Review Article

African American elders' psychological-social-spiritual cultural experiences across serious illness: an integrative literature review through a palliative care lens

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Abstract: Disparities in palliative care for seriously ill African American elders exist because of gaps in knowledge around culturally sensitive psychological, social, and spiritual care. The purpose of this integrative literature review is to summarize the research examining African American elders' psychological, social, and spiritual illness experiences. Of 108 articles, 60 quantitative, 42 qualitative, and 6 mixed methods studies were reviewed. Negative and positive psychological, social, and spiritual experiences were noted. These experiences impacted both the African American elders' quality of life and satisfaction with care. Due to the gaps noted around psychological, social, and spiritual healing and suffering for African American elders, palliative care science should continue exploration of seriously ill African American elders' psychological, social, and spiritual care needs.

Keywords: African American; mental healing; social support; spiritual healing; literature review

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Introduction

As the population of African American (AA) elders increases, there is a need to focus on delivery of culturally congruent care (1). In 2010, there were 38.9 million AA elders, and by the year 2050, AA older adults are projected to account for more than 21.5% of the US population, an increase from 10% in 1990s (2). Yet, according to the Agency for Healthcare Research and Quality Health Disparities Report (3), AA elders are less likely than Whites to receive the right amount of support during the time of serious illness. Disparities in seriously ill AA elder care exist because of gaps in knowledge around culturally sensitive physiological, psychological, social, and spiritual palliative care practices (4-7). To facilitate psychological, social, and spiritual healing for the seriously ill AA elder, palliative care practices must be informed by the perspectives of the seriously ill AA elder. Defined for this study, palliative care's role is "to anticipate, prevent and relieve suffering; to support the best possible quality of life for patients and their families, regardless of the stage of the disease", not just care provided at end-of-life [(8) p. 9]. Serious illness is defined conceptually as "a persistent or recurring condition that adversely affects one's daily functioning or will predictably reduce life expectancy" [(8) p. 8].

A review of the current research into psychological, social, and spiritual experiences of seriously ill AA elders can provide insight into creating culturally sensitive approaches for improving quality of life and overall satisfaction with the healthcare received. Research in this area is growing; however, research examining psychological, social, and spiritual healing experiences remains limited in scope, quantity, and location. Through a culturally congruent framework (1), the integration of psychological, social, and spiritual experiences provides holistic, patient-centered care that "identif[ies], respects and address[es] differences

in patient values, preferences and expressed needs" [(9) pg.1]. However, a knowledge gap remains in this area, particularly through a culturally focused framework. A view that encompasses the multidimensional concepts of psychological, social, and spiritual healing must evaluate both culture-specific and culture-universal factors to provide culturally congruent care that is beneficial to the people being served (1). Nurses contribute to the healthcare experiences of AA elders through interactive "transpersonal caring moments" [(10) p. 12]. When inadequate care is given, AA elders have experienced insufficient symptom control, difficult interactions with their healthcare providers, lack of spiritual psychosocial support and the possibility of dying without access to high quality care (11-16)

Purpose

The purpose of this culturally focused integrative literature review is to summarize the current research examining AA elders' psychological, social, and spiritual experiences during serious illness. The following questions guided this review: What cultural experiences contributed to psychological, social, and spiritual healing for AA elders living with serious illness? What cultural experiences contributed to psychological, social, and spiritual suffering for AA elders living with serious illness? The insights obtained from this literature review can contribute to a framework for guiding future empirical research around the cultural phenomenon of psychological, social, and spiritual healing in seriously ill AA elders, thus guiding culturally sensitive approaches to interventions for patient-centered palliative care.

Key definitions

For this review, the following definitions were used to conceptualize the following terms: sociocultural, serious illness, healing, and suffering. Sociocultural was broadly defined: "the interaction between people and the culture in which they live" (17) Serious illness was limited and operationalized in this review to the top four leading causes of death in African Americans: heart disease, cancer, stroke, and diabetes mellitus (18). Healing was defined as generating a "sense of wholeness as a person" [(19) p. 657] despite one's illness. Healing has also been regarded as a subjective and multidimensional concept (19-30). For this review, healing in the setting of serious illness was defined as a "life transforming, positive, subjective change"—psychological, social, and spiritual healing—that occurs when one experiences a serious illness [(31) p. 1]. Suffering, on the other hand, was defined as a negative psychological, social, and spiritual experience (32).

Methods

Using Whittemore's (33) method for integrative literature review, an organized and rigorous approach to the literature review process was followed via five steps: problem identification, literature search, data evaluation, data analysis, and presentation of findings (33,34). Through this process, existing evidence, from both qualitative and quantitative methodologies was synthesized.

A computer assisted literature search was conducted during July 2013-September 2013. The following electronic databases were searched: PubMed, CINAHL, EBSCO, and Web of Science. Many different combinations of search terms were used. Initially, zero articles were found when searching the term "psychological-social-spiritual healing." Twenty four articles were found using the terms "psychological healing", "social healing", and "spiritual healing". Of the 24 found, 4 met the inclusion criteria and were retained for this review.

Because of the scarcity of the literature, related concepts to psychological, social, and spiritual healing were searched with the assistance of a reference librarian. Broader search terms were used in an attempt to capture the psychological, social, and spiritual healing/suffering phenomenon of seriously ill AA elders. The broader terms searched were: healing, psychological healing, social healing, spiritual healing, spirituality, faith, wisdom, meaning-focused coping, coping, recovery, subjective well-being, thriving, resilience, and optimism. Each of these terms was joined with the term "African American". Boolean operators were applied to define relationships between keywords like African Americans (and) Blacks. These searches were delimited by the following: samples that included an average age of the sample of their participants age 60 or older; discussed psychological, social and/or spirituality dimensions of AA elders; serious illnesses of cancer, heart disease, stroke or diabetes mellitus; published within the last twenty years; and peer-reviewed primary research reports. Theoretical, commentary and review articles were excluded; however, some of these articles' reference lists were used as secondary sources of primary studies for comparison to the database searches.

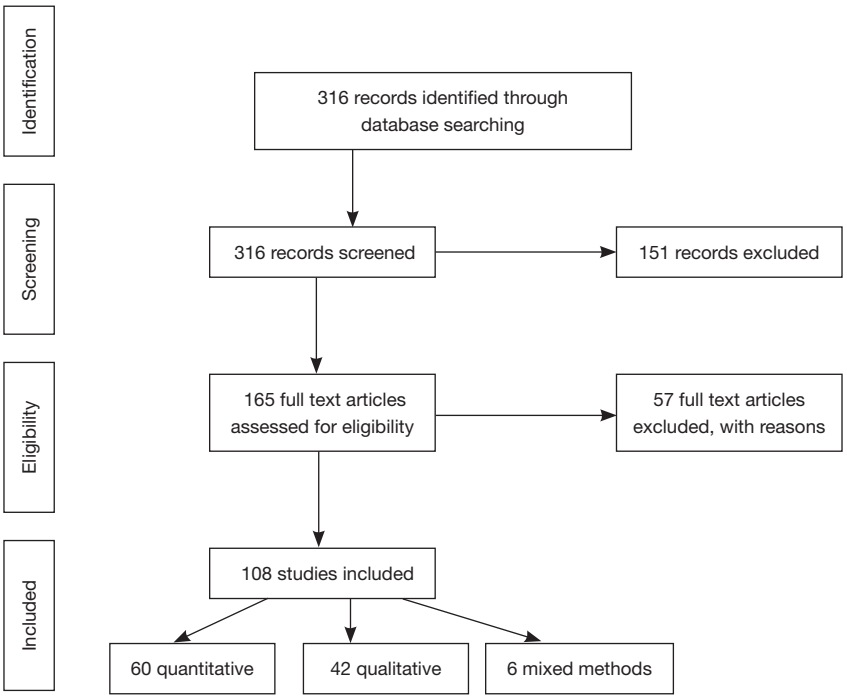

Figure 1 PRISMA flow diagram. Liberati A, Altman DG, Tetzlaff J, *et al.* The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. PLoS Med 2009;6:e1000100. Copyright: 2009 Moher *et al.* This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Search results

The initial multiple searches, using the above search terms, identified 316 publications. The primary author screened the titles, abstracts, and key words of these 316 publications. Due to duplicates and/or not meeting inclusion/exclusion criteria, 151 articles were removed, leaving 165 publications. The remaining articles were read in their entirety for continued screening with the inclusion/exclusion criteria, leaving 108 articles for this integrative review. The 57 articles removed after this second screening were excluded for several reasons: articles were literature review only; articles only discussed methodological implications of recruitment of AA elders; articles did not include samples with average age of 60 or older, and/or the sample did not include serious illnesses as defined above. From the final 108 publications, the research design, aim/purpose, sample and main findings were extracted into a data matrix. The 108 studies remaining were reviewed for quality and findings (see PRISMA flow diagram, *Figure 1*).

Results

Evaluation of the literature

The sample consisted of 60 quantitative, 42 qualitative, and 6 mixed methods studies. The samples of the quantitative studies ranged from n=17 to n=98,528. Of these, 53 were survey research. The remaining 7 of the 60 quantitative studies incorporated several types of methods. Of the 42 qualitative studies, the sample size ranged from n=6 to n=167. Of these, 4 used focus groups and the remaining used interviews for data collection. There were a variety of methodological designs, yet not all of them explicitly stated a design. Of the 6 mixed methods studies, the sample size ranged from n=30 to n=200. These articles used surveys and interviews. The details of the quantitative, qualitative, and mixed-methods studies are shown in *Tables 1*,*2*.

Despite the variety of research methodological approaches, many limitations relevant to the current review were noted. In the quantitative articles, 13 samples were

Table 1 Methodological approaches (I)

Design	Number of studies	Sample size range
Quantitative	60	17–98,528
Qualitative	42	6–167
Mixed Methods	6	30–200

Table 2 Methodological approaches (II)

Design	Number of studies
Quantitative	
Survey	53
Retrospective chart reviews	4
Confirmatory factorial analysis	1
Intervention	1
Qualitative	
Focus groups	4
Grounded theory	8
Qualitative description	4
Content analysis	5
Ethnography	3
Phenomenology	1
Other/unspecified[a]	15
Mixed methods	
Surveys with Interviews	6

[a] thematic analysis, framework analysis, in-depth Interviews.

made up of only African Americans, whereas, 47 included multiple ethnicities. For example, in the largest study (n=98,528), a retrospective chart review of Medicare heart failure patients, only 8.5% of the sample was AA (12). Of the quantitative studies, one study sampled African Americans only as part of the "National Survey of American Life" (35,36).

As with the quantitative studies, some of the qualitative studies did not use exclusively AA samples (n=22). However, 20 of the qualitative studies exclusively sampled only AA elders. Joining 3 large narrative analysis studies, the largest qualitative sample, n=167, used only AAs for their sample (37).

Also, there was lack of conceptual clarity around psychological, social, and spiritual concepts. Only 23 of the 108 publications specifically reported a conceptual framework, necessary for providing conceptual clarity. In this survey research, there was no consistency in surveys/instruments or measures employed to measure psychological, social, and spiritual dimensions. For example, the spiritual domain was defined in a variety of ways: spirituality, religiosity, and/or religion practice. Although there was a lack of conceptual clarity of the spiritual domain throughout all the studies, the measurement of the spirituality domain occurred at a much higher frequency than measurements for psychological or social domains. In fact, in the initial literature searches, "spiritual healing and African American," yielded the largest number of publications (n=29) compared to "social healing and African American" (n=9), and "psychological healing and African American" (n=9).

In the quantitative survey articles, the authors reported difficulty with item non-response, recall bias with self-reported measures and potential selection bias on the part of participants who returned mailed surveys. Large numbers of the survey articles were cross-sectional, and longitudinal studies were frequently recommended by the authors to capture the multi-dimensional psychological, social, and spiritual experiences of serious illness. Most of the 53 survey research studies incorporated only cross-sectional analyses, while only one incorporated a longitudinal approach. Within the survey research, the authors discussed the difficulty of collecting the wide variety of cultural dimensions of AAs elders' psychological, social, and spiritual aspects due to difficulty using instruments that were not developed within the AA culture. In the survey articles, the authors recommended future research should include qualitative approaches to allow for a more descriptive approach to gain knowledge about culturally focused qualities of the psychological, social, and spiritual dimensions.

A variety of qualitative methodological designs were used; however, not all of them explicitly stated a design/method. However, within the qualitative approaches, specific information such as clinical information, severity of disease, comorbid illnesses or functional status was frequently under-reported. For the mixed methods studies, the authors reported choosing this approach to triangulate the findings of the survey and interviews. All six used surveys and interviews for data collection. Of the largest study (n=200), 200 surveys and 80 ethnographic interviews were conducted. Again, this study's sample was not made up of

Table 3 Psychological experiences

Authors	Date	Sample	Method	Findings
Reynolds *et al.* (40)	2000	442 AA & 405 White women with breast CA	Longitudinal survey	Expression of emotion associated with better survival. AAs more likely to suppress emotions. White woman had wishful thinking and positive reappraisals of illness
Rankin *et al.* (41)	2002	76 post AMI women (19% AA; 81% White)	Longitudinal survey	Similar recoveries in depression, anxiety, and coping. White women had quicker physical recovery
Popoola (42)	2005	20 Nigerians and 11 AAs with diabetes	Ethnography	Balance between fear and fully living as main coping strategy for balancing lives. When uncertainties higher, more suffering occurred
Porter *et al.* (43)	2006	155 AA & 369 White women with breast CA	Structural modeling	Cognitive processes important for psychological adaptation to survivorship. More depression occurred when patient unable to care for self. Less ability to use coping strategies when physical co-morbidities increased
Deimling *et al.* (44)	2006	121 White and 200 AA adults with cancer (breast, colorectal, prostate)	Cross-sectional survey	Skills to deal with illness developed in survivors with most complex illnesses. Planning and acceptance most common coping skills. Less worry and anxiety in AAs when attitudes linked to optimism
Amoako *et al.* (45)	2008	68 AAs with diabetes	Experimental- psycho-educational telephone intervention	When uncertainty in illness reduced, improvement in self-care and psychosocial adjustment noted
Agarwal *et al.* (46)	2010	238 AAs with cancer (breast/lung, colon)	Survey	Higher prevalence of depression in older AA survivors. Depression attributed to identifiable risk factors: living alone, being uninsured, fatigue, and pain
Holt-Hill (47)	2009	135 elderly AAs (age 65–88 years)	Survey	Coping used: positive reappraisal, self control. Planning with problem solving
Warren-Findlow *et al.* (48)	2010	12 AA women with HF	Interviews	Stress reported as contributor to HF. Patients reported need to decrease stress in their lives

only AA individuals, but also included European Americans, Korean Americans and Mexican Americans individuals (38). Finally, many studies only used one geographical location or one healthcare institution, decreasing the ability to collect broader findings across different settings. All studies were completed in the United States except for one in Britain (39).

Psychological experiences

As detailed in *Table 3*, individual psychological experiences found in these studies included depression, fear, anxiety, worry, psychological distress/stress, and sadness. Despite the multitude of negative experiences found, some positive psychological experiences were noted when cognitive reframing of illness occurred. This reframing was described by terms such as optimism, wishful thinking, positive reappraisals, outlook and coping, resilience, and well-adjusted adaptations to one's illness. The review findings do indicate that positive psychological outcomes do occur for seriously ill AA elders if negative experiences are decreased. When negative experiences decrease, perhaps opportunities emerge for psychological, social, and spiritual healing for the seriously ill AA elder. However, multiple components of seriously ill AA elder's psychological experiences are still highly understudied, with conflicting evidence of what and how AA elders' healing/suffering are impacted (see *Table 3*).

Social experiences

Social support was shown to impact seriously ill AA's experiences (see *Table 4*). Despite research that has shown the benefits of social support, not all AA elders reported a positive role of social support. Negative experiences occurred for some, such as social isolation, decreased intimacy with others; negative social support from family,

Table 4 Social experiences

Authors	Date	Sample	Method	Findings
Guidry *et al.* (49)	1997	593 cancer survivors (white, Hispanic, and AA)	Cross-sectional survey	Informal social support networks such as extended families and civic clubs more helpful for AAs and Hispanics than Whites
Bourjolly (50)	1998	41 AA and 61 White women breast CA	Cross-sectional survey	Higher reliance on spirituality (private and public) in AA women than White women as a coping resource
Bourjolly *et al.* (51)	1999	41 AA and 61 White women breast CA	Cross-sectional survey	Greater difficulty in social functioning (self-care, household, occupational, social, and community activities) in AAs than in White counterparts
Bowie *et al.* (52)	2003	14 AA and 24 White men prostate CA	Mixed: Survey and focus groups	Higher importance of religion and spirituality noted in AA men. Membership and attendance at church important factors of spirituality
Henderson *et al.* (53)	2003	66 AA females with breast CA	Descriptive focus groups	Supportive networks and culturally sensitive support groups vital and reported a need for culturally sensitive support groups
Shellman (54)	2004	7 AA males/females >70 yrs. of age	Phenomenology	Religion helped them "get through life"; discrimination reported
Jones *et al.* (55)	2008	14 AAs with prostate CA	Interviews	Support from family and friends played an important role in helping men cope with treatment and recovery
Black *et al.* (56)	2009	6 AA males >80 years of age	Ethnographic interviews	Struggles of racism provided strength for dealing with insensitivities of medical community
Agarwal *et al.* (46)	2010	238 AA cancer survivors (breast, lung, colon)	Cross-sectional survey	Higher QOL present with perceived support from family friends
Jones *et al.* (57)	2011	23 AAs with prostate CA	Hermeneutic phenomenological approach with focus groups	Themes found: major social resources were wives. Physician support also important. Having insurance led to decreased anxiety
Tkatch *et al.* (58)	2011	115 cardiac rehab patients: White and AA	Cross-sectional survey	More support, better health behaviors, and higher coping efficacy in AAs with large inner networks
Hinojosa *et al.* (59)	2011	77 (AA, White, and Puerto-Rican) stroke patients	Mixed: grounded theory and surveys	AA's less socially isolated than white counterparts. If participants socially isolated during first year post stroke, higher levels of depressive symptoms and decreased ability to manage daily activities existed
Chatman *et al.* (60)	2011	32 AA females with breast CA	Mixed: focus groups then structured interviews	Cancer had negative impact on intimate social relationships
Dilorio *et al.* (61)	2011	320 males with prostate CA (42% AA)	Cross-sectional survey	Cancer did not have negative impact on intimate relationships. Participants reported some physician bias in cultural beliefs
Harper *et al.* (62)	2013	17AAs with colorectal cancer	Focus groups	Medical mistrust, suspicion, and negative attitudes linked to concern about HCP's motives

friends or healthcare providers, concerns about burdening others, and low socioeconomic resources or limited access to care. Social experiences can be impacted either positively or negatively by the healthcare that is provided. AA elders' social experiences may be negatively impacted by healthcare system discrimination caused by lack of culturally sensitive care, socioeconomic factors, and limited access to care. The findings of this review are consistent with other

Table 5 Spirituality definitions

Psychological construct	References
"A state of being"	Casarez, Engebretson & Ostwald, 2010, p. 227 (63)
Inner peacefulness	Harris & Berger, 2010 (64)
Meaning and purpose in life or connectedness with self	Lin & Bauer-Wu, 2003 (65); Delgado, 2007 (66)
Sociocultural construct	
A connectedness with others or a higher being	Lin & Bauer-Wu, 2003 (65); Delgado, 2007 (66)
Comfort in faith	Mount & Kearney, 2003 (19)
A feeling of comfort relieved by from a connection to a higher power that is sacred and transcendent	Edmondson *et al.,* 2008 (67)
Integrated holistic dimension that included interconnectedness with self, other and sacred which shapes their way of life	Harvey & Cook, 2010 (68)
Religion	
Public and private behaviors, attitudes and beliefs	Taylor, Chatters & Joe, 2011 (35)
Public and private behaviors, attitudes and beliefs organized around a structured system of tenets, practices and rituals	Ellison & Levin,1998 (69), Idler *et al.*, 2003 (70)
Intrinsic religion- one's inward practices such as prayer and belief in God; extrinsic religion- one's outward practices such as religious affiliation/church attendance	Dickson *et al.*, 2013 (71)

research on financial, socioeconomic, and access issues in minority populations (3). Studies evaluating the social relationships of seriously ill AA elders with others reveal conflicting evidence. Even in the presence of negative social interactions, some individuals developed strength despite their suffering. The mechanisms contributing to social healing for seriously ill AA elders remains unclear. Therefore, gaining more knowledge from the perspectives of seriously ill AA elders is necessary to determine how these social interactions provide opportunities for healing (see *Table 4*).

Spiritual experiences

Significant differences were found among definitions of spirituality, religion, and religious practices among publications due to the complex nature of the term spirituality. The incorporation of a broad view of spirituality was important to fully describe healing/suffering for the seriously ill AA elder. For purposes of this integrative review, the source articles defined spiritual healing in the following ways: existential and/or religious practices, psychological and/or sociocultural constructs of spirituality, and with the following terms: spirituality, religion, religiosity or religious practices. *Table 5* depicts the most common definitions.

Spirituality has been shown to play important roles for AA elders dealing with serious illness (see *Table 6*). When experiences were positive, spirituality provided healing for seriously ill AA elders, whether this occurred through existential, psychologically constructed, or sociocultural religious practices. Based on geographic location, gender or illness, there were noted differences in the roles spirituality played in the lives of seriously ill AA elders. Spirituality was strongly linked to the quality of life of seriously ill AA elders. However, spirituality defined as religious practice did not always show a positive effect on the well being of the AA elder. There remains a lack of conceptual clarity regarding what spirituality is and how spirituality affects suffering/healing for seriously ill AA elders (see *Table 6*).

Discussion

Psychological, social, and spiritual healing/suffering

AA elders' definitions of "health" incorporated mind, body, and spirit (87), and poor subjective health reports predicted lower levels of personal efficacy and spiritual wellbeing (88).

Table 6 Spiritual experiences

Author	Date	Sample	Method	Findings
Chatters *et al.* (72)	1992	446 AA, age >55	Survey	Older age, women and living in south had higher religiosity
Powe (73)	1997	55 AA & 18 White elders	Cross sectional survey	Fatalism was present but no sig relationships were shown between fatalism and spirituality
Bourjolly *et al.* (51)	1999	41 AA and 61 White women with breast CA	Comparative survey	Black women relied on both public and private religiousness as a coping resource to a greater extent than white women.
Cunningham *et al.* (74)	1999	99 AA elderly, age 60–95	Cross sectional survey	When measuring health related-Quality of Life (HR-QOL)-spiritual well being was found to be more important than physical, social or psychological well being
Henderson *et al.* (53)	2003	66 AA women with breast CA	Focus groups	Spirituality played a strong role in coping. Coping strategies used were: relying on prayer; avoiding negative people; developing a positive attitude; having a will to live; and receiving support from family, friends and support groups
Bowie *et al.* (52)	2003	14 AA and 24 white males with prostate CA	Mixed focus groups and survey	Religion and spirituality was important for AA. This importance included membership in a church and regular attendance Due to this important role of spirituality, most had spoken with their physicians about their beliefs
Ark *et al.* (75)	2006	274 AA, age >55	Survey	AA elder women had higher subjective religiosity and engaged in more religious behaviors *vs.* non-Hispanic White (NHW) participants. Higher religiosity was associated with better health status and decreased use of health services
Harvey (76)	2006	10 AA female with arthritis, severe HTN or heart disease	Narrative analysis	Self -management of illnesses combined traditional medicine and spiritual practices
Taylor *et al.* (36)	2007	837 AA, 298 Non-Hispanic White (NHW) and 304 Carribean Blacks (CB), over age 65	Survey	AA and CB reported higher levels of religious participation, religious coping and spirituality than NHW
Arcury *et al.* (77)	2007	220 AA, 181 Native American, 297 White with diabetes	Survey	AA engaged in more private religious practices. No differences in public religious practices amongst groups. No associations found among mental health and religious participation

Table 6 (*continued*)

Table 6 (*continued*)

Author	Date	Sample	Method	Findings
Dunn *et al.* (78)	2007	17 non-White and 11 White community dwelling older adults	Focus groups	Activities reported contributing to well being were: Participating in faith ways- intrinsic or extrinsic Keeping positive energy by: staying active, engaging in leisure activities, having a sense of self motivation, and for older male adults- being competitive Keeping active support systems by: visiting health care provider, attending support groups, participating in rehab and/or staying connected to family and friends Participating in wellness activities through: doing= taking meds, prescribed and OTC, using medical devices, diet, exercising, getting plenty of rest Being= meditating, listening to music, putting bad things out of your mind Engaging in affirmative self-appraisal through positive self -reflection and having a sense of accomplishment
Hamilton *et al.* (79)	2007	15 AA women with breast CA; 13 AA men with prostate CA	Grounded theory	Participants discussed their personal relationship with God as: I called on god I know God was with me God will do his will Types of support believed to come directly or indirectly from God were: 1. Healing their cancer 2. Taking away worries 3. Giving no more than they could bear 4. Sending someone to help 5. Keeping cancer from spreading 6. Giving them the medicine Participants discussed need for repaying God through acts of service to him and others
Levine *et al.* (80)	2007	36 AA, 52 Asian/Pacific, 52 Caucasian, 21 Latino females with breast CA	Mixed- survey then interviews	Themes found: 1. God as comforting presence 2. Questioning faith and anger at God 3. Spiritual transformation of self and attitude toward others 4. Recognition of one's own mortality 5. Deepening of faith and acceptance AA, Latino's or Christians with spiritual beliefs had higher comfort from god over other groups. Higher spiritual well- being was found in survivors who used prayer. No significant differences existed amongst the ethnic groups in psychological or social QOL

Table 6 (*continued*)

Table 6 (*continued*)

Author	Date	Sample	Method	Findings
Hamilton *et al.* (79)	2007	54 AA male/female with stressful life events, average age= 68	Mixed methods-survey and interviews	Overall themes noted: 1. God as Protector 2. God as beneficent, praise and thanksgiving 3. God as healer 4. Memory of forefathers, 5. Prayers to God and 5. Life after death
Koffman *et al.* (39)	2008	26 CB and 19 British with CA	Interviews	Stronger religious beliefs were more pronounced in CB. Themes found:
				1. Religious beliefs in God helped them comprehend their cancer
				2. Their faith, emotional and practical support provided by church communities assisted them to live with the physical and psychological effects of the illness
				3. The experiences of cancer promoted their religious identity
Samuel-Hodge *et al.* (81)	2008	185 AA with diabetes	Cross sectional Survey	A positive role for church involvement was associated with psychological adaptations to living with diabetes and was linked to self-efficacy and competence
Levine *et al.* (82)	2009	41 AA, 52 Asian/Pacific, 53 Caucasians, 23 Latino females with breast CA	Mixed methods	Higher spiritual well-being was found in survivors who used prayer. No significant differences existed among the ethnic groups in psychological, social support of QOL
Black *et al.* (56)	2009	6 AA male >80 years of age	Ethnographic interviews	Religious beliefs helped decrease suffering caused by racism
Zavala *et al.* (83)	2009	9% AA, 53% Latino, 20% Caucasian males with prostate CA	Survey	Higher levels of spirituality were noted in AA and Latino men with high school education. HR-QOL was higher when spirituality was measured as purposeful meaning and peace
Hamilton *et al.* (84)	2009	1. 28 AA with cancer, average age=63	Mixed methods:	Findings: developed Ways of Helping instrument
			Multiphasic-Samples 1 and 2-Interviews	Ways of helping were:
		2. Context experts 7 post-doc and 5 faculty		1. Help received- emotional, instrumental, and information support received from family and friends
		3. 38 AA cancer, average age=65	Sample 3-Cognitive interviewing	
		4. 382 AA cancer, average age=64.1	Sample 4-Survey	2. Help given to others-activities that made them feel connected to and supported by their network of family and friends
				3. Help from God
				4. Self help strategies- staying busy, praying, meditating, thinking positively
Taylor *et al.* (35)	2011	3,570 AA, 1,621 CB, 891 NHW	Survey	In AA and CB, 90% reported religion and spirituality as important *vs.* 75% of NHW
Casarez *et al.* (63)	2010	4 AA male and 14 AA women with diabetes	Qualitative descriptive	The ability to self manage their illness was connected to relationship with God

Table 6 (*continued*)

Table 6 (*continued*)

Author	Date	Sample	Method	Findings
Agarwal *et al.* (46)	2010	50 AA with head/neck CA	Cross sectional survey	Higher QOL was found if "turned to God", had family and friends for support, and helped others by encouraging their participation in cancer screening and/or treatment
				If participants coped by being strong/self-reliant, then dependence on others for physical care was associated with lower QOL and social functioning
Jones *et al.* (57)	2011	23 AA males with prostate CA	Phenomenological interviews	Rural participants had higher spirituality than urban counterparts
Holt *et al.* (85)	2011	98 AA and 171 White with lung/colorectal CA	Survey	Women were more religious. AA's were more religious than whites. AA religious behaviors were positively associated with mental health and vitality and were negatively associated with depression
Dilorio *et al.* (61)	2011	320 AA males with prostate CA	Cross sectional survey	Higher levels of religious coping were associated with high school education or less, lower income and/or those with one or more comorbid conditions
Hamilton *et al.* (86)	2013	65 AA male/female with stressful life events	Qualitative descriptive	Religion expressed through song was a coping strategy
Harper *et al.* (62)	2013	17 AA male/female colorectal CA	Focus groups	Cultural beliefs regarding spirituality, religious practices and/or expression of faith were related to higher power, god or spiritual being. Fatalism about their illness was linked to beliefs about divine control and destiny

Higher spirituality and a sense of control were shown to be significantly associated with decreasing depressive symptoms in AA elders (89). If AA elders experienced stressful life events, this seemed to predict lower subjective health ratings, decreased self-esteem, and lower senses of spiritual wellbeing (88). The use of religious practice to promote mental health among AA elders is well documented (79,84,86,90). Cognitive reframing, religious practice, and the ability to express emotions increased psychological healing and, in some instances, physical function (45).

AA elders were shown to have resiliency and tenacity despite the seriousness of their illnesses (91). Independence gave meaning to life. A strong faith that God was in control guided them through their illnesses (37). Socially, if the AA elder was in a happy marriage, positive effects were also noted on their spiritual wellbeing (88). AA elders' coping strategies across many illnesses included engaging in life through exercising, seeking information, relying on God, changing dietary patterns, medicating, self-monitoring, and self-advocating (92).

In the studies noted, negative experiences occurred across all three psychological, social, and spiritual dimensions. The negative psychological experiences reported included depression, fear, anxiety, uncertainty, distress, sadness, and fatalism. Negative social experiences stemmed from the following contributors: decreased social support from family, friends or healthcare providers; concerns about burdening others; isolation; low socioeconomic resources; limited access to care; and overt racism and discrimination within their healthcare interactions. When insensitivities to AA elder's cultural beliefs/values were reported, a concurrent mistrust of the provider was also reported (60). Within the spiritual dimension, negative experiences were not as prevalent. However, a few articles suggested that not all extrinsic religious interactions contributed positive healing effects.

Similarly, positive experiences were reported across all three dimensions. In the psychological dimension, positive experiences included: optimism, resilience, positive coping, and positive outlooks. When cognitive reframing was present, healing could occur. In addition, when individuals had the ability to express their emotions, a social interaction occurred that could also allow for psychological healing. Within the social dimension, quality of life for the seriously

ill AA elder is highly linked to positive social support among family and providers, suggesting that positive interactions could lead to less suffering.

For seriously ill AA elders, much overlap occurred in the interactions among culturally relevant psychological, social, and spiritual experiences. Seriously ill AA elders' psychological and social quality of life were related to their spiritual healing, but a fuller understanding of their cultural values, preferences, and spiritual beliefs is still needed. When discussing healing/suffering, it is important to note that all three dimensions—psychological, social, and spiritual—play important roles for the AA elder's overall healing.

AA elders' psychological, social, and spiritual healing within serious illness of cancer

Beliefs based in religiosity were seen in all studies of cancer survivors, but the ways in which religion was expressed in relation to their cancer were culturally determined (39). One study demonstrated that, in cases where breast, prostate, and colorectal AA cancer survivors initially showed poorer physical and mental health quality of life ratings, these ratings changed when adjusted by socio-demographic, clinical, or psychosocial factors, indicating only lower mental health quality of life ratings (93). In another study of cancer survivors, patients reported needing help with overcoming fears, finding hope, finding meaning in life, finding spiritual resources, finding peace, finding meaning to their death and dying, and hoping for someone to talk with about these issues (94). Of these patients, 41% of the AA elders reported needing help with spiritual/existential issues (94). Specifically, in breast cancer, AA women reported positive changes in their faith after diagnosis (95). Finally, in a study of AA lung and colorectal cancer patients, religious behaviors were positively associated with mental health and vitality but had negative associations with depressive symptoms (85).

Breast cancer survivors reported many psychosocial concerns. Other important issues for AA breast cancer survivors included body appearance, social support, health activism, menopause, and learning to live with a chronic illness (96). Breast cancer survivors who had higher coping capacities experienced less psychological distress, higher spiritual wellbeing, and less catastrophizing about their illnesses (97). Coping strategies of breast cancer survivors incorporated all of the following dimensions: relying on prayer; avoiding negative people; developing a positive attitude; having a will to live; and receiving support from family, friends, and support groups (53). Belief in divine control was positively associated across all ethnic groups with not only the positive reframing of illness but also active coping and planning (98).

In AA prostate cancer patients, faith helped patients overcome the fear resulting from initial perceptions of their cancer diagnoses. Faith was placed in God, healthcare providers, self, and family, and these men came to see their prostate cancer as a "new beginning that was achieved through purposeful acceptance or resignation" [(99) p. 470]. This faith was their source of empowerment, and with this empowerment, they became more proactive in their self-care (99). Beliefs based in religiosity were seen in all cancer survivors, but the ways in which religion was understood and expressed in relation to their cancer were culturally determined (39).

In AA cancer survivors, spiritual transformation came through the recognition of personal mortality (80) and through redemption stories that related positive transformations of initially negative perspectives regarding survivorship (100). These transformations occurred through upholding existing beliefs in God, knowing this God as a directing force, and understanding one's personal strengths (100). The sense of a directing force from God also created a desire to be of service to others (100). Skeath *et al.* (31) also noted a life transformative experience within a multi-ethnic group of cancer survivors, which impacted all dimensions of their lives. For individuals with serious illness, this positive subjective change impacted the ability to decrease psychological, social, and spiritual suffering, even after a cancer diagnosis (31).

AA's psychological, social, and spiritual healing within cardiac related serious illnesses: heart failure or stroke

For cardiac illnesses, there was significantly less literature. In contrast to cancer survivors, in AA patients with heart failure, spiritual wellbeing was negatively associated with psychological wellbeing (101). For instance, patients reported feeling less meaning and peace and more depression and anxiety in their lives (101). Yet, these same patients reported greater faith, showing a different relationship to quality of life and faith than that experienced by cancer survivors (101). However, as noted in cancer illnesses, some AA elders were able to maintain a strong sense of self even after the life disruptions caused by heart failure by using the culturally relevant coping strategies of

resiliency, spirituality, and self-care (102). In stroke patients, acceptance of illness came as a normal part of aging (103). Patient's age, other comorbidities, and knowledge about strokes further impacted their overall levels of acceptance (103).

Conclusions

The quantitative literature contained a large proportion of cross-sectional surveys measuring the multidimensional concepts discussed above; however, the studies did not always include a large portion of AA elders. Of most concern is the dearth of literature incorporating all phenomena of psychological, social, and spiritual healing. Despite the lack of conceptual clarity among spirituality and/or religiosity, the spiritual dimensions have been shown to play an important role in healing for seriously ill AA elders, whether this occurred through intrinsic or extrinsic mechanisms. Because of these complex relationships among the psychological, social, and spiritual dimensions, the literature conveys conflicting evidence of what results in suffering for the seriously ill AA elder.

To decrease distrust among AA elders with serious illness, healthcare practice should incorporate physiological, psychological, social, spiritual, and cultural domains to provide patient-centered care of the seriously ill (3,8,104,105). These domains are all part of the National Quality Framework for Palliative Care: Clinical Practice Guidelines for Palliative Care (8).Within this framework, approaches to palliative care interventions in AA elders with serious illness integrate cultural beliefs and values (106-109).

Even with attempts to incorporate psychosocial and cultural concepts into healthcare curricula, inequalities remain (9). "The 21 century brings heightened awareness of how beliefs, values, religion, language and other cultural and socioeconomic factors influence health and help seeking behaviors" [(9) p. 1]. The next generation of healthcare providers, trained through a holistic paradigm (10), will choose to incorporate culture, complexity, and care stemming through relationship-based patient centered care for co-creating a caring and healing environment for AA elders with serious illness (110).

Overall, to facilitate psychological, social, and spiritual healing for the seriously ill AA elder, palliative care practices must be informed by the perspectives of the seriously ill AA elder. When psychological, social, and spiritual dimensions are not incorporated in healthcare delivery, healing can be obstructed and suffering can occur. This integrative review was the first to appraise the state of the science on psychological, social, and spiritual healing in AA elders. The findings identified limitations of the literature and suggested the continued need for healthcare to adopt culturally competent patient centered palliative care. Further research on psychological, social, and spiritual healing is vital to address these limitations and to support culturally focused patient centered palliative care.

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Footnote

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