Prayer and Faith: Spiritual Coping among American Indian Women Cancer Survivors

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Although cancer disparities among American Indian (AI) women are alarming, research on spiritual coping among this population is virtually nonexistent. This is particularly problematic, given the importance of medical practitioners' discussing the topic with cancer patients, along with the centrality of spirituality to many AI patients. The purpose of this article was to explore AI women cancer survivors' spiritual coping with their experiences. Using a community-based participatory research approach, this qualitative descriptive study included a sample of 43 AI women cancer survivors ($n = 14$ breast cancer, $n = 14$ cervical cancer, and $n = 15$ colon and other types of cancer). Qualitative content analysis revealed that most participants (76 percent, $n = 32$) cited prayer as an important part of their cancer recovery and coping strategies. Many participants expressed how prayer and spirituality connected them to family, to faith communities, and to others. In addition to prayer, over a third (36 percent, $n = 15$) of participants emphasized faith as a recovery and coping strategy. Results indicate that most women drew great comfort, strength, hope, and relief from their spiritual and faith traditions, indicating that religious and spiritual practices may be an important protective factor against the strain of the cancer experience.

KEY WORDS: *American Indian or Native American women; cancer; qualitative studies; spiritual and religious coping*

According to the U.S. Department of the Interior, Bureau of Indian Affairs (2018), the treaty agreements between the United States and the 573 federal sovereign tribes include a trust responsibility to provide for the health and well-being of American Indian and Alaska Native (AI/AN) people (U.S. Commission on Civil Rights, 2004). Yet, AI/AN people experience prevalent health disparities as compared with the general U.S. population (U.S. Commission on Civil Rights, 2004). Cancer, the leading cause of death among AI/AN women, is experienced at 1.6 times the rate of white Americans (Espey et al., 2014).

Cancer incidence and death rates vary by tribes, cancer types, regions, and gender (Plescia, Henley, Pate, Underwood, & Rhodes, 2014). For example, lung cancer rates continue to increase for AI/AN women while decreasing for their male counterparts (Plescia et al., 2014). Breast cancer death rates are lower for AI/AN women than for white women, but there is variation by age group and region. Moreover AI/AN women did not experience a decline in breast cancer death rates as white women did (White, Richardson, Li, Ekwueme, & Kaur, 2014). For both kidney and colorectal cancers, incidence rates were higher for AI/AN people; AI/AN women, in particular, experienced higher incidence and death rates than both AI/AN men and white women (Perdue, Haverkamp, Perkins, Daley, & Provost, 2014). Cancer rates and related factors vary by gender, making it important to examine AI women's cancer experiences separately.

A literature review indicates that research on AI/AN women cancer survivors' spiritual coping is virtually nonexistent, which impairs the ability of social work practitioners to adequately understand and incorporate information related to spiritual coping into practice. This absence is also problematic given the importance of spirituality to many AI/AN people (Burhansstipanov & Hollow, 2001) and because spirituality can be an important protective factor related to the quality of life among cancer patients (Vallurupalli et al., 2012). Indeed, spiritual coping has been found to be highly relevant for cancer treatment and care (Burhansstipanov & Hollow, 2001; Kalish, 2012).

SPIRITUAL COPING AMONG AI/AN PATIENTS

The context of cancer and spiritual coping among AI/AN women is situated in a broader context of

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historical oppression (Burnette & Figley, 2017). *Historical oppression* includes the chronic, impactful, and intergenerational experiences of oppression that AI/AN people have experienced throughout colonization and into the present that over time may be introduced, normalized, and internalized into peoples' daily lives (Burnette & Figley, 2017). The concept is inclusive of *historical trauma*, which describes the massive and chronic trauma imposed on a group, such as land dispossession, early death, forced removal and relocation, environmental injustice, assimilative abusive boarding schools, and the prohibition of AI/AN spiritual practices (Evans-Campbell, 2008; Harper & Entrekin, 2006). Historical oppression focuses on *both* historical *and* contemporary forms of oppression (that is, proximal stressors), which can exacerbate and perpetuate oppression (that is, stress, poverty, and health disparities).

Religious and spiritual suppression have been insidious forms of historical oppression that have affected AI/AN people, such as the Indian Religious Crimes Code of 1883 (Irwin, 1997). This law prohibited AI/AN ceremonial activity under the penalty of imprisonment (for a history of AI religious suppression and resistance, see Irwin, 1997). The multitude of legal precedents outlawing AI/AN religious and spiritual practices has legitimized non-AI/AN spiritual traditions while delegitimizing AI/AN spiritual traditions (Irwin, 1997). This marginalization is perpetuated in the health care arena, where the centrality of AI/AN spiritual practices tend to be ignored and deterred by health care workers (Shelley et al., 2009).

Despite this suppression, spirituality and AI/AN healing practices have been found to have profound importance and meaning for cancer survivors (Struthers & Eschiti, 2004). Despite heterogeneity across tribes' spiritual practices, some important concepts that tend to be true across tribes are holistic conceptualizations of health and wellness that focus on the balance and harmony across environmental, physical, mental, and spiritual dimensions of health (See Portman & Garrett, 2006 for more detail on AI/AN spiritual practices). AI traditional beliefs may include the following beliefs: (a) one sacred power, known as Creator or Great Spirit, among other names, who may not necessarily be one gender and may have spirit helpers; (b) plants, animals, and humans are part of the spirit world that never dies, and this spirit world exists parallel to and interacts with the physical world; (c) mind, body, and spirit are interconnected, both in health and in sickness; (d) wellness is harmony across the mind, body, and spirit, as is disharmony or "unwellness"; (e) unwellness may be caused by a violation of the sacred or natural law of creation (for example, participating in a ceremony while under the influence of drugs or alcohol); and (f) all are responsible for their own wellness through attunement to others, the environment, and the universe (Portman & Garrett, 2006).

Sweat lodge ceremonies, spiritual healing, and herbal remedies are some of the more commonly reported healing practices (Marbella, Harris, Diehr, Ignace, & Ignace, 1998). Ceremonies can serve various functions including giving thanks, acknowledging rites of passage, and connecting communities (Portman & Garrett, 2006). Ceremonies include the following: (a) the sweat lodge ceremony, which is a purification ceremony; (b) the vision quest, which is a healing ritual requiring an individual to withdraw from daily activities to spiritually focus and self-reflect; (c) smudging, or burning special herbs as a form of cleansing and purification; (d) the pipe ceremony, which is thought to connect the physical and spiritual realms and turn prayers into smoke; (e) the Sundance, which is a complex ceremony that may involve fasting, receiving visions, and receiving treatments; and (f) the Blessing Way, which may contain songs and prayers to restore harmony to individuals, families, clans, and communities (Portman & Garrett, 2006).

AI/AN spiritual and health practices are commonly used among AI/AN people, with 70 percent of an urban AI/AN sample reporting that they use such practices often (Buchwald, Beals, & Manson, 2000). Another study reported that 38 percent of AI/AN patients used AI/AN healers, with this rate being higher for AI/AN women and older patients (in contrast to men or younger patients) (Marbella et al., 1998). Even among AI/AN participants who did not report using healers, 86 percent expressed an openness to their use in the future (Marbella et al., 1998). Although patients generally want health practitioners to talk about spirituality and alternative or complimentary medicine (Best, Butow, & Olver, 2015), research with a subsample of AI participants revealed barriers to such open discussions, including the clinician's lack of knowledge and receptivity to initiating such conversations (Shelley et al., 2009).

If spirituality is germane to AI/AN people and social work practice and cancer care, it is important for social work practitioners to facilitate an open discussion about the topic and gain some knowledge about AI spiritual coping. This information is important for cancer patients' health care experiences. Therefore, the purpose of this article was to explore AI women cancer survivors' spiritual coping with their experiences, particularly their description of their experiences of prayer and faith.

METHOD

Research Design

We used a community-based participatory research approach, with a community advisory board (CAB) made up of leaders in the AI community, along with health care professionals working in two AI communities. The responsibilities of the CAB members were to (a) identify the community needs relevant to cancer survivors; (b) assist with recruiting and dissemination; and (c) enhance community and research engagement. We used a qualitative descriptive study design, a naturalistic and inductive inquiry that provides a rich account of experiences in easily accessible language (Sullivan-Bolyai, Bova, & Harper, 2005), to investigate AI women cancer survivors' experiences as they related to familial social support. Our overarching research question was: "What are AI women cancer survivors' spiritual coping practices?" Qualitative description has been found to be especially useful in working with populations that tend to be marginalized to understand culturally specific phenomena, as it prioritizes the voices of participants themselves rather than the highly abstracted interpretation of researchers (Sullivan-Bolyai et al., 2005). Because highly abstracted interpretations are not focal, the direct suggestions of participants results in practical knowledge with broad applicability, such as what roles family supports play in AI women's cancer experiences (Sullivan-Bolyai et al., 2005).

Setting and Sample

This research was conducted in collaboration with two community hospitals in the Northern Plains region, in the state of South Dakota: (1) the Avera Medical Group Gynecologic Oncology in Sioux Falls and (2) the John T. Vucurevich Cancer Care Institute, Rapid City Regional Hospital, in Rapid City. These sites were chosen as the primary medical institutions serving AI women in the eastern regions and western regions of South Dakota, respectively.

The sample was composed of 43 AI women cancer survivors ($n = 14$ breast cancer, $n = 14$ cervical cancer, and $n = 15$ colon and other types of cancer). We were inclusive of cancer types to assess the underlying spiritual coping practices that were present across types. We used purposeful sampling, determining who was most capable of adequately addressing research questions (that is, AI women cancer survivors) and when the data reaches *saturation* (that is, when redundancy, or no new information is gleaned from results) (Sandelowski, 1995). Inclusion criteria for participants were (a) having a personal history of any type of cancer in the previous 10 years; (b) completion of cancer treatment without signs or symptoms of recurrence; (c) being female; (d) being 18 years or older; (e) living in South Dakota; and (f) being AI.

Participant ages ranged from 32 to 77 years ($M = 56.33$, $SD = 12.07$). Regarding educational attainment, 97.7 percent of participants held a high school degree or GED. Regarding monthly household income, almost half (49 percent) of participants reported less than $1,499. Although 32.5 percent of participants self-reported poor or fair health, 67.5 percent reported their health as good or excellent. Participant cancer types included breast ($n = 14$, 32.6 percent); cervical ($n = 14$, 32.6 percent); colon ($n = 5$, 11.6 percent); lung ($n = 2$, 4.7 percent); non-Hodgkin's lymphoma ($n = 2$, 4.7 percent); and others ($n = 6$, 13.9 percent). Most respondents ($n = 39$, 90.7 percent) indicated membership to a religious affiliation, and 93 percent had medical insurance. The average time with cancer was approximately 2.5 years ($SD = 2.19$).

Data Collection

The approvals of the following institutional review boards were secured before data collection began: (a) University of South Dakota, (b) Avera McKennan Hospital, (c) Rapid City Regional Health, and (d) Sanford Research Center. Participants completed voluntarily signed consent prior to study enrollment. The lead author and two extensively trained and experienced research assistants with backgrounds with AI populations and cancer survivors conducted the interviews. Recruitment efforts included mailing fliers to cancer survivors at the two hospitals, posting fliers at community agencies, newspaper and public radio announcements, and word-of-mouth at local agencies and churches. A total of 46 potential participants responded

with interest, and the three respondents who had more than 10 years of cancer history were excluded; the final sample was 43. Data were collected where participants preferred (for example, participants' homes, a private conference room at a hospital, community church, or the lead author's office) from June of 2014 to February of 2015.

The semistructured qualitative interview guide was developed in collaboration with CAB. Guides were developed according to the research questions and community research needs identified by CAB, who reviewed the interview guide, paying attention to the language used and how culturally appropriate each question was, ensuring cultural sensitivity for AI women cancer survivors. Examples of interview questions included, "Do you have spirituality that has helped you cope with your cancer? Is there anything in your beliefs that helps you cope with cancer?" The audio-recorded interviews, transcribed verbatim by graduate students, ranged from 30 to 120 minutes, with participants being compensated $50 for their time, along with a gift card to cover travel and participation expenses. Transcribed interviews were entered into NVivo data analysis software (QSR International, 2015).

Data Analysis

Qualitative content analysis, which is the analysis of choice for qualitative descriptive studies (Milne & Oberele, 2005; Sandelowski, 2000; Sullivan-Bolyai et al., 2005), enabled inductive themes to arise from data directly (Milne & Oberele, 2005). Data analysis involved the following steps: (a) researchers becoming immersed in data through listening to audio transcriptions and reading interview transcripts numerous times to gain a holistic understanding of data; (b) coding each line of the data adding notes to identify salient concepts; (c) identification of 430 preliminary *meaning units*, or themes, that were sorted into broader themes with respective subthemes; (d) coauthors engaged in dialogue about themes and subthemes, identifying whether significant distinctions were present with respect to cancer types (no distinctions were identified); (e) broad themes were used to create meaningful clusters of themes with definitions for clusters; and (f) clusters were presented to participants with respective quotes through member checks, identifying whether interpretations were on-target with participants' intentions. Authors contacted all participants up to three times for member checking. Over half ($n = 23$, 53.5 percent) responded, with close to half ($n = 21$, 46.5 percent) having phones that were disconnected, and thus being unreachable. Participants requested no changes in the data or interpretations.

Strategies for Rigor

We used Milne and Oberele's (2005) strategies for rigor specific to qualitative descriptive studies (Milne & Oberele, 2005), which ensured (a) authenticity to the purpose of the research; (b) credibility, or trustworthiness, of results; and (c) criticality, or intentional decision-making processes. These strategies were incorporated through use of a semistructured and flexible interview guide (ensuring that participants were free to speak), making sure participants' voices were heard by probing for clarity. We gained an accurate understanding of participants' perceptions by conducting member checks, and maintaining inductive analysis, so that coding emerged from the data through conventional content analysis. We also promoted authenticity by examining potential bias and engaged in peer review across coauthors, ensuring study integrity (Milne & Oberele, 2005). Participants were given anonymous identification numbers for reporting purposes, demonstrating that quotes are representative across the continuum of participants.

RESULTS

Results revealed that most participants (76 percent, $n = 32$) cited prayer as an important part of their cancer recovery and coping experiences. Prayer was spoken about as an indispensable coping tool by the majority of participants. Participant 3 stated, "I pray all the time. Every morning, every night, in between if I think about it, whenever I have a chance." Prayer tended to provide meaning through the adversity of cancer experiences and connect cancer survivors with family and community members, whereas faith tended to provide hope and strength throughout the cancer experience.

Providing Meaning through Adversity

Participant 40 spoke about how her faith gave her cancer journey meaning, stating,

> You don't give up just because you have it, because, like my mother used to tell me all the time . . . "When you get cancer or something like that, He [God] puts these obstacles in front of us."

She added, "Each time we overcome . . . we become stronger people." Similarly, participant 28 felt, "In the long run, you have to pull yourself together and understand that there is . . . there is a path for you, this is where God wants you to be." Participant 42 remarked,

> Faith helped really a lot because I believe that all things happen for a reason. God puts us in a situation for reasons. We don't know . . . and I told my kids that, we don't know why things happen to us, but we just have to have faith that it is there for a reason, and it will be revealed to us or it may not be revealed to us, and so this is just one of those things that we just have to live through.

Participant 8 added, "I just have a lot of faith and I do. It's supportive. It gives you strength. It helps you."

Some participants exercised spiritual coping in faith communities, where they experienced much support throughout their cancer experience. When asked about her spiritual coping, Participant 30 talked about her Catholic faith community, stating, "I guess the church . . . a lot of times, uh, people, um, find out or hear or know that you're ill and they pray for you, and keep you in your prayers, just like we always do when someone's sick." Likewise, Participant 32 explained,

> Yes, I am a Christian, and I believe in God and I feel like God has helped me through the breast cancer diagnosis, the treatments. I feel like without God I couldn't have gotten through all of the stuff that I've been through, and my family and I would go to church every Wednesday and twice on Sunday, and I think for me I was kind of taken from our, from the Lakota culture, from the ceremonies, and I love the smell of sage. A lot of our people, it's called smudging. You just get the sage and you burn it and then you just kind of use it for incense. I've done that. I've used that. The cedar. We use cedar, but I just got cedar from trees in our yard and burned some of that.

Spirituality and prayer helped many of the cancer survivors we spoke with to confront their own mortality. Participant 3 stated,

> I didn't want to face death and dying so I had to do the let go and let God, you know, spirituality-type thinking and—until I got my positive. All I can do is one step in front of the other, one at a time, one day at a time.

Prayer Fostering Connection to Others

Many participants expressed how prayer and spirituality connected them to family, faith communities, and others. Participant 37 talked about the support from her family, and how much it meant that they were doing tribal ceremonies for her:

> It really helped my prayer, with the healing ceremonies and knowing that I had that type of support from family that were doing the ceremonies for me; that I knew that I had that support and the prayers were there for me, and that helped me get through with the diagnosis and just getting through the whole ordeal.

Similarly, Participant 31 shared how she and her family's spiritual practices also made a difference in her cancer experience:

> We're praying. . . . Having relatives, my uncle and my grandpa, pray a lot, and they go into sweats. I myself haven't been to a sweat, but just doing what I'm told, or instructed, I should say, by my grandfather and my uncle. And just staying positive and praying, and being focused.

Participant 18 stated,

> It really helped my prayer, with the healing ceremonies and knowing that I had that type of support from family that were doing the ceremonies for me—that I knew that I had that support and the prayers were there for me and that helped me get through with the diagnosis and just getting through the whole ordeal.

Participant 18 also experienced benefits from maintaining connection to her tribal faith community, stating,

> Whenever I felt like the radiation burns or the chemo, the nausea, and all of that [were too much], I just asked for help and strength to deal with this—to bear it. I think that's what I . . . did anyway. And I followed up and I went back when they didn't find any more of the cancer, I did a thank-you ceremony, and then I asked

> again to continue to be with me, and just this past weekend, I had another ceremony. And kept them all updated, saying that things are working well, you know, I've been asking for help. I've been praying. Things are going well.

Some of this connection to others had to do with helping others, taking participants out of themselves and their own circumstances. When asked how her spirituality and faith help her, Participant 18 replied,

> Every morning I have my devotional time with God, and then throughout the day I say prayers and stuff, but if I'm feeling bad or something I'll just say a little prayer. I pray for everybody else that I know. It makes me feel better.

Participant 19 noted,

> I go ahead, and I do a lot of praying. And another thing that I do. I go out and I help other people. Since I'm retired, I go out and help other people. I go and you know, like, I help other people, like you challenge yourself to help someone that you don't even know to do something nice for them.

Faith and Hope Providing Relief and Strength

In addition to prayer, over a third (36 percent, $n = 15$) of participants emphasized faith in their cancer experiences. Participant 8 talked about her faith and related hope:

> Because I have strong faith. I have strong spirituality. . . . I believe in a higher power that—I pray a lot and I just believe that I wanted to do this and I knew it would work for me because I believe.

Many participants expressed a faith that healing was possible through spiritual means. Participant 32 explained,

> Yes, I believe that in my religion, which is Christian Pentecostal, I believe that we just need to go to God and tell Him everything that is going on in my life, and I believe that He is my healer.

She also stated it helped her cope with feeling ill:

> A lot of times when I don't feel good I listen to music, and I have a lot of good Christian music. A lot of times I'll pray, and then I'll listen to the music, and it helps me lift my spirits.

Faith that God answers prayers was an important part of some survivors' stories. Participant 8 relayed,

> Yes. I feel like I can pray to God and ask Him, you know, sometimes I get to hurting too bad, and I ask Him to take away the pain. I believe He does. I believe He answers my prayer, yeah. So I believe in prayer. . . . It's a strong, to me it's a strong force that really works.

Participant 16's faith made all the difference in her perspective on cancer, as she explained:

> I just believe that when God speaks that He means it, and I believe. I was told that everything would be OK. I would go through this, but in the end it wouldn't be long. In other words, OK. And that's what I stood on.

Likewise, Participant 22 explained how prayer and faith removed the burden of her cancer:

> Whenever I pray, . . . I ask God to take it away from me, and to help me, to guide me and give me the direction I need in my life to cope with it, or to cope with anything in general. And then it's like, you know, my stomach hurts so bad, but you know, please take this pain away. And then, if I really, really give it my all, then He takes the burden away. Then I feel better. Yeah. He takes it . . . it feels like there's a big old heavy weight on my shoulders, but whenever I meditate and give it to Him, then it's lifted. And then I don't have to worry.

In a similar way, when asked how her higher power or spirituality helped her, Participant 18 replied, "Turn everything over to Him," which made all the difference.

DISCUSSION

Results indicate that prayer and faith were integral protective aspects of our respondents' cancer experiences, and women practiced both AI/AN (for example, smudging, seeing spiritual healers) and Judeo-Christian (for example, attending church) spiritual traditions. Some women felt that their cancer experience was a challenge that promoted

personal growth, and that there was a broader purpose and meaning to the experience (that is, "all things happen for a reason"). Although the reasons for enduring cancer were not always clear, many women felt assurance that it was part of their life path. Most women were part of faith communities, both Christian and tribal, and felt support when members of this faith community prayed for them, even if the women themselves did not partake in the given activity. Indeed, prayer connected women with others in an important way, buffering against feelings of having to endure cancer alone.

AI women cancer survivors often felt they experienced healing through spiritual practices and faith. They believed that if they prayed, God or a higher power would answer, providing hope and healing. Women also focused on helping others, which tended to broaden their perspective for the greater good and lessen the burden of the cancer experience. Indeed, many women talked about prayer and faith providing relief or lifting the "heavy weight" and "taking the pain away." Thus, women tended to report great importance and relief from their prayer life and spiritual practices, indicating that this is a crucial component of the cancer experience for many AI women.

Limitations

Given the dearth of research, more studies examining spiritual coping practices among AI/AN cancer survivors are needed. Results are self-report only, and this study does not examine the efficacy of any specific practices; conclusions on this regard are beyond the scope of this inquiry. This qualitative study is not generalizable beyond its setting. Although no differences were found across participants with distinct cancer types, future investigations may further explore whether cancer type may affect spiritual coping. Finally, distinctions need to be examined across AI/AN contexts, and the spiritual experiences and practice may vary considerably by tribe, individual, and region.

Implications

Results reveal the personal experiences of spiritual coping among AI women cancer survivors. It is important for social work practitioners to become familiar with some of the potential ways that AI women may talk about their faith. Although some AI cancer survivors may talk about God, some may prefer other language, such as "creator" or other common AI terms (Portman & Garrett, 2006). The language surrounding AI/AN spiritual traditions may vary, as do the practices requiring medical practitioners and social workers to broach this topic. Part of what enables practitioners to open this dialogue is their comfort and familiarity with the topic (Shelley et al., 2009); patients are sensitive to judgment or skepticism about alternative or complementary healing practices, and it is important that medical practitioners, including social workers, keep these values in check so that patients can have open and honest discussions about factors related to their cancer journey (Shelley et al., 2009). In closing, the overwhelming majority of AI women cancer survivors expressed receiving great comfort, strength, hope, and relief from their spiritual and faith traditions, indicating that these practices may be an important protective factor, buffering against the strain of the cancer experience. HSW

REFERENCES

Best, M., Butow, P., & Olver, I. (2015). Do patients want doctors to talk about spirituality? A systematic literature review. *Patient Education and Counseling, 98*, 1320–1328.

Buchwald, D., Beals, J., & Manson, S. M. (2000). Use of traditional health practices among Native Americans in a primary care setting. *Medical Care, 38*, 1191–1199.

Bureau of Indian Affairs. (2018). *Mission statement*. Retrieved from https://www.bia.gov/bia

Burhansstipanov, L., & Hollow, W. (2001). Native American cultural aspects of oncology nursing care. *Seminars in Oncology Nursing, 17*, 206–219.

Burnette, C. E., & Figley, C. R. (2017). Historical oppression, resilience, and transcendence: Can a holistic framework help explain violence experienced by Indigenous people? *Social Work, 62*, 37–44.

Espey, D. K., Jim, M. A., Cobb, N., Bartholomew, M., Becker, T., Haverkamp, D., & Plescia, M. (2014). Leading causes of death and all-cause mortality in American Indians and Alaska Natives. *American Journal of Public Health, 104*(Suppl. 3), S303–S311.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities. *Journal of Interpersonal Violence, 23*, 316–338.

Harper, S. S., & Entrekin, C. M. (2006). *Violence against native women: A guide for practitioner action* (No. 96-VF-GX-K005). Washington, DC: Office on Violence Against Women and the National Center on Protection Orders and Full Faith and Credit.

Irwin, L. (1997). Freedom, law, and prophecy: A brief history of Native American religious resistance. *American Indian Quarterly, 21*(1), 35–55.

Kalish, N. (2012). Evidence-based spiritual care: A literature review. *Current Opinion in Supportive and Palliative Care, 6*, 242–246. doi:10.1097/SPC.0b013e328353811c

Marbella, A. M., Harris, M. C., Diehr, S., Ignace, G., & Ignace, G. (1998). Use of Native American healers among Native American patients in an urban Native American health center. *Archives of Family Medicine, 7*, 182–185.

Milne, J., & Oberele, K. (2005). Enhancing rigor in qualitative description: A case study. *Journal of Wound, Ostomy, and Continence Nursing, 32*, 413–420.

Perdue, D. G., Haverkamp, D., Perkins, C., Daley, C. M., & Provost, E. (2014). Geographic variation in colorectal cancer incidence and mortality, age of onset, and stage

at diagnosis among American Indian and Alaska Native people, 1990–2009. *American Journal of Public Health, 104*(Suppl. 3), S404–S414.
Plescia, M., Henley, S. J., Pate, A., Underwood, J. M., & Rhodes, K. (2014). Lung cancer deaths among American Indians and Alaska Natives, 1990–2009. *American Journal of Public Health, 104*(Suppl. 3), S388–S395.
Portman, T. A., & Garrett, M. T. (2006). Native American healing traditions. *International Journal of Disability, Development and Education, 53*, 453–469.
QSR International. (2015). NVivo version 11 [Qualitative data analysis software]. Melbourne, Australia: Author.
Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18*, 179–183.
Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*, 334–340. doi:10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G
Shelley, B. M., Sussman, A. L., Williams, R. L., Segal, A. R., Crabtree, B. F., & Rios Net Clinicians. (2009). 'They don't ask me so I don't tell them': Patient-clinician communication about traditional, complementary, and alternative medicine. *Annals of Family Medicine, 7*, 139–147. doi:10.1370/afm.947
Struthers, R., & Eschiti, V. S. (2004). The experience of Indigenous traditional healing and cancer. *Integrative Cancer Therapies, 3*(1), 13–23.
Sullivan-Bolyai, S., Bova, C., & Harper, D. (2005). Developing and refining interventions in persons with health disparities: The use of qualitative description. *Nursing Outlook, 53*, 127–133.
U.S. Commission on Civil Rights. (2004). *Native American health care disparities briefing: Executive summary*. Washington, DC: Author.
Vallurupalli, M., Lauderdale, K., Balboni, M. J., Phelps, A. C., Block, S. D., Ng, A. K., et al. (2012). The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *Journal of Supportive Oncology, 10*(2), 81–87. doi:10.1016/j.suponc.2011.09.003
White, A., Richardson, L. C., Li, C., Ekwueme, D. U., & Kaur, J. S. (2014). Breast cancer mortality among American Indian and Alaska Native women, 1990–2009. *American Journal of Public Health, 104* (Suppl. 3), S432–S438.

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