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Spiritual Expressions of African Americans and Whites in Cancer Pain

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Abstract

Background—Spiritual practices are one way that individuals cope with cancer pain.

Purpose—Describe and contrast expressions and values about the use of spirituality for pain in African American (AA) and White (WH) oncology patients.

Methods—Six groups (3 AA; 3 WH; n=42; mean age 58) were conducted. Focus group and qualitative methodology with a cultural interpretive lens was utilized. The Model of Integrated Spirituality provided the conceptual framework for understanding the narratives.

Findings—AAs and WHs did not differ on demographics, pain status, or integrative therapies. Three spirituality themes emerged: 1) pain and distress as antecedents to the use of spirituality; 2) active and existential attributes of the use of spirituality; and 3) mobilization of internal and external resources as outcomes. There were commonalities between AAs and WHs but greater frequency of certain subthemes and keywords in AAs.

Conclusions—Future studies should examine whether differences in overt expressions translate into different types and levels of spiritual usage.

Implications for Practice—Clinicians should recognize similar as well as different uses and descriptions of spirituality between African Americans and Whites.

Keywords

spirituality; cancer patients; pain; African American; qualitative; oncology

Introduction

Unrelieved cancer pain is devastating to patients and to their loved ones. Spiritual practices are one way that some individuals chose to cope with their cancer pain. Previous studies have investigated spirituality in the setting of cancer or pain (Bowie, Sydnor, Granot, & Pargament, 2004; Levine, Aviv, Yoo, Ewing, & Au, 2009; Rippentrop, Altmaier, Chen, Found, & Keffala, 2005), but no studies were found that studied individuals' spiritual practices in cancer and pain. In addition, although racial and ethnic differences have been substantiated in pain perception, impact, assessment, and treatment across multiple settings and pain types (Cintron & Morrison, 2006; Green et al., 2003), no studies were found that described and contrasted the differences in use of spiritual practices using a cultural lens.

The purpose of this study was to describe and contrast expressions and values about the use of spirituality for cancer pain using a cultural lens in African American and White oncology patients.

Background

Culture is a complex construct but for the purposes of this article is defined as a socially constructed system of shared knowledge, belief, and behavior (Princeton University, 2006). Spirituality is defined as an inherently human experience, sometimes involving religious structures, that connects the person to others, nature, and/or a Supreme Being providing meaning and purpose (Buck, 2006). Culture shapes each domain of spirituality, and the person defines and integrates self in reference to his or her culture. How connections with others are experienced is also culturally shaped (e.g., role expectations). Integration of transcendence, whether in the form of polytheism (or pantheism), monotheism, or atheism, is also a function of culture (Johnson, Elbert-Avila, & Tulskey, 2005). It has been suggested that people with cancer have increased spiritual needs because of the existential stresses of living with a potentially life-threatening disease (Post-White, 2003; Sherman et al., 2005; Taylor, 2003).

Culture influences how cancer and other chronic diseases are experienced (Chesla, Skaff, Bartz, Mullan, & Fisher, 2000; Powe, 2007). A qualitative study conducted among seven culturally distinct groups found that cancer was feared across all groups and all reported communicating with God or Allah in culturally shaped ways (Papadopoulos, 2006). When an ethnically diverse group of 161 breast cancer survivors were interviewed, 83% of them talked about their spirituality, but a higher percentage of African Americans, Latinas, and Christians expressed being comforted by God in their experience of the disease (Levine, Yoo, Aviv, Ewing, & Au, 2007). Cancer patients report that spirituality helps them deal with cancer by providing hope and a positive outlook (personal integration) and connection to supportive communities (integration with others; Bowie, Sydnor, Granot, & Pargament, 2004; Weaver & Flannelly, 2004). Positive outcomes of spirituality for the person include personal growth, increased self-esteem, and optimism (Ano & Vasconcelles, 2005; Mattis, Fontenot, & Hatcher-Kay, 2003). Negative outcomes include poorer symptom management and barriers to some treatment choices (Bosch & Banos, 2002). Cancer patients also report that some interpersonal connections can be ambiguous or negative rather than supportive (e.g., perceived abandonment by friends, meddling by family members; Schulz et al., 2008).

Culture and spiritual beliefs have also been shown to influence the understanding and response to pain (Chen, Miaskowski, Dodd, & Pantilat, 2008; Papadopoulos, 2006). In studies of Christians with cancer or pain, it was found that African Americans report more religious practices such as church attendance, social support from faith communities, and use of prayer than do other groups, such as Whites and Hispanics (Bowie, Sydnor, Granot, & Pargament, 2004; Edwards, Moric, Husfeldt, Buvanendran, & Ivankovich, 2005; Hamilton & Sandelowski, 2004). However, other studies report that these differences disappear when groups are controlled for religious versus nonreligious affiliation (Glover-Graf, Marini, Baker, & Buck, 2007). But no research was found that studied the use of spirituality in the setting of cancer pain through a cultural lens—exploring what is known, believed, and acted on by a group of people.

Method

Conceptual Framework

The model of integrated spirituality (Buck, 2006) provided the conceptual framework for understanding the narratives. This model was developed from a concept analysis of the

nursing literature to situate the domains in the current nursing discourse surrounding spirituality. Spirituality is seen as three concentric domains of coexisting connectedness. The human being experiences first personal integration (connection to self), then integration with others (connection to friends, family, all humans), and finally integration with transcendent dimensions (connection to nature and/or a Supreme Being). Necessary criteria for this concept of spirituality include the following: humanness, ontologically and teleologically informed, self-transcendence, connection, and possible (but not necessary) involvement of religious structures and traditions. Spirituality, according to this conceptualization, contains both global characteristics common across cultures, such as a search for meaning and purpose, and characteristics unique to particular cultures, such as monotheism, polytheism, or pantheism (Conner & Eller, 2004). It is considered a broader construct than religiosity and is present in all human beings.

Participants

Individuals took part in six focus groups made up of six to nine participants per group in August of 2008 as part of a larger study to identify attributes relevant to patients' decision to use analgesic treatment for cancer pain (Meghani, 2009). In response to questions about nonpharmacologic management practices, participants described their use of spirituality in the setting of cancer pain. Interviewer prompts are provided in Table 1. Three of the six groups had African American (AA) participants and three had White (WH) participants (the abbreviations AA and WH are used when referring to the participants in the study groups). Groups met separately to allow for an analysis of factors important and specific to each group. This technique is preferred as the ground work for the development of a conjoint analysis survey used in the parent study. Inclusion criteria were the following: (a) at least 18 years old, (b) self-identified AAs and WHs using National Institutes of Health categorization for these racial groups (U.S. Department of Health and Human Services, 2001), (c) diagnosed with cancer, and (d) cancer-related pain in the 1 month prior to the interview. Patients with limited English proficiency or those with cognitive inability to understand study aims or provide informed consent were excluded. Eligible participants from diverse backgrounds were recruited by a professional focus group company using a variety of methods and sites including cancer support groups, wellness communities, and a large database of patients main tained by the company.

Procedure

Institutional review board approval was obtained from the University of Pennsylvania. Staff from the focus group company contacted potential participants by phone and determined eligibility using an investigator-designed eligibility checklist. Eligible participants were provided information about the study aims and invited to participate. Those interested in participating were mailed detailed information about the study and the date, time, and venue of their assigned focus groups. Age, gender, race/ethnicity, marital status, education, income, health insurance, and pain status data were collected via self-report. The focus groups were conducted based on recommended focus group format (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007) involving an opening question, transition questions, key questions, and concluding question. The entire data collection lasted 1.5 to 2 hours. Participants were compensated \$60 per hour for their time and participation. Moderators used prompts such as "What are your thoughts between the use of pain medications or some other kinds of treatments, for example, massage, natural remedies, or even prayer or something of that sort?" or "Are there any sorts of other treatments that any of you have pursued? It could be religion and prayer as a way to deal with things. It could be natural remedies" (Table 1). Only those data relating to the use of spirituality for cancer pain were used for this subanalysis.

Data Analysis

Digital audio-recordings of the focus groups were transcribed verbatim by a professional transcriptionist. A two-part analysis of the narratives was conducted. First, line-by-line thematic coding was conducted, and then words were counted using the conceptual framework's three-domain structure to inform the choice of words related to spirituality as either connection or integration with self, other, and transcendence. In the first part of the analysis, themes related to spiritual knowledge, belief, or behavior were identified using a line-by-line hand coding. A coding structure was used to categorize distinct themes and subthemes as antecedents, attributes, and consequences to the use of spirituality in the cancer pain setting. The structure was based on identifying the frequency (measured by how often something was said), specificity (measured by the presence of specific answers), and extensiveness (measured by how many different participants verbalized the same theme) of the codes. In the second part of the analysis, frequency of words used by participants in each of the groups was analyzed. These terms were then coded as present or absent, and their frequencies were counted as suggested by qualitative methodologists, including Sandelowski (2001). These frequencies allowed for a visual (in the form of bar charts) representation of the data, which facilitated the recognition of patterns within and across groups, derivation of meaning, and generation of further lines of inquiry. Counting also allowed for the assessment of the frequency, specificity, and extensiveness of the themes. Care was taken to avoid the pitfalls of counting: verbal counting by providing actual numbers, overcounting by reporting the results in a separate section but linked to the themes by the conceptual framework, and acontextual counting by providing the numbers after the reader has had the opportunity to assess the themes (Sandelowski, 2001).

Further constant comparative analysis techniques were used to explore and understand the use of spirituality in the setting of cancer pain (Strauss & Corbin, 1998). The responses of each participant were compared within and across groups by placing quotes side by side. The reliability of the codes and categories was established by two investigators independently coding and categorizing the data. Any differences in the codes were agreed on with discussion between the investigators. Limited quantitative analysis was conducted on the demographic information using nonparametric tests (Fisher's exact test for categorical variables; Mann–Whitney *U* test for continuous variables).

Findings

Forty-two individuals completed the focus groups (21 AAs, 21 WHs). The typical group member was likely to be insured, educated, married and in his or her late 50s. There were no significant differences between groups on age, gender, marital status, income, education, pain status, or complementary and alternative medicine (CAM) use (see Table 2). Of the individuals, 31% had breast cancer, 14% had multiple myeloma, 12% colorectal, 10% prostate, and the rest had lung, head, and neck cancer and other cancer types. There were no statistical differences in diagnosis between the AA and WH groups. Seventy-six percent reported that they were Christian, 2% Muslim, 5% Jewish, and 17% "other" (Table 3). A statistical difference was found on a self-identified religious characteristic ($p = 0.036$) between the AA and WH groups with 20 AAs versus 12 WHs reporting that they considered themselves Christian. Figure 1 provides the temporal link between the conceptual framework and the findings. Table 4 provides the linkages between the model and the narrative themes.

Antecedents to the Use of Spirituality in the Cancer Pain Setting: Pain/Distress

For both AAs and WHs, pain is a stimulus to pray, to call on spiritual support, and to stand strong. When they experience pain, the immediate response is to reach out to God in prayer.

Distress as a trigger to spirituality was expressed only by the AAs. They respond to cancer pain by asking for a chaplain in the acute care setting or for their pastor when at home.

Attributes of the Use of Spirituality: Active/Existential

The active subthemes related to spiritual actions and how participants viewed their actions. The subthemes that emerged were the *perceptions of prayer* and *role of prayer*. For AAs, prayer was perceived to be powerful, involved mind over matter, and worked. Prayer's role was to help keep things in perspective, to get them through the illness, to put them at peace, and to distract them from the pain. For the WHs, group prayer's role is one of several options. Some respondents in the WH groups also apologized for mentioning their use of religion. One stated, "I don't want to keep on throwing religion out there, 'cause that's not what this is about ..."

Existential subthemes related to the experience of spirituality in cancer. There were more existential than active subthemes as would be expected in any discussion of spiritual topics. Once again, there were differences in the expressions of spiritual themes between the two groups. The AAs mentioned existential issues more frequently (17 times vs. 6 times). The existential subthemes that emerged were *state of blessing* (mentioned by both AAs and WHs), *being accompanied by God* (AAs), *not dwelling on it* (i.e., the cancer; WHs), *finding meaning* (AAs), *transcending self* (AAs), *the duality of dying* (AAs and WHs), *living paradox* (AAs), and *euphemisms* (AAs and WHs).

State of blessing—For AAs, the subtheme *state of blessing* encompassed the counting of lifelong blessings, such as having lived for a long time without pain prior to their cancer experience and feeling blessed despite the pain, whereas WHs expressed it more as gratitude to God—"I thank God every day it (the pain) got a little better."

Being accompanied by God—Only the AAs expressed the subtheme *being accompanied by God*. This sub-theme included experiencing God's presence in the pain, discussing the pain with God, or believing the pain to be mitigating abandonment feelings. God's presence was expressed as tangible by these individuals: "Faith doesn't stop the pain but just to have Jesus to talk to in the night," stated one informant.

Not dwelling on it—The subtheme *not dwelling on it* (the cancer) was expressed only by individuals in the WH focus groups. It was expressed as bracketing the cancer pain experience by giving it to God. One person tied it to previous coping, whereas another individual saw it more as a function of positive thinking.

Finding meaning and transcending self—The sub-themes of *finding meaning* and *transcending self*, once again, occurred only in the AA groups. *Finding meaning* involved using their experience to reach out to others. One person described finding poems on the Internet and sharing them with other people with cancer. The cancer pain experience was viewed as a place where growth and giving can take place. *Transcending self* was related to finding meaning but is more connected to community. One informant described his or her role in a cancer support group at his or her church, making his or her phone number available to anyone newly diagnosed with cancer, and visiting others while still experiencing pain. In connecting to others and caring for them, their perception of pain is lessened.

Duality of dying—The *duality of dying* subtheme was present in both groups. It encompassed remaining engaged with this life while becoming aware of one's own mortality and feeling that pain was part of the experience and so was God.

Living paradox—The living paradox subtheme expressed only in the AA groups related to experiencing blessing in the midst of pain. This was different from the *state of blessing* subtheme in that one could experience blessing in the pain, not just in its relief.

Euphemisms—Both groups used *euphemisms* for death or dying, such as “going on home,” “take that long walk,” and “start to sign off.” Interestingly, only one WH informant used the term *mortality*, and neither group used the word *death*.

Outcomes of the Use of Spirituality: Mobilization of Internal and External Resources

Both groups expressed that the use of spirituality in cancer pain had expected outcomes—the mobilization of internal and external resources to deal with the cancer pain. The subthemes that arose were *expectations of God* (AAs and WHs), *humor* (AAs), *formal/informal support* (AAs and WHs), and *role switching* (AAs).

Expectations of God—*Expectations of God*, for AAs, involved experiencing his strength, presence, and power to give them time with loved ones. The WH groups' expectations of God had a more temporal dimension. One WH participant stated this as, “I truly believe in my case the Lord saved me and is saving me to this day, because my situation was really bad.”

Humor—In the AA group, spiritual *humor* emerged as a resource to help them deal with cancer pain and mortality. The informant stated, “There's a joke, everyone wants to see Jesus, just not right now.” The joke used a euphemism “see Jesus” for death while adding the existential tension of “not right now.” The informant used the joke to diffuse the tension that had built up after the previous person in the focus group shared the experience of being diagnosed with cancer and not wanting to die. The whole group laughed after the joke, and then another person began explaining that his or her faith was the only way that he or she got through the whole cancer experience.

Formal/informal support—*Formal/informal support* was mentioned by both groups. AAs talked about support from cancer groups at church involving both group meetings and phone ministries where survivors called or were called on by other people newly diagnosed with cancer. One respondent mentioned that people from his church came to visit him in the hospital, yet another referenced the more informal support that music provided. An informant in the WH group expressed the subtheme of *support* but noted that the pain can break the connection by limiting their activities.

Role switching—The final subtheme under mobilization of internal and external resources was *role switching*, which was only used in the AA group. This involved the persons with cancer pain being enabled to support distressed loved ones and visitors even though they were the ones with cancer and pain.

Keyword Analysis

Overall, there were only slight differences in the AA and WH groups with regard to the use of words associated with spirituality, but AAs consistently were more likely to use terms and expressions associated with spirituality (Figure 2). Of the AA individuals, 47% mentioned using “prayer” (or pray, praying) as compared with 35% of the WH informants. Keywords, including “blessed” (8% AA vs. 5% WH), “pastor or chaplain” (3% AA vs. 0.02% WH), and “church” (6% AA vs. 4% WH) are examples of the slight but consistent differences. Only in the use of the word *religion* did the WH group have a greater response than the AA group (2 uses vs. 0 uses). The AA groups were also more likely to express verbally that the pain was a “test” and made mention of using support groups. Overall, 65% of the AA

individuals used the names of deity (God, Jesus, Lord), whereas 61% of the WH individuals did so. An interesting finding was that 40% of the WH group used the name of deity casually or as an interjection (i.e., “Oh my God,” “thank God,” and “God forbid”), whereas none of those phrases were used by the AA groups. Frequency of the three themes (*Antecedents, Attributes, and Outcomes to the Use of Spirituality in the Cancer Pain Setting*) showed a comparable pattern, but the AA groups mentioned the themes more. A further difference is noted. Interestingly, one of the WH groups did not discuss spirituality for cancer pain in the same overtly religious terms even when given a prompt by the moderator. They, instead, embarked on a discussion of the efficacy of acupuncture for pain control.

Discussion

Linkages Between the Conceptual Model and the Themes

This study was conceptually driven, and an understanding of the framework is necessary to understand the analysis and findings of the narratives. In this conceptualization, spirituality has three concentric layers of connectedness. Connection with self, others, and the transcendent are co-occurring phenomena in the human experience. After the line-by-line coding was completed by the investigators, the temporal dimensions of the narrative were clear. The informants often shaped their accounts by beginning with “When I have pain ...” or “When it got rough ...” This led the investigators to the understanding that pain or distress anteceded the implementation of spirituality to cope. Then the narratives were analyzed for whether the informant described a connecting with self and/or others in their stories of what he or she did or how he or she felt. All of the narratives included language that had a reaching in (connecting with self) or reaching out (connecting with others or transcendence) to draw strength or courage to deal with the pain. These became the attribute themes. And finally the narratives usually ended with an outcome or a result. The informants use their spiritual resources because they have found them to work—they enable the person to cope with the uncertainty of cancer and the experience of pain.

Use of a Cultural Interpretive Lens

This study described and contrasted expressions and values about the use of spirituality for cancer pain in AA and WH oncology patients. Overall, there was concordance between the two groups reflecting, perhaps, a common culture, although there was greater frequency of use of the subthemes and keywords in AA groups. This study does not suggest that all AAs share the same unique knowledge, beliefs, and behaviors. Nor is it suggested that WHs share a separate set. Furthermore, it is not suggested that all Christian (or Muslim, Jewish, or “other”) groups would endorse the same knowledge, beliefs, and behaviors. There was within-group variability in the narratives in this study. What this study does uniquely reflect is that when a cultural lens is used to analyze descriptions of the use of spirituality in the setting of cancer pain, new ways of viewing the phenomena are constructed. The common culture suggested by these narratives may reflect that 76% of the informants self-identify as Christian, or it may reflect that 100% of the informants were human. But as nurses delivering care in a pluralistic society, there is a need to be aware of both differences in expressions and values concerning spirituality as well as similarities.

In all groups, both pain and distress served as antecedents and stimulated the person to make use of personal, professional, and community spiritual resources. Furthermore, the informants' uses of spirituality had both active and existential attributes. The outcome of the use of spirituality was to mobilize resources both within the person and in the community. The analyses show that both AA and WH participants expressed many similar subthemes but differences were also noted. Theis, Biordi, Coeling, Nalepka, and Miller (2003) conducted a qualitative study examining spirituality in caregivers and patients with cardiac

diagnoses or arthritis, which compared themes in AA and WH subjects and found that although there were differences in the caregiver groups, there were no appreciable differences in the AA and WH patients. Pain is a great equalizer. Our study found that although there was overall concordance, the differences in expression were important. Understanding the similarities and differences between the two groups, in the setting of cancer pain, will further the science of integrative pain management in both research and clinical practice. In tailored interventions that include spirituality, care should be taken in word choices. Some groups may appreciate the use of “their words” to express spirituality.

Antecedents to the Use of Spirituality

Pain and distress have been found to be significantly associated with praying in chronic pain patients (Andersson, 2008; Edwards et al., 2005; Glover-Graf et al., 2007). One sample of pain clinic patients reported that the two most frequent self-care practices were taking their medication (89%) and praying (61%; Glover-Graf et al., 2007). In a matched-group–design study involving African Americans, Hispanics, and Whites, no significant differences were found in levels of pain or distress, but African Americans and Hispanics scored higher (relative to the Whites) on a prayer scale (Edwards et al., 2005). This supports the findings of this study where prayer (pray, praying) is mentioned in both groups but more often in the AA groups than in the WH groups (47% vs. 35%).

Attributes of the Use of Spirituality

Our findings clearly illustrate that AAs are more likely to verbalize the role of prayer and faith when discussing spirituality in cancer pain. Whereas some WH respondents apologized for mentioning prayer or equated it with other CAM therapies, AAs articulated that prayer was powerful, life changing, and signified a direct connection to God. This is supported by Bowie, Sydnor, Granot, and Pargament (2004) who found that AA (when compared with WH) participants had higher reported levels of quality of spiritual life and voiced the importance of God in prostate cancer recovery. The current study themes are also supported by the content analysis of Gibson and Hendricks (2006) in AA breast cancer survivors. Themes identified in that integrative review included belief that God is near, is the healer, and is in control. A study examining the role of spirituality among breast cancer survivors found that a higher percentage of AAs and those identifying themselves as Christians felt comforted by God (Levine et al., 2007). Further analysis of these subjects showed that ethnic minorities reported finding more comfort from prayer and felt closer to God than WHs (Levine et al., 2009). However, Glover-Graf et al. (2007) found that differences between AAs and WHs in religious/spiritual practices, beliefs, and attitudes disappeared when controlling for whether the persons identified themselves as religious or nonreligious. Our study shows that for both groups, the use of spirituality is multidimensional—it involves greater connection with internal resources as well as external resources.

Outcomes of the Use of Spirituality

The primary outcome to the use of spirituality in this sample was to mobilize internal and external, personal, and community-based resources to deal with the cancer pain experience. Newlin, Knafl, and Melkus (2002) in an evolutionary concept analysis of AA spirituality reported similar consequences. Consistent and persistent themes in the literature on AA spirituality are both the report of connectedness to God and a deepening relationship with God because of the difficult experiences in life and connectedness to their community and a deepening relationship with their community because of the same experiences. Hamilton, Powe, Pollard, Lee, and Felton (2007) extend what is known about the role of spirituality among AA cancer survivors in reporting on the social support that AAs believe that God provides and that the cancer experience provides spiritual benefit and meaning. In a mixed (AA and WH) noncancer pain population, the majority of respondents were reported to

perceive God or a Higher Power as helping them cope and as a source of meaning, purpose, and connection in life (Glover-Graf et al., 2007). What this study adds is that there are similarities in the outcomes to the use of spirituality, but there are some distinct differences in the context of frequency (more AAs mentioned consequences of spirituality), specificity (AAs were more specific in describing the mobilization of resources), and extensiveness (more AA participants verbalized this same theme).

Limitations

Several limitations exist in this study, which may affect the trustworthiness and transferability of the findings. Although demographic diversity was sought, these groups show a high degree of homogeneity. Both AA and WH groups were generally middle-aged, educated, and insured. Three quarters of the sample identified with the Christian faith. The similarities in the findings between the two groups may reflect this commonality. The science would be advanced by using maximum variation sampling procedures to increase heterogeneity in future studies. There is also the potential for social desirability on the part of the respondents in personal discussions with professionals. However, adherence to established focus group format and qualitative analyses increased the rigor of the study (Halcomb et al., 2007). Finally, there are conceptual limitations related to the current understanding of spirituality. Pesut, Fowler, Taylor, Reimer-Kirkham, and Sawatzky (2008) have noted the daunting nature of constructing adequate conceptualizations of spirituality in our current pluralistic, globalized environment. Furthermore, they suggest that Western thought and biases now limit our ability to understand spirituality and religion. Since the definition of spirituality and the conceptual model used for this study were derived from English language nursing literature related to spirituality, this study may suffer from these limits.

Conclusion

The findings of this study suggest that the use of spirituality in the setting of cancer pain is prevalent and more similar than different for Africans Americans and Whites, suggesting a common underlying spiritual, human culture. We also found that while the spiritual themes were mostly common, there were differences in sensitivities (e.g., the casual use of the name of deity may not be appropriate or appreciated by Africans Americans) and frequencies of use of certain words and phrases. It is not clear if higher frequency or use of certain words or phrases actually translates into high levels of spiritual concern. This calls for further research. In the meantime, clinicians should approach the issue of spirituality by moving beyond the quantitative differences in the expressions of words and phrases recognized as epitomes of spirituality while being cognizant of patients' expressions and sensitivities. Transcultural models of cancer pain management should account for both the similarities and differences in spiritual expressions and values when implementing care.

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Biographies

Harleah G. Buck, PhD, RN, CHPN is an assistant professor of nursing at the Pennsylvania State University. Her research focuses on quality of life in end of life populations. She studies how patients and caregivers implement strategies, like spirituality, to maintain their quality of life.

Salimah H. Meghani, PhD, MBE, CRNP, RN is an assistant professor of nursing at the University of Pennsylvania. Her research focuses on racial and ethnic disparities in cancer pain treatment, specifically patient-level factors affecting negotiation of treatment for cancer pain among African Americans.

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Figure 1.
Temporal Linkage Between the Conceptual Framework and the Findings

Figure 2.
Frequency of Word Use for African Americans (AA) and Whites (WH)

Table 1**Focus Group Interviewer Prompts**

What are your thoughts between the use of pain medications or some other kinds of treatments, being either massage, or some kind of natural remedies, or even using prayer or something of that sort?

Are there any sorts of other treatments that any of you have pursued or have wished to pursue specifically? It could be religion or prayer, natural remedies as a way to deal with things.

... some of you mentioned about using other methods for treating your pain, other than medications. And some of you mentioned about prayers or distraction. Can you talk more about how you manage your pain when you're not able to take pain medications?

... has anyone else experimented, not necessarily just with that [macrobiotics] but any other kind of alternative remedies, whether it's acupuncture, whether it's massage, even just prayer or just anything like that?

... and is that [prayer] something you find helpful in dealing with pain?

... and I know some other people have mentioned acupuncture as well. So has anybody else had experience with any of those sorts of remedies or any other kind of natural remedies?

Note: Capitalized prompts reflect that the interviewer initiated the line of questioning. Ellipses indicate that an informant initiated the line of questioning and the interviewer responded.

Table 2

Demographic Characteristics

Variable	Total	White	African American	Difference Between African American and White Groups; <i>p</i> Value
Age (years)	57.5	54.7	56.1	.696
Gender (% male)	48.0	42.9	52.4	.758
Marital status (% married)	59.5	61.9	57.1	.602
Income (>\$50,000/year)	47.6	66.6	28.6	.160
Education (% college)	54.7	57.1	52.4	.463
Insurance (% yes)	95.2	95.2	95.2	.368
Pain worst (0–10)	6.0	5.4	6.1	.294
Pain least (0–10)	3.0	2.6	3.2	.361
% Pain relief with analgesics	70.0	71.1	63.4	.328
Complementary and alternative medicine total	2.0	2.6	2.2	.380

Table 3

Self-Identified Religious Characteristics

	African Americans	Whites	Total
Christian	20	12	32
Muslim	0	1	1
Jewish	0	2	2
Other	1	6	7
Total	21	21	42

Table 4

Linkages Between the Conceptual Framework and the Narrative Themes

Model Concept	Definition	Attribute Theme
Intrapersonal connection in spirituality	Connection of the individual with self, observable as a sense of personal integration	State of blessing Duality of dying Living paradox
Interpersonal connection in spirituality	Connection between individuals, observable as friendship/trust	Finding meaning Transcending self Euphemisms
Transpersonal connection in spirituality	Connection of the individual with transcendence, observable as existential experiences	Role of prayer Perceptions of prayer Being accompanied by God Not dwelling on it