bolton [22], the twenty-nine themes were synthesized across the eight studies in order to identify common relevant patterns, themes and factors regarding diabetes, depression, fatalism and spirituality among African Americans, as well as to develop theoretical memos.

Author and Year	Extracted Themes
Egede & Bonadonna (2003)	Meaning of Diabetes Illness Experiences Coping Responses Religious/ Spiritual Beliefs
Liburd, Namageyo-Funa & Jack (2007)	Diabetes Related Fears Treatment by Others Self-Perceptions Reactions by Others
Penckofer, Ferrans, et al. (2007)	Struggling with Their Changing Health Situations (Depression) Encountering Challenges in Their Relationships (Anger) Worrying About the Present and Future (Anxiety) Bearing Multiple Responsibilities for Self and Others (Stress and Burnout) Choosing to Take a Break (Choice making)
Peek, Odom-Young, Quinn, et al. (2010)	Relevance of Race Mechanisms for Race Influencing Shared Decision Making Influence of Race on Shared Decision Making
Polzer & Miles (2005)	Coping by "Turning to God" Relinquishment by "Turning It Over to God"
Shelman, Mokel & Wright (2007)	"Keeping the Bully Out" (Depression) **"God Will Provide" (#1 Coping Mechanism) "Losing Control" "That's Not Me" (Mental Health Stigma)
Cooper-Patrick, Powe, Jenkes, et al. (1997)	Coping Strategies Treatment Attributes by Type
Wenzel, Utz, Steeves, Hinton & Jones (2005)	Diabetes as "Betrayal by (my) Body" Provider-Individual-Family Relationships Self-Care Management Difficulty Getting Help

Table 2: Original Themes Extracted from Included Studies.

These twenty-nine themes were synthesized into each other, resulting in four categories that were combined to reveal a synergistic understanding of these phenomena. These four synthesized themes were "betrayal of (my) body" (diabetes), "keep the bully out" (depression), "what will be, will be" (fatalism), and "if it had not been for the Mighty One on our side" (spirituality).

Triangulation

Triangulation, a QIMS component, is a method that should be used at every step to regulate the trustworthiness of qualitative research. In the actual synthesis process, the QIMS is an additional layer. This synthesizing process included triangulation with co-analysts (social work colleagues) and research mentor/advisor (senior faculty member) and myself (first author) occurred throughout this process to verify evaluation accuracy and to label choices.

Issues of Internal Validity

For many qualitative researchers, the ideas of reliability, i.e., consistency over time, and validity, i.e., that which is true and relevant, are not in keeping with their post-modern epistemological rejection of assumptions connected with objectivity [23]. Instead, some qualitative researchers believe that it is possible to recognize the critical role of reliability and validity in qualitative studies, while at the same time appreciating the need to take a different perspective on the role of reliability and validity in qualitative studies [23].

Consequently, it has been reported that qualitative researchers are more likely to use terms such as *trustworthiness, credibility, dependability, and confirmability*, instead of the term validity [27]. Additionally, other qualitative researchers speak about the operational definition challenges to many of the criteria, e.g., *credibility, comprehensiveness and coherence*, which are often used in evaluating the trustworthiness of their own writings and that of others [28]. Furthermore, other qualitative researchers have described four validity criteria, i.e., *consistency, completeness, convictions and meaningfulness* [29]. Given this internal validity discussion, the terms trustworthiness, credibility and meaningfulness will be utilized in the concluding discussion regarding this QIMS.

Credibility Statement

As is the norm in qualitative research, the research analysts serve as research instruments [30], and are the main instruments of the study [22]. For this QIMS, the authors are the analytic mechanisms across the eight studies. Thus, the following brief description indicates the first and second author's credibility as research analysts to conduct this Afrocentric QIMS. The first author is an African-American woman, who has been a master's prepared clinical social worker for more than 45 years and has experience in diverse

fields of social work practice. I am also an ordained Christian minister with experience in church pastoring, pastoral care and pastoral counseling. Additionally, I am a social work educator with a PhD in social work research. Since 2010, I have served as a clinical social worker, behavioral health care manager and diabetes educator, with patients who are living with diabetes, depression, anxiety, stress and other conditions, by providing psychotherapeutic interventions, resource and referral information in an outpatient diabetes health, wellness and education center in a low-income urban community in Texas, a southern state in the United States.

It was necessary for me to examine my reactivity and biases about conducting this Afrocentric QIMS about African Americans who are living with diabetes and/or depression. The majority of my patients had significant challenges in accessing health care resources, due to their lack of health insurance and limited income. However, so many of them remained empowered and sustained, largely through their Christian faith frame of reference, their faith community, spirituality and/or their supportive family and friends. They had powerful stories to tell about "how they got over", i.e., how they survived and thrived, regarding the multi-problems life stressors that they faced. I have certainly appreciated and been blessed by having an opportunity to learn about the stories of people who were trying to live life "one day at a time".

For this QIMS, as recommended by Padgett [31], I sought to minimize threats to trustworthiness through *prolonged engagement (in the social work profession), interdisciplinary triangulation (in seeking some non-social work qualitative research studies for this QIMS), collegial triangulation, peer debriefing and support (with social work colleagues and senior faculty mentor/advisor), and auditing (journaling)* [31].

Results

The results of this Afrocentric QIMS suggested that (1) faith-based, culturally sensitive and gender specific health care programs should be created and supported for African Americans, (2) health care providers must recognized the primary role and influence of spirituality in healthy coping and diabetes self-management care with African Americans, especially if these patients have fixed/limited incomes, low literacy skills, are older adults, and/or may be evangelical Christians from the southern United States, and (3) health care systems should endeavor to have culturally specific health care providers whenever possible.

The results of this analysis indicated that four primary themes emerged from the original theme extraction, i.e., diabetes ("betrayal of (my) body"), depression ("keep the bully out"), fatalism ('what will be, will be"), and spirituality ("if it had not been for the Mighty One on our side"). In each overarching theme, subthemes have been reviewed in detail, and are thematically represented in Tables 2 and 3.

Synthesized Themes
"Betrayal by (My) Body" (Diabetes)
"Keep the Bully Out" (Depression)
"What Will Be, Will Be" (Fatalism)
"If It Had Not been for the One who was on our Side" (Spirituality)

Table 3: Synthesized themes.

Through the constant comparison of articles, along with, triangulation of sources was used to decrease error and bias of sources (i.e., focus groups. illness narratives, interviews), triangulation of analysts was used (i.e., research mentor/faculty advisor , social work colleagues, and myself), triangulation of theories (i.e., critical race theory impacting access to health care providers and health systems, ISAS paradigm – a social psychology theory, and chronic disease models), and triangulation of methods (ethnographic, phenomenological, narrative). Furthermore, the purposive sample of eight qualitative research articles were studied in depth, to explore the essential meanings and commonalities of the described experiences of a purposive sample of eight articles about 372 African Americans adults, who were at risk of depression and/or living with diabetes. The lessons learned from this culturally specific qualitative interpretive meta-synthesis highlighted the role of fatalism (inevitability) and the ontological protective factors of spirituality/higher consciousness and religion/belief/worship in the lives of African-Americans who are living with chronic conditions. The large number of this sample size, i.e., eight articles about 372 African American adults, provides data saturation, qualitative rigor, increases the likelihood of generalizability.

Primary Theme One: Diabetes

Within the overarching theme of diabetes, seven sub-themes were identified across the eight studies as culturally relevant bio-psychosocial factors that influenced healthy lifestyle behaviors. These subthemes included: self-perceptions, diabetes related fears, treatment by others and reactions of others (for Black/African American men), relevance and influence of race in shared decision making (as indicated by both some Black/African American women and men, i.e., trust between patients and providers, racial bias of the health care providers, limited health knowledge of patients, "bad attitudes" of patients, internalized racism/self-hatred, providers who engaged in racial discrimination and patient/provider cultural discordance, diabetes being viewed as a "betrayal by (my) body", and the complexities of the provider-individual-family (inter) relationships [32-34].

Primary Theme Two: Depression

In the synthesized studies, depression, emotional distress, and dysphoric symptom clusters (depression, anger, anxiety, stress and burnout) were identified as culturally relevant bio-psychosocial contributing factors that influenced healthy lifestyle behaviors. Nine sub-themes within the overarching theme of depression were identified across the eight studies. These subthemes included: treatment attitudes based on type of treatment, coping strategies (unhealthy and unhealthy), struggling with their physical and mental health (exacerbating depressive symptoms for Black/African American women), encountering challenges in their

relationships (especially regarding racial and obesity bias, exacerbating feelings of anger in Black/African American women), worrying about the present and the future (heightening feelings of anxiety for both Black/African American women and men), bearing multiple responsibilities for self and others (leading to stress/distress, particularly in Black/African American women), choosing to take a break (e.g., prayer and choice making to lessen diabetes and/or depression burnout, particularly in Black/African American women), the need to "keep the bully out" ("bully" = depressive symptoms, as expressed by Black/African American older adults), and by saying "that's not me" (denial, minimization and disavowal of depressive symptoms because of the big stigma associated with the mental health diagnosis of depression as expressed by Black/African American older adults). Here, somatic complaints are "ok", but emotional complaints are "not ok" [34,35].

Primary Theme Three: Fatalism

In their 2003 research study, Egede and Bonadonna [36] discovered that among their sample of Black/African Americans who were living with type 2 diabetes, health fatalism (i.e., feelings of powerlessness to change life events, attitudes of "what will be, will be", and feelings of hopelessness and social despair, with external locus of health control predominantly in the hands of Whites) was associated with their diabetes self-management. This fatalism appeared to be multidimensional and was related to the meaning of diabetes in their lives, their illness experience, their individual coping responses, and their individual religious or spiritual beliefs. Furthermore, these researchers discussed the participants' thoughts about fate, chance, inevitability, external locus of health control (God/health care providers/others) *vs.* internal locus of health control (self). Ten subthemes within the overarching theme of fatalism were identified across the eight studies, and it was the singular focus of one study. Culturally relevant bio-psychosocial factors that influence healthy lifestyle behaviors were identified and these sub-themes included: coping responses (healthy and unhealthy), life meaning of diabetes, illness experiences, ambivalence (mixed feelings: faith *vs.* health care system), integration of support (health care providers, family, friends), "losing control" (perception that high blood pressure and diabetes are not controllable, but depression is controllable), "that's not me" (due to mental health stigma), self-management (passively by others or actively by oneself), difficulty in getting help ("turned away" because of financial and social constraints) and distrust of health care providers and health care systems due to historical racism [34,36,37].

Primary Theme Four: Spirituality

The ontological centrality and "hope-filled" mediating role of spirituality in the lives of Black/African Americans and its relationship to health care is of paramount importance when providing care to Black/African Americans [12,13]. Four sub-themes with the overarching theme of spirituality were identified across the eight studies, and particularly in two studies. Culturally relevant bio-psychosocial-religious well-being and spiritual well-being factors that influence healthy lifestyle behaviors were identified and these sub-themes included: coping (with chronic illnesses of diabetes and depression, etc.) by "turning to God", relinquishment (partial or full) by "turning it over to God", with God first as the Ultimate Controller of health and illness, "turning it over" secondarily to the health care provider, and then lastly "turning it over" to oneself , as primary coping mechanisms and protective factors against depression, knowing that "through it all God will provide" and "if it had not been…". On this latter point, God/The Creator was seen as The Mighty One who prevents depression and assists in controlling adversity [13]. Additionally, the strong role of God and a faith frame of reference, along with the following spiritual disciplines and religious practices: 1) prayer, 2) church support and attendance, 3) Scripture/Bible study, 4) meditation, 5) religious rituals, and 6) watching/listening to Christian television, videos, and radio programs, were seen as critical elements in lessening one's distress. God was seen as The Mighty One who provided the strength to deal with daily diabetes self-care management challenges in seeking blood glucose control and healthier coping in the face of depression, anxiety and stress. Therefore, God was seen as The Ultimate health care provider, and human health care providers were seen as healers or instruments though which God administered healing [13]. Consequently, human providers needed to be trustworthy, caring, compassionate, prayer warriors, who were able to provide guidance, help and healing. Spiritual care was said to be an essential aspect of diabetes self- management education and depression care [13].

Discussion

Although it is not applicable in all situations, the multiple layers of triangulation, systematic sampling and extensive documentation of the synthesis process, enhances the transferability of the meta-synthesis findings and results [38].

Built upon existing research, the results of this QIMS, as exemplified by the synthesized themes of diabetes ("betrayal of (my) body"), depression ("keep the bully out"), fatalism ("what will be, will be"), and the protective factors of spirituality/religion ("if it had not been…"), indicated that further exploration should occur. These synthesized themes indicated (1) with diabetes, culturally relevant biopsychosocial factors that influenced healthy lifestyle behaviors; (2) with depression, emotional distress and dysphoric symptom clusters were also identified as influential factors; (3) with fatalism, feelings of powerlessness, hopelessness and social despair with an external locus of control were influential factors; and (4) the ontological centrality of spirituality and religion were essential to the health and wellness of many African Americans.

This QIMS and its synthesized thematic results addressed the research questions regarding the essence of the lived experiences of African Americans who were living with diabetes and/or depression, the role of fatalism (due to racism) with African Americans, and how spirituality/higher consciousness and religion/belief/worship serve as protective factors for African Americans. These results speak

affirmatively to the trustworthiness, credibility and meaningfulness of this meta-synthesis. In summary, this QIMS provided a greater depth and breadth of information about the life experiences of low-income African Americans who were at dealing with fatalism, were risk for depression, living with diabetes, and the protective factors of spirituality and religion.

Limitations of Research and Directions of Future Research

Despite the substantial useful information that was obtained, there were several methodological limitations with this QIMS. First, even though the total number of African American adult participants was large, the number of study articles included in this meta-synthesis was small (n=8), and this may decrease the likelihood of generalizability. Second, because of the purposive sampling method, other potentially relevant studies which could have been screened and included, may have been missed. Third, based on the specific research questions which primarily focused on diabetes and depression, the data specifically collected related to spirituality and fatalism were limited. Thus, future research, expanded knowledge and further reflections on all of these topics are needed. Overall, the results of this study made valuable contributions to our knowledge base about diabetes, depression fatalism and spirituality.

Conclusion

There is existing literature on the blood glucose dysregulating condition of type 2 diabetes, as it co-occurs with the mood disorder of depression. However, a comprehensive empirical and theoretical knowledge base pertaining to these co-occurring conditions among African Americans and the positive impact of spirituality is lacking. Consequently, this article furthered the knowledge base related to diabetes, depression, and fatalism, and the protective factor of spirituality among African Americans and demonstrates a unique method of qualitative data analysis that has been used in social work – qualitative interpretive meta-synthesis (QIMS). This author conducted an Afrocentric QIMS of eight qualitative studies. This method was specifically developed for social work, as it is focused on human behavior in the social environment. Grounded in traditional qualitative methodology, it draws from other disciplines that have used qualitative meta-synthesis as common practice. A new, synergistic understanding of the topic under study emerges from the QIMS process of synthesizing the results of multiple qualitative studies on a topic. This Afrocentric QIMS generated four themes: "Betrayal by (My) Body" (Diabetes); "Keep the Bully Out" (Depression); "What Will Be, Will Be" (Fatalism); and "If It Had Not Been for the Mighty One on Our Side" (Spirituality). The findings demonstrated implications for three areas that relate to social work services with African Americans who are living with type 2 diabetes and/or depression and fatalism: culturally sensitive and gender specific programs should be developed for African Americans who are living with diabetes and/or at risk of depression; spirituality should be infused in psychotherapeutic interventions and diabetes education; and community based health care programs should endeavor to have culturally specific providers, whenever possible. Furthermore, extensive triangulation and broadening of extrapolation possibilities were identified as two major strengths in using QIMS.

Relevance and Implications for Social Work Practice and Personal Reflections

While conducting and upon completion of this extensive qualitative meta-synthesis research study, the first author/principal investigator recognized several things. I was personally saddened and angry to learn about the dismal unhealthy state of Black America, due to health disparities and inequities across a wide range of diseases, behavioral risk factors, environmental exposures, social determinants of health, lack of access to health care, discrimination and cultural barriers, and this represented a personal bias for me. As a result, as a African American clinical social worker and diabetes educator, given my keen awareness of professional attributes: knowledge, ethics, values, purpose and sanction, I will continue in my clinical social work practice, research and educational endeavors to serve all individuals, families, groups, communities and organizations. More specifically, I will increase my commitment to the social work values to advocate for racial, social, economic and environmental justice. These values speak to the dignity and worth of all human beings, common human values and human behavior in the social environment, because "all people matter" [39,40]. However, as an African American social worker, I have a special burden on my heart to advocate and people of African descent, in keeping with the mission statement of the National Association of Black Social Workers, who work to create a world in which people of African ancestry will live free from racial domination, economic exploitation, and cultural oppression… to leverage its collective expertise to strategically develop capacity of people of African ancestry to sustain and flourish [41] in the development of holistic approaches to health and wellness, and given the epidemics of diabetes, depression, and fatalism…and the healing inherent in "if it had not been for the Mighty One who was on our side…"

Author Note

Data collection and preliminary analysis was originally compiled on September 30, 2017 and was revised on March 19, 2021. There are no conflicts of interest to disclose.

References

1. De Groot M, Lustman PJ (2001) Depression among African-Americns with diabetes: A dearth of studies. Diabetes Care 24(2): 407-408.

2. Briere J, Elliot DM (2003) Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. Child Abuse Negl 27(10): 1205-1222.

3. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2014) Black or African American populations.
4. National Vital Statistics Reports (2013) Deaths: Leading Causes for 2010 62(6): 31.
5. https://www.joydegruy.com/post-traumatic-slave-syndrome
6. Institute for Scripture Research (2010) The Scriptures. Republic of South Africa: Institute for Scripture Research
7. U.S. Census Bureau (2014) Annual estimates of the residential population by sex, race alone or in combination and Hispanic origin for U.S. and counties, April 1, 2010 to July 1, 2012. U.S. Census Bureau-population division.
8. American Diabetes Association (2011) Statistics about diabetes: Data from national diabetes fact sheet. (Report released January 26, 2011). Alexandria, VA.
9. National Vital Statistics Reports (2011) Death: Preliminary data for 2011. 61(6): Table 6.
10. Powe BD, Weinrich S (1999) An intrvention to decrease cancer fatalism among rural elders. Oncol Nurs Forum 26(3): 583-588.
11. Powe BD, Johnson A (1995) Fatalism among African Americans: Philosophical perspectives. J Relig Health 34(2): 119-125.
12. Mbiti JB (1969) African religions and philosophy. Heinemann, Portsmouth, NH.
13. Polzer R, Miles MS (2005) Spirituality and self-management of diabetes in African Americans. J Holist Nurs 23(2): 230-249.
14. Bell D (1995) Whos's afraid of critical race theory? University of Illinois Law Review pp: 893-910.
15. Mental Health America (2007) What is depression? Mental Health America, Alexandria, VA.
16. American Diabetes Association (2014) Depression. Alexandria, VA.
17. Anderson RJ, Freedland KE, Close RE, et al. (2001) The prevalence of comorbid depression in adults with diabetes: A meta-analysis. Diabetes Care 24(6): 1069-1078.
18. Lustman PJ, Freedman KE, Griffith L, et al. (2000) Fluoxetine for depression in diabetes: A randomized double-blind placebo control trial. Diabetes Care 25(5): 618-623.
19. Piette JD, Richardson C, Valenstein M (2004) Addressing the needs of patients with multiple chronic illness: The case of diabetes and depression. Am J Manag Care 10(2): 152-162.
20. Lin EHB, Katon W, Von Korff M, et al. (2004) Relationship of depression and diabetes self-care, medication adherence, and preventive care. Diabetes Care 27(9): 2154-2160.
21. Whittemore R (2004) Strategies to faciliate lifestyle change associated with diabetes mellitus. J Nurs Scholarship 32(3): 225-232.
22. Aguirre RTP, Bolton KW (2013) Qualitative interpretive meta-synthesis in social work research: Uncharted territory. J Social Work 14(3): 1-16.
23. Rubin A, Babbie E (2011) Research methods for social work. Brooks/Cole, Cengage Learning, Belmont, CA.
24. Loftman J, Loftman LH (1995) Analyzing social settings: A guide to qualitative observation and analysis, Part 2. Independence, Wadsworth, KY.
25. Geertz C (1973) Thick description: toward aand interpretive theory of culture. In Geertz, C. (Ed.). The interpretation of cultures; Selected essays (pp. 3-30). Basic Books, New York.
26. Dixon-Woods M, Cavers D, Agarwal S, et al. (2006) Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. BMC Med Res Methodol 6: 35.
27. Seidman I (2006) Interviewing as qualitative research. Teachers College Press, New York.
28. Alvermann DE, O'Brien DG, Dillon DR (1996) On writing qualitative research. RRQ 31(1): 114-120.
29. Enthoven AC, Kronick R (1989) A consumer-choice health plan for the 1990s: Universal health insurance in a system designed to promote quality and economy, first of two parts. N Engl J Med 320(2): 94-101.
30. Marshall C, Rossman GB (1999) Designing qualitative research. SAGE Publications, Thousand Oaks, CA.
31. Padgett DK (1998) Qualitative methods in social work research. SAGE Publications, Thousand Oaks, CA.
32. Liburd LC, Namageyo-Funa A, Jack Jr. L (2007) Journal of the National Medical Association 99(5). 550-552, 554-558.
33. Peek ME, Odom-Young A, Quinn MT, et al. (2010) Race and shared decision-making: Perspectives of African Americans with diabetes. Soc Sci Med 7(1): 1-9.
34. Wenzel J, Utz SW, Steeves R, et al. (2005) "Plenty of sickness": Descriptions of African Americans living in rural areas with type 2 diabetes. Diabetes Educ 31(1): 98-107.
35. Penckofer S, Ferrans CE, Velson-Friedrich B, et al. (2007) The psychological impact of living with diabetes: Women's day-to-day experiences. Diabetes Educ 33(4): 680-690.
36. Egede LE, Bonadonna RJ (2003) Diabetes self-mamagement in African Americans: An exploration of the role of fatalism. Diabetes Educ 29(105): 105-115.
37. Shellman J, Mokel M, Wright B (2007) "Keeping the bully out": Understanding older African Americans' beliefs and attitudes toward depression. J AM Psychiatirc Nurses Association 13(4): 230-236.
38. Finfgeld-Connett D (2010) Generalizability and transfereability of meta-synthesis research findings. J Adv Nurs 66(2): 246-254.
39. National Association of Social Workers (2008) Code of ethics.
40. National Association of Social Workers (2014) All people matter: 2014 social work month theme.
41. National Association of Black Social Workers (2017) Mission statement. National Association of Black Social Workers, Washington, DC.

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Received date: March 19, 2021; **Accepted date:** May 10, 2021; **Published date:** May 13, 2021

Citation: Pamela L Fox (2021) "If It Had Not Been for the Mighty One Who Was on Our Side" Diabetes, Depression, Fatalism and Spirituality among African Americans: An Afrocentric Qualitative Interpretive Meta-Synthesis (QIMS). *J Soc Work Prac Educ* 1(1): 101.

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