TYPE 2 DIABETES MELLITUS (DM) IN AN AFRICAN-AMERICAN

SUBCULTURE: GROUNDED THEORY OF AFRO-THEISTIC

FAITH, KNOWLEDGE, AND AFRO-THEISTIC

SOCIAL CONSTRUCTS

by

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DEDICATION

To "Mama" and Great Grandpa "Levi"

2 Corinthian 12:9 But he said to me, "My grace is sufficient for you, for my
power is made perfect in weakness." Therefore I will boast
all the more gladly of my weaknesses, so that the
power of Christ may rest upon me.

ACKNOWLEDGEMENTS

along with Dr. Oliver, who helped me to be real to African-Americans and myself. How significant? Whenever you see the word "Afro", it is a reminder that Dr. Larrotta guided me into being mindful about the impact that my research can have on the African American population suffering the effects of diabetes. Finally, thanks to my confidant and department Chair Dr. Rohde, he gave me daily encouragement and guidance in completing the doctoral program. I truly and deeply love my committee members.

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ABSTRACT

The purpose of this study was to develop a theory grounded in data of how diabetic COGIC members combine their Afro-Theistic faith with their knowledge of type 2 diabetes mellitus (DM), through Afro-Theistic social constructs. With grounded theory as a methodology, this study unequivocally followed Corbin and Strauss (2007) processes of developing a grounded theory. The interview of only five participants provided enough thick and rich data to saturate five categories that emerged on the way to developing a grounded theory. The five categories that emerged were: (1) Faith, the most prevalent, (2) Fix and (3) Fatalism, both actions, and (4) Fear and (5)Frustration, both emotions. A Theory in 3-D emerged as a portrait of the grounded theory developed along with the actions, interactions and the emotions relative the subculture (COGIC) of African-Americans with type 2 diabetes mellitus (DM). This Theory in 3-D captured a theory of Substantive Living. The Theory in 3-D also morphed into a model called Permeated Learning.

In the process of developing a theory concerning DM, this study traces the African-American culture back to slavery. The tracing of the African-American culture is in two areas, theism and health. Theism provided the source of African-Americans subcultures through the divisions of churches. Most of the health discussions relates to diabetes in the African-American culture, but a discussed recreational exercise of the African-American ancestors is at the end of chapter 5.

I.   EDUCATION, AFRICAN-AMERICAN THEISM, AND DIABETES

My first philosophical discussion came at the age of seven and continues to have an impact. Sister Amanda Alexander (see Figure 1), my Sunday school teacher, had died. The philosophical joust came because of a new word I encountered a few days before the event and that word was "death." My mother told me we were going to the funeral. My question was why, but mama understood I did not know the purpose of a funeral. She said because Sister Amanda Alexander died. "What's death," I asked. "When people go to sleep and don't wake up," she responded. "Why," I asked. "They go home to be with the Lord," she replied. After these exchanges, she saw I did not understand death. She then
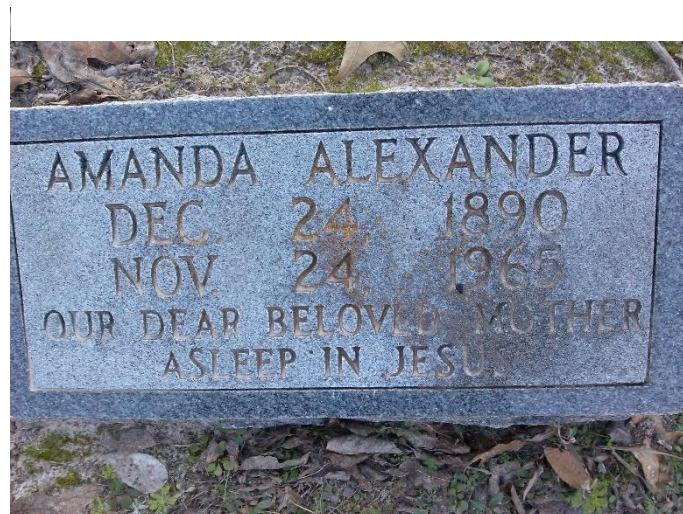
Figure 1: Sunday School Teacher.
Amanda Alexander 1890 -1965

gave me some shocking news to make her point. She said, "One day I am going to die and no longer be with you." I immediately understood death and began to wail. I cried bitterly from that morning until two or three in the afternoon. Early on, she sent my brother to console me, but I shook off my shoulders and refused his condolence. Many years later while serving in the Air Force, she visited me at Randolph Air Force Base in

Texas, and I asked her if she remembered my crying episode, to which she responded,

"Yes." I said, "If you die before me know that I've already done my crying." She smiled

as though she knew I would still cry but when I did weep, it would not be due to shock. I

knew it was coming one day.

In 1991, while serving overseas the American Red Cross informed me that my

mother (see Figure 2) had passed. She was only 62 years old; she died from

complications of type 2 DM. When I received the news I thought, "Lord it is not

reasonable that a woman who devoted her life to answering you, her church and the

Figure 2. Roberta: Mother.
1927- 1991
(50s, Researcher's current age)

community as a missionary, would die without receiving some benefit." In 33 years

observing her, I never heard her complain or reveal personal information before, during,

or after she assisted family, friends, neighbors, and church members with personal issues.

In fact, she never let others know when she gave assistance or complained that those

needing help were a burden. She faithfully served at her church and loved her husband,

my dad, 40 years her elder, until his death at the age of 97 (see Figure 3). All family

members called him Papa, whether his children, grandchildren or in-laws, the name

"Papa" was the same.

Figure 3. Fernander: Papa.
1888 - Aug. 7, 1985
(Age 84, in photo)

Following Papa's death, mom became 100% blind within one month due to the

stress of family members complaining about the death of her husband. DM caused her to

have periodical lapses into comas for the next five years. Despite those obstacles, she

continued to serve at the country church, living alone, and blind. Finally, complaints from

family members forced her to leave what had been her home for nearly 30 years. I had

always thought I could take care of my mother, but realistically, it would have created an

unreasonable expectation of my wife. I married her when she was 18 years old (see

Figure 4), and six years later we had four children. She had already sacrificed a career to

rear our children, all under the age of eight, and adding her blind mother-in-law would

have been unreasonable.

Figure 4. Wife (aged 18) and me.
She was 18 and I was 21 when we married.

With my military obligations limiting my ability to assist my wife, and with utter

consternation, I sent my mother to her sister. She cried, pleading, saying, she would not

be a burden. That ripped me apart; I made the best decision under the circumstances.

Remorsefully, I thought it was so unfair that the timing was such that I could not take

care of my mother who had served everyone so well. She certainly was not deserving of

continuous moves from one house to another, but DM was the source of this problem.

Consequently, in February 1991, while stationed at Bitburg Air Base Germany, I received

the dreaded call that made it impossible to make restitution to someone I owed so much.

My baby brother said one-month earlier mama surreptitiously and slowly examined his

firstborn's body, and extremities, as though she was making certain he no longer needed

her. Apparently having a healthy grandson and daughter-in-law to take care of her baby

child triggered a martyr's type response (Wood, Pilisuk, & Uren, 1973), since, within a

month she slipped into her final coma and died. My mother's response seems equivalent to Watson's (2002) statement, "The martyr is not a victim of circumstances. The martyr chooses" (p. 15). Unlike Watson's (2002) belief, "…the martyr must capture the imagination of those hearing his or her story" (p. 15), my mother would never bring attention to herself in that manner. As she would put it, "that was between her and God."

About 10 years after my mother died I developed DM. Reflecting on the circumstances of my mother's death, I panicked. I thought, "I cannot allow diabetes to kill me at an early age like it did my mother." For the next two months, I literally lived on soup and water and lost 40 pounds. Consequently, doctors discontinued my prescription of Glucophage, faster than they prescribed it. With determination, I managed to keep the weight off for five years. However, over the following three years, I regained about 15 pounds, and the insidious DM reemerged.

In 2011, while feverishly perplexed over the focus of my research on diabetes for my dissertation, my wife received a call stating an ambulance had rushed her mother to a local hospital. Doctors immediately started life support, all because of DM complications. Once the family members arrived, on Thanksgiving Day, they made the decision to end life support. Consequently, I, along with family members, including children, were grief stricken as they watched her mother, affectionately known as "Grannie Reen," gasp for her last breaths of life; DM had struck a crushing blow once again, to my family. Ironically, this occurred shortly after I lamented to my cohort in a History of Adult Education class that my mother-in-law's children could not see what was happening. They had taken away her independence by insisting that she ate properly, and be submissive to the nurse's aide provided for her. Most important of all, they stopped

supporting. Much like my mother, the effects of diabetes seemed to trigger a martyr's response, since, within a month she went into a fatal coma.

In addition to these DM related deaths, about a year prior to my mother-in-law's death, a first cousin in her 40s died from gas gangrene. Her death was sudden and unexpected, resulting from neuropathy that caused her to be unaware of an infected toe. Emergency staff admitted her into the hospital, and the intravenous medication seemed to arrest the infection. She was conscious, in excellent spirits and talking one day, but the next day she died. About a year prior to my first cousin's death, an older brother had a kidney donated by his wife. The transplant was necessary because DM had destroyed his kidneys. Lastly, in 2011, doctors admitted me into a local hospital while experiencing severe abdominal pain. The cause was uncontrolled DM, which overwrote my belief that by faith that I was healthy.

Each of these cases of diabetes had the Pentecostal faith of the Church of God in Christ (COGIC), in common, though members prefer the term Holiness because that was the message preached in this denomination prior to Pentecostalism. The commonality of historical background, membership in, or primary attendance in a local COGIC assembly makes this an Afro-Theistic study. From these cases, considering the prevalence of DM in African-Americans (CDC, 2012b), and the potential number having an association with the COGIC faith, a need was seen to focus this research on understanding how DM affects this group of African-American diabetics. Specifically, this qualitative research is based on an Afro-Theistic theory grounded in data that explain how faith coalesces with diabetes education (Glesne, 2011). The method of inquiry is through the interviews of the COGIC diabetic adults. The theory developed is to benefit other diabetes sufferers by

having the means of making a comparison. It will also serve as a guide to healthcare providers in assisting these fervent believers to live a healthy life in addition to living by faith. An initial understanding of an Afro-Theistic relationship between faith, knowledge and the social constructs of the COGIC members requires a look at this church's history.

COGIC History

The Church of God in Christ (COGIC, pronounced Cō-jic) began during a critical theological and pedagogical juncture in American history that saw initial shifts from traditional educational institutes such as a family, church, and schools toward industrial workplaces (Enns, 1989; Kasworm, Rose, & Ross-Gordon, 2010). This transition was during the late 1800s, when America had moved from colonialism into the prosperous industrial age. Former seminarian Charles Darwin (1859) had written a book called "The Origin of Species" that made an indelible impact in the traditional interpretation of biblical scriptures and initiated relativism "in the guise of biblical criticism" (Brown, 1995, p. 554). As a result, it challenged many conservative theological views and promoted liberal (feeling) theology traceable back to Friedrich Schleiermacher (1763-1834), and infiltrated Christian seminaries (Enns, 1989). During this time, African-Americans, more than 90% of whom lived in the South (Bureau, 2002a, 2002b), were also trying to find their place as citizens following slavery.

IN THE MATTER OF THE
ESTATE OF

NO. 803

H. D. REDWINE, DEC'D

LAST WILL & TESTAMENT

DATED: Feb. 22, 1864 (?)

FILED: April 11, 1864
RECORDED: Vol. J, page 589
PROBATE RECORDS, RUSK COUNTY,
TEXAS

===

THE STATE OF TEXAS }
                    }   FEBRUARY 23d, 1846
COUNTY OF RUSK }

IN THE NAME OF GOD, AMEN –

I, Hulkern D. Redwine, do make and declare this my last will
and testament in manner and form following:

FIRST: I resign my soul unto the hands of almighty God, hoping
and believing in the remission of my sins through merits and
mediation of Jesus Christ, and my body I commit to the earth to be
buried at the discretion of my friends and my worldly estate, I
give, bequeath and devise as follows:

ITEM FIRST: I wish my funeral expenses and all my just debts
paid, also all the just debts of my deceased son, Rufus.

2nd: I give to my wife Rachel Redwine, the following negroes,
to-wit: Jack, George, King, Louisa Jane & Laura & a support for
his & her children and all their negroes for twelve months after my
death; also my saddle horse & carriage.

ITEM 3RD: I give One Thousand Acres of land including my
homestead to be so laid off as to include a fair and reasonable
portion of timber to my wife & my daughter Mary E. Redwine & my son,
Frances P. Redwine, to be kept in the possession of my wife until
my son Frances P. arrives at the age of 21 years, then to be
equally divided according to quality & quantity between them.

I give to my wife all my household, furniture, all my farming
& black Smith tools, four mules & one wagon & harness.

I wish my stock of every description except the horse & mules
before mentioned to be equally divided between my wife & my four
children & except such other horses & mules as I may dispose of by
the will.

I give to the child of my son H.D.M.Redwine & any other children
which may be born to him hereafter the following property, to-wit:

Negro Levi, Maria, Henry, Amos, Cynthia & Caroline the undivided
half of one thousand acres of land a part of the tract I live on, to

Figure 5. H. D. Redwine; Slave Owner's Will. From the Rusk County
Court Record

My historical background is typical of those in the South at that juncture. As seen in Figure 5, Redwine willed his slaves Levi (1831-1895), my Great-grandfather, and Henry (1853-1930), my grandfather to his children. However, the Emancipation Proclamation of January 1, 1863 had occurred over one year prior. Allegedly, Texas "got the news" on June 19th, 1865, although Redwine's son Hullum Duke Erasmus was a Confederate cavalry officer (see: http://www.tshaonline.org/handbook/online/articles/fre70). Eventually, Grandpa Henry inherited 1,000 acres, owned a cotton gin, employed laborers and owned the first tractor in his East Texas area. When Henry died, the bank did not want the tractor, and refused payment on the loan. Instead, it took the five hundred (500) acres he had put up for collateral on that tractor. When I asked my dad why he and his siblings did not pay the loan, he said, "they wu'en let us." Currently, the descendants of my dad, Fernander (1888-1985), are one of only three families who have retained ownership of their inheritance of 50 acres.

The slow traveling news of the Emancipation reveals the antiassimilationist feelings of the White South establishment against African-Americans. Their power enabled them to push back after losing the Civil War, enacting laws to prevent leveling equality (Samad, 2013). Most African-Americans were poor and uneducated, making them easy targets of racial prejudice. In the true sense of the term, bricolage of resources (Crotty, 1998), to survive African-Americans had to "make do" with whatever was available including medical care. This type of survival strategy was the case as late as the 1960s. For example, all 19 of my siblings were born at home except one, and somehow the clinicians were not able to prevent the umbilical cord from choking Gayla Masha to

death. Other examples of the necessity of using home remedies to treat medical situation include: a) the severe laceration I received from the bottom of the sternum to the naval, b) a foot cut in half by a broken mason jar, and c) a severe burn resulting from chasing a toy into a wood stove. All were treated with home remedies and prayer. Likewise, churches played a vital role in former slaves survival both physically and educationally, where clergymen were usually the most educated in the African-American community and the church was usually a haven from physical violence (Giles, 2010; Weaver, 2003).

The founder of the COGIC denomination was Charles Harrison Mason, born during this period, in 1866, on Mr. John Watson's plantation in Bartlett, Tennessee. His parents were Jeremiah and Eliza Mason. Eliza's conversion (accepting Christ as Lord and savior) came during slavery at the Missionary Baptist Church (Brown, 1995; Whitehead, 2001a). His dad could not afford Charles the time for education, but apparently a precocious child, Charles' mind blossom with imagination (Greene, 1995), seeing what he called visions, from Biblical stories. In fact, documents state the church's name came to him as he was pondering in 1897. He said, "God spoke to him out of I Thessalonians 2:14...the churches of God which in Judea are in Christ" (Whitehead, 2001a, p. 9). In the meantime, Mason's conversion came at the age of 12. Then, at 14, he became deathly ill in 1880. His mother was devout and known as a woman of great faith and prayer. On the first Sunday, that September, Mason received what he described as miraculous healing. As a result, this idea of receiving miraculous healing became a key feature of faith within the COGIC denomination.

The remaining steps in the evolution of the COGIC denomination are a combination of ontologies (Kincheloe & McLaren, 2008) that were countercultural to

both White Americans and African-Americans of those times. Mason's baptism came from the hands of his brother at Mt. Olive Baptist Missionary Church, near Plumerville Arkansas. "Bishop Mason dedicated his entire life to preserving one thing--the spiritual essence of the Black religious experience and the prayer tradition that those old slaves had back in the brush arbors" (Whitehead, 2001a, p. 7). His love for the Bible is in opposition to Cremin's premise that the "whip and the Bible" were the pedagogies to keep Blacks in a White version of their existence; instead it reflects a second pedagogy premise that "through family and clandestine religious assembly" African-Americans maintained their identity (Kasworm et al., 2010, p. 89). The "whip and the Bible" was Thurman's grandmother's experience. White preachers would embellish the writings of Paul, the apostle, who admonished slaves to obey their masters. Although his grandmother would balance these teachings with those of a circuit slave minister who "reminded them that they were not niggers nor slaves, but God's children," yet, she forbad her grandson to read the Pauline letters (Giles, 2010, p. 336).

Other churches, like COGIC members, simply did not believe everything people said, as was evident by Mason's rejection of the teachings of C. L. Fisher, the academic Dean of the newly founded Arkansas Baptist College, and an Arkansas Baptist Convention leader. Fisher was a Greek and Latin scholar who graduated from Morgan Park Seminary in Illinois, now called the University of Chicago Divinity School. Although Fisher, A. M. Booker (Arkansas Baptist College president), and his wife took Mason in as a son, he rejected their way of Biblical interpretation, called higher criticism. He believed he could do a better job with the Bible and prayer alone. This example later became another fundamental feature of the COGIC denomination which recognized

ministers' (men) and missionaries' (women) licenses came from their felt inspiration by the Holy Spirit to preach and teach. Unlike other denominations that primarily qualify individuals based upon their education.

After Mason acknowledged his conviction to preach, he preached his first message based upon the autobiography of Amanda Smith (1837-1915), known as the greatest Black evangelist of the 19th century. This willingness to follow women's teachings led to another fundamental, yet countercultural, feature of the COGIC denomination, which permits women, then and now, to participate in ministry equally with men, up to the point of being a minister. C. P. Jones worked alongside Mason, and they extracted from Scripture the idea of *living holy*, which was countercultural to what they observed in society then. In 1895, C. P. Jones attended the Baptist Convention in Salem, Alabama and was disappointed with the convention's focus:

> Because while they [Baptist] were concerned about the racism in America, the political disfranchisement of Blacks and the great dehumanization process that was going on in America, they organized, but were not putting much emphasis on the spiritual element in the Black religious experience. They were putting the emphasis on the social side, on the political side, and on the educational side, but were putting no emphasis on the spiritual needs (Whitehead, 2001a, p. 9).

Holiness, the idea of living free from sin through sanctification, became another fundamental feature of the church, but this teaching caused conflicts within the Baptist Church, and in 1896, those who believed this teaching were disenfranchised (Whitehead, 2001a). This countercultural belief is yet another fundamental feature of this church since it chooses to hear messages that emphasize living a spiritual life versus messages that

engage the entanglements of current events. This countercultural praxis led to another fundamental feature of this church. Since its inception, it has openly embraced all races even during the time of segregation. Blacks and Whites often fellowshipped together during this dangerous time, in secret.

Later, when the number of Whites serving under Bishop Mason grew in numbers, the elders asked Mason for his blessing to separate into their own denomination, presumably from racist pressure during that time. Consequently, Bishop Mason after ordaining many White ministers over the years agreed, some of these men started the Pentecostal "Assemblies of God" (Weaver, 2003). Sadly, Mason and his COGIC choir were the only two African-American churches invited to their initial Hot Springs Convention in 1914 (Weaver, 2003).

Weaver (2003, p. 49) states, "David Daniels says the early interracial impetus existing in COGIC has been neglected, Mason's contribution to the interracial impulse within Pentecostalism and American Protestantism remains an understudied topic of American religious history." For example, when the American South condemned interracial gatherings, the predominantly African-American COGIC church crossed racial barriers and welcomed fellowship with Whites. In other instances, they welcomed Dr. Martin Luther King at Mason Temple COGIC in Memphis, Tennessee, even when he was experiencing his worse criticism. Finally, Faith Temple COGIC in Harlem, New York, welcomed Malcolm X's funeral when others would not. However, COGIC has several dogmas over which many Evangelicals disagree, such as, "…their emphasis upon healing, gifts of prophecy, speaking in tongues, spirit possession, and religious dance" (Weaver, 2003, p. 35). Notably, the conviction that all believers must speak in tongues

came after Mason's Los Angeles visit with Elder William Joseph Seymour, and the Azusa Street revival, caused Mason and C. P. Jones to part ways. Upon returning from this revival, Mason conducted meetings (revivals) that had thousands of converts (African-American and White) to the new belief. At that time, the Memphis Commercial Appeal published the following:

> Fanatical worship of Negroes going on at Sanctified Church... Strange things have been going on at this [COGIC] church...and if the authorities do not interfere some lives are sure to be sacrificed to the fanatical spirit which has been controlling the church for the last month (Weaver, 2003, p. 45).

Admittedly, COGIC does have core dogmas, but it also give each pastor the flexibility to interpret these meanings, based upon their own spiritual convictions. The previously mentioned cases of helping non-membered leaders are examples of this flexibility, since the church, as an organization, did not vote on those decisions. Although many COGIC leaders did not agree, a few used their liberty to act according to their conviction. As a result, members of local congregations' understanding of church dogmas come from Bible studies and pastors (primarily), or ministers, speaking to the congregation. If we compare this type of organization to a business, most congregations operate as independently owned franchises, submitting to a limited set of cooperate rules in order to carry the cooperate logo.

Nonetheless, pastors must first be ordained as an elder before they are eligible to establish, or receive, an appointment to the pastorate. This process usually takes years of faithfully serving under a pastor as a member, then as a minister. This system is efficient in weeding out those who do not qualify based upon core beliefs. The organization

maintains unity through an annual fall pilgrimage to a Holy Convocation, held for many years in Memphis, Tennessee. Historically, the timing allowed its members, nearly all farmers located throughout the United States, time to gather and sell their crops in order to have the money to make the trip. Increasingly, COGIC is developing its own curriculum to educate its ministers and missionaries.

However, Mason recognized the need to educate youth from the beginning and developed educational schools and curricula, stressing Godliness and Holiness (Whitehead, 2001b). Over the years, through the education of younger leaders and the death of elders, COGIC leadership has relaxed some of its earlier extreme views. Some examples include, deferring to conscientious objection in wars, or the notion that it is a sin to go to the movies, or sporting events. Furthermore, depending on the preacher, some even believed watching television was a sinful endeavor. The fact that education and time have fostered changes in this austere subculture of African-Americans highlights the importance of developing a theory, grounded in data, explaining the relationship between diabetes education and COGIC members.

Problem Statement

There is a lack of diabetes support in the African-American diabetic community resulting from a disconnect between those who have access to resources, like diabetes education, and the African-American community. Those who possess the ability to educate this community do not understand its culture. For this reason, those willing to help with education and financial resources typically provide aid to church-based organizations because the majority of African-Americans has a church affiliation. The problem with church-based organizations is twofold. First, church-based support groups

operate without the benefit of having a theory grounded in the participants data that would help facilitate changes based upon principles of adult education. Secondly, relatively few churches take advantage of the opportunities available to help those with diabetes because that is not the primary function of a church. The result is a decrease in support for the African-American culture that prolongs suffering and continues to affect the economy. The development of a theory grounded in the participants' data in order to encourage more support needs to start by demystifying the reasons for the church affiliation of many African-Americans.

Church-based support rightfully suggests a sharp division of the African-American culture into socially based subcultures. The reason for these divisions is the number of church denominations, such as the Church of God in Christ (COGIC) used in this study. Each African-American denomination or religious organization has beliefs that divide the community, and affects their understanding of how they relate to DM. Familiarity with the COGIC church helps by providing details of a significant population of African-Americans. Historically, those associated with the COGIC denomination have been subjected to double marginalization due to their militant and dogmatic style of preaching the gospel (Range, Young, Ross, & Winbush, 1973). This marginalization extends from its African-American founding and fundamental beliefs in Holiness and in living by faith. However, this marginalized African-American Holiness group represents 6.5 million people worldwide, and 5.5 million people in America (Houdmann, 2012). This research, as a result, serves as a foundational manuscript for African-Americans, based on research performed by an emerging African-American researcher. Two Feathers (2005) indicates that faith-based support groups are the best means of helping many in

the African-American and Mexican-American communities learn about, cope with, and adjust to, life as a diabetic. In recognition of the benefits of faith-based support, the American Diabetes Association (ADA, 2013a) developed programs like Project Power for African-American churches in an effort to manage diabetes. However, the COGIC church has other beliefs, like divine healing as in the days of the apostles of Christ, which further distinguishes them as a unique African-American subculture (Range et al., 1973). The uniqueness of the COGIC church has resulted in marginalization that makes members reluctant to participate in support groups.

Marginalization of the COGIC church began with physical violence and gunfire in 1897, at the church's founding. Disgruntled gunmen fired five shots from multiple guns into the crowd of worshipers during its second revival (Range et al., 1973). Preceding this attack the Baptist Church denomination, in 1896, ordered its doors to close to the teachings of the founder and his followers (Range et al., 1973). Ironically, another marginalized individual named Martin Luther King Jr., (Estate of Dr. Martin Luther King Jr., n.d.), a Baptist preacher, preached his last and famous "I've Been to the Mountaintop" message in the COGIC headquarters, in Memphis Tennessee. In this vein, Boucouvalas and Lawrence (2010) argue every person is a product of the multiple identifications imposed upon them by systems in which they participate. COGIC members' multiple identifications come from marginalization, or being "othered" (Charmaz, 2011, p. 371), as African-Americans, plus the marginalization of their church denomination, and finally, marginalization as strong believers in living by faith.

The COGIC church is a humble, sacrificial, and relatively private African-American subculture. Traditionally, church attendance, Biblical living, and emphasis on

the eternal order of heaven have prominence over temporal affairs on earth. One example is fasting, which traditionally meant refraining from eating food or drinking water for a period of hours or even days. In the place of food and water, members pray to God while continuing to engage in daily activities without anyone knowing. However, fasting poses a problem when it comes to diseases such as DM, where clinicians expect these patients to eat smaller portions six times a day while continuing to take their prescribed dosages of medication. Discussing fasting with a doctor is unheard of due to ethnic differences. Even with African-American physicians, the chance of them being Pentecostal is small. The risk of appearing ignorant or bringing shame upon African-Americans is a constant worry. The conclusion, therefore, is that doctors do not know of these cultural practices; if so, they certainly do not let patients know. The fear of negative feedback prevents African-Americans from discussing DM with clinicians, especially the COGIC subculture which believes in divine healing. COGIC diabetic adults accept problems as their fate in this life, and manage in private in the best manner possible. However, marginalization can be avoided with a theory grounded in data, that brings understanding of this subculture. Having knowledge of this subculture in relationship to diabetes will eventually erode the reluctance of COGIC church members to take advantage of resources to help themselves by developing and participating in an African-American support group.

In addition to adult education theory making it possible to develop a deeper understanding of COGIC diabetic members, it has the potential of affecting the economy through changes they make. Already, many in the African-American community feel the medical community thinks they will eventually develop diabetes. Such thinking gives the

impression that African-Americans are the cause of increasing medical expenses in the

United States. Even if that was true, and it is not, theory grounded in the interviews of

African-Americans invites opportunities for discussions leading to changes. For

clarification, and to erase the negative impressions in the minds of many African-

Americans, in reality the per capita rate of occurrence for DM is consistent with each

ethnicity's population percentage. In other words, ethnic groups with the greatest

numbers in the population also have the highest number of citizens with DM. What is

disproportionate is the rate per capita in each ethnic group. For example, combining 2010

census statistics, Table 1 shows the actual number of African-Americans with DM is next

to last, but have almost the greatest percentage of its ethnic group affected (CDC, 2012a;

Ennis, Ríos-Vargas, & Albert, 2011; Hixson, Hepler, & Kim, 2011; Norris, Vines, &

Hoeffel, 2012; Rastogi, Johnson, Hoeffel, & Drewery, 2011). Although the statistics

show the number of African-Americans with DM is next to last they also revealed they

rank second for the greatest percentage of the ethnic groups affected. Therefore, these

statistics reveal the urgent need for African-Americans to have dialogues about how to

reverse this trend. However, to ensure a high probability of success, these discussions

need a point of reference that is uniquely African-American. The development of a theory

grounded in the data of diabetic adults in the COGIC subculture provides an initial

reference for dialogue.

Table 1

National Diabetes Statistics by Ethnicity

Ancestry	Population Percentage	Percentage Diabetic	Number with Diabetes*
White Americans	77.1	7.1	17 million
Hispanic or Latino	16.3	11.8	6 million
African-Americans	13.6	12.6	5 million
American Indians & Alaskan Native	1.7	16.1	0.8 million

Note. Based on total population of 309 million.
*All rounding was to the nearest million and based upon un-rounded calculations.

To date, the chance to talk about DM in the African-American community has been small since there are relatively few support groups for this culture. As an example, of the two support groups discovered within the region, Hispanics facilitated both, and though open to the public, the audience was predominantly from this same culture. One of the two diabetes educators demonstrated the importance of exclusivity in the Hispanic and African-American support groups. When clients detected subtle differences between them, he told them he was a South American. Thus, when discussing personal issues of diabetes two things essential to participants become apparent, the importance of cultural exclusivity, and cultural knowledge. Upon further investigation, the only local African-American support groups were sporadic, informal, church-based short-termed programs facilitated by pastors. The observation of church-based local support served as another reminder that African-Americans have subcultures based on religious practices. Without in depth knowledge of the subculture, facilitators have little chance of helping those with an already small support structure. The fact that research such as Two Feathers' (2005) reveals church-based support groups as working best for African-Americans gives

evidence there is a gap in knowledge about this culture. A theory grounded in the data of diabetic adults in an African-American faith-based subculture provides a platform for diabetes educators to communicate with the culture.

African-Americans, based on the latest census (2010), statistically are among the greatest per capita percentage of those living below the poverty level (DeNavas-Walt, Proctor, & Smith, 2011). Poverty warrants further considerations based on a collaborative initiative between "faith-based health advocates, lay church members (facilitated by Interfaith Partnership's Abraham's Children), and academics that began in 1999, in St. Louis, Mo." (Baker et al., 2006). The intervention program that started in 1999 continued through the publication of the peer-reviewed Journal article in 2006. Baker et al. (2006) found social and environmental factors significantly influenced the eating behaviors of African-Americans in St. Louis MO. For example, socially, they found grocery stores in low-income and minority neighborhoods have fewer healthy choices for shoppers, contributing to obesity, which is in turn, a contributing factor to diabetes. Environmentally, they observed the transportation systems in these neighborhoods influenced a community's level of obesity. According to the 2010 census the COGIC African-American diabetic communities in this study have the same obstacles to making healthy choices. In addition, Baker et al. (2006) noted other intervention studies focused on two aspects of obesity; eating habits, and physical activity, while ignoring social and environmental causes. Taken further, the Baker et al. (2006) intervention magnifies the importance of developing a theory for a better understanding of diabetes from the African-Americans' perspective. This means beginning with one subculture of African-Americans, divided by Afro-Theistic beliefs.

If we think further about the statistics in Table 1, we can gain insight into the reasoning for selecting the COGIC church as the representative Afro-Theistic subculture for this study. The COGIC membership alone outnumbers the entire population of American Indians and Alaska Natives, who represent the largest percentage affected by DM. The COGIC fervent belief in divine healing by faith makes them an easy target for marginalization because of their Afro-Theistic faith. Therefore, discovering how they process knowledge of diabetes by using their own data, we are showing the COGIC members with DM respect, and giving them a reason to trust that their participation in a faith-based support group is for their benefit. Two Feathers (2005) and Ruder, Blank, Hale, Nienow, and Rollins (2007), show an understanding of a subculture helps people build trust in the process and gives them the space required to self-identify conflicts. These moments of discovery are what Brazilian philosopher and educator Freire called "conscientization" (1998). Self-identity facilitates the American philosopher and educator Horton's (2003) belief that members of a culture should take responsibility to solve their problems, in conjunction with available help. In order to promote this democratic process, also called the relocation of power (Cornwall & Jewkes, 1995), a theory grounded in the data of diabetics, seen through the lens of the fervent convictions of Afro-Theistic faith, is essential. Moreover, a theory grounded in the data of this admittedly dogmatic (Range et al., 1973) Afro-Theistic subculture provides a model for studies of less dogmatic Afro-Theistic subcultures.

Purpose of Study

The purpose of this study is to develop a theory grounded in data about how diabetic COGIC members combine their Afro-Theistic faith with their knowledge of DM,

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through Afro-Theistic social constructs. The objective of the theory is to understand this Afro-Theistic subculture of COGIC members' efforts to manage DM and provide an instrument to reverse the current trend of increasing rates of diabetes in African-Americans. Missing in the African-American diabetic community is a theory that investigates the problems of diabetes in order to develop a supportive and collaborative effort to promote healthy living that supplants the desires for isolation. Although support groups appear to be the best means of diabetes maintenance in the African-American population, there is another crucial consideration for this populous. This culture has multiple unique subcultures within it.

Many subcultures resulted from religious differences. A significant polarization is the 5.5 million members of the COGIC denomination (Grissom-II, 2013; Houdmann, 2012; U.S. Census Bureau, 2012; Waldron, 2008). This polarization resulted from "dogmatic" (Range et al., 1973, p. 25) spiritual convictions marginalizing them in the eyes of other African-American religious groups. For this reason, it is necessary to understand how diabetics in this subculture reconcile their faith with diabetes education, through their social constructs, prior to an invitation to a support group. Understanding this subculture helps in the design of a support group by considering the affected adults' ages, the number of years they have lived with the disease, and other findings that help facilitate changes. We already know knowledge about diabetes, information on self-management, and short-term intervention alone do not provide sufficient long-term changes in the management of diabetes (Saydah, Fradkin, & Cowie, 2004; Two Feathers, 2005; Williams, Manias, Liew, Gock, & Gorelik, 2012). Thus, having a theory grounded in the data of this culture helps to build a sustainable diabetes support group with long-

term benefits for the community of African-Americans with diabetes (Baker et al., 2006). Finally, Kuhn's (1999) critical thinking through action and reflection on activities is a necessary part of managing diabetes in the COGIC subculture. However, for sustainability through support groups, this study develops a theory grounded in data that combine Afro-Theistic faith, knowledge about diabetes, and Afro-Theistic social constructs.

Research Questions

The question guiding this study is, "What are the processes involved when COGIC members with DM construct knowledge about the disease through their Afro-Theistic faith and Afro-Theistic social constructs?" The means of ascertaining a theory grounded in data is from the following questions:

1. What does diabetes education look like for the Afro-Theistic COGIC diabetes mellitus sufferers?

2. How can Afro-Theistic faith and diabetes education coexist to help DM sufferers?

3. What are diabetic COGIC members' Afro-Theistic social constructs' beliefs about diabetes mellitus?

   - What are the Afro-Theistic social constructs?

4. How does the Afro-Theistic social constructs' interpretation of diabetes mellitus, overtly or covertly influence COGIC member's resolve to disregard intervention?

These research questions require an understanding of African-Americans, and this requires knowledge of Theism that divides African-Americans into subcultures.

Answers to the research questions provide a qualitative approach to help African-Americans have space to self-identify means and obstacles to managing diabetes.

Especially since the American Diabetes Association (ADA), lists diabetes as the seventh leading cause of death in America. According to the Centers for Disease Control and Prevention (2011), diabetes has maintained that status for several years. In addition, there exists a relationship between diabetes and Coronary Heart Disease (CHD), the number one killer in America. CHD is one of many complications associated with type 2 diabetes mellitus (ADA, 2011; Roger et al., 2010). Currently, 18.7% of African-Americans (NDEP, 2011), and more than 7% of the American population (Davis-Smith, 2007) are diabetic with no sign of decreasing. In fact, the ADA predicts one in three Americans will suffer from DM by 2050. However, the prospects are even more abysmal for African-Americans and Mexican-Americans. Today one-in-three of them are predicted to develop DM within their lifetime (ACS, ADA, AHS, & ASA, 2011; Roger et al., 2010). In other words, within the lifetime of all African-Americans and Mexican-Americans presently living, more than 33% will develop DM.

Missing are qualitative studies of African-Americans that approach the problem from their perspective. This qualitative study has research questions to develop a theory grounded in the data of African-Americans from their theistic perspective. For this reason, answering the research questions for African-Americans also addresses multifaceted problems with DM. These problems involve not only the individual, but also American society, given the rising cost of healthcare (ACS et al., 2011). Diabetic related costs accrue directly in the form of kidney diseases and complications that can result in renal (kidney) failure and the need for a long-term dialysis or a kidney transplant. Diabetes indirectly accrues costs in the form of heart disease and stroke, high blood pressure, nervous system disease and amputations. Added to the conundrum is that the

exact cause of DM has yet to be determined (ADA, 2011), despite knowing genetics and the environment are contributing factors. Regardless of what causes diabetes, doctors, and the federal government welcome partners working to reverse these trends and bring the disease under control. Therefore, the government initiated "The Catalyst to Better Diabetes Care Act of 2009, which is part of the Patient Protection and Affordable Care Act" (CDC, 2012a).

A term that indicates change, popularized by Adult Educator Jack Mezirow (1991), is Transformational Learning. Mezirow (1991) explains that adults have lifelong learning experiences that give them a *Frame of Reference*. In order for transformation or change to occur, an individual must first experience a *disorienting dilemma or personal crisis* (Baumgartner, 2000; Mezirow, 1991). In this vein, there is a wealth of quantitative data and governmental intervention programs (CDC, 2012b) focusing on evidence-based lifestyle changes leading to the prevention and treatment of DM. An Afro-Theistic theory grounded in the data of the COGIC members with DM, based on the research questions guiding this project, provides missing knowledge needed in the African-American community. Many researchers indicate the need for answers. Most relative is Melancon, Oomen-Early, and del Rincon (2009) and Two Feathers (2005) mixed method studies. Also important is Davis-Smith's (2007) mixed method study, and Ntiri and Stewart's (2009) quantitative research. These gave evidence that intervention groups promote self-directed learning which results in transformational learning. The promising evidence ranged from the reduction of diabetes complications to the prevention of DM in pre-diabetics, which accounts for 90% - 95% of all diabetes. In addition, an article by Gaillard (2007) that stressed the importance of faith-based subcultures in diabetes

management, corroborated these findings. Furthermore, these studies, especially the research conducted by Two Feathers (2005), revealed the importance of cultural exclusiveness as a vital factor that leads to transformation.

If the culture requires exclusiveness for changes to occur, then it makes sense to consider a large subcultural segment that potentially impedes the desired effects of diabetes maintenance. COGIC is a large body of Afro-Theistic African-Americans, unique in their belief in living by faith. This peculiarity makes them a subculture with views paradoxical to diabetes education. This denomination consists of 5.5 of the 42 million African-Americans, constituting more than 13% of this population segment, representing a group which could have a significant impact on reversing the trend of diabetes in the African-American community.

Because of the gap in qualitative research, there is a dearth of theory focused on how Afro-Theistic subcultures reconcile faith with diabetes education through social constructs. This lack of a theory is a significant gap in understanding *exclusivity*, relative to the African-American culture. An Afro-Theistic theory grounded in data of how the diabetic COGIC subculture within the African-American culture constructs knowledge about diabetes provides a conduit for dialogue with those outside the culture. Therefore, this study begins filling this gap in understanding by interviewing COGIC members with diabetes. The findings answer questions related to socially constructed meaning of diabetes through Afro-Theistic faith, the diabetes education of the COGIC DM sufferers, and how they juxtaposition the two in managing the disease.

Researcher's Perspective

I have an insider's perspective for this study with type 2 DM COGIC members.

My historical roots are in the Church of God in Christ (COGIC) from its establishment in

1897 (Whitehead, 2001a). My grandfather, a former slave, (see Figure 5 and Figure 6)

donated the land for the only COGIC church in my East Texas country community. My

grandfather's son, my dad, an ordained elder born in 1888, possibly knew the COGIC

founder, Bishop Charles Harris Mason. My mother was a missionary in this church. In

1995, I received my ordination as an elder in this COGIC denomination as well.

In 1979, prior to my conversion to Christianity, I became a member of a

historically black fraternity called Phi Beta Sigma, an organization dedicated to serving
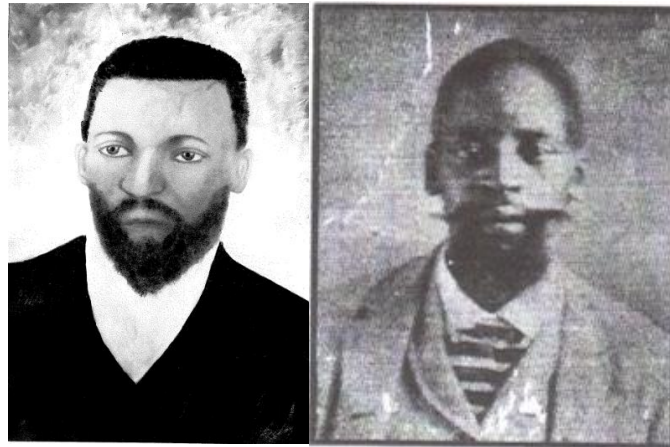
Figure 6. Henry: Grandfather.
1853-Aug. 7, 1930

others, especially within the African-American community. Subsequent to the ordination,

I completed a Masters of Ministry and a Doctorate of Ministry from Louisiana Baptist

University. My academic studies resulted in doctrinal differences, primarily concerning

speaking-in-tongues, differing from my COGIC ordination. Nevertheless, my ordination

qualified me to pastor a congregation or establish a COGIC church. Subsequent to the

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ordination, I incorporated an interracial Bible Church. Ironically, when I sought advice from my White brother, who was ardently against speaking-in-tongues, he gave me the cold shoulder when I mentioned having an interracial church. For more than 12 years, his indifference has reminded me of the separation that cultural differences cause. In addition, concurrent with my ordination, I received a degree in Medical Laboratory Science (MLS). As a nationally certified Medical Laboratory Scientist and with continual education I accepted an appointment as a professor in the Clinical Laboratory Science department at Texas State University. In addition to my ordination, certification as an MLS scientist, and continual education, I am a diabetic patient. Finally, my spirituality, education, and health converge in my emergence as a qualitative researcher in adult education.

I have conducted quantitative research on the prevalence of pre-diabetes among college students who are under stress. My interest in pre-diabetes and diabetes extends from the aforementioned tragedies and having diabetes myself. Diabetes concerns me as a citizen since it ranks as the seventh leading cause of death in America and its complications can lead to coronary heart disease (CHD), the leading cause of death in America. My journey as a diabetic patient has crossed many educational settings, with varying degrees of effectiveness, towards long-term changes in health behaviors. For example, the announcement that I was a diabetic had an effect that resulted in severe modifications in my diet for more than five years. But, as time passed, I reverted to some of the old dietary habits. Hospitalization resulted in more permanent modifications, sufficient to prevent a repeat of that event. Through a literature review of transformative learning in diabetics, and through studies such as Davis-Smith (2007) and Bricker et al.

(2010), I discovered the existence of support groups for diabetics. Consequently, I sought out counsel by diabetes educators and participated in a support group congruent with the recommendations of researchers from my literature reviews (Gay, Mills, & Airasian, 2006; Mills, 2007). For example, my interview with a diabetes educator created a lasting impression of hope that has not dissipated. As a result, I have attended several support group meetings for diabetics and obtained individual diabetes counseling that has led to a greater awareness of the need for diet control and exercise. At no time has my primary care physician suggested or mentioned the existence of support groups for diabetes sufferers. Nevertheless, in spite the benefits of the support group and the individual diabetes educational sessions with a diabetes educator, participation in these activities also revealed some problems.

One of the problems with the support group is a matter of belonging. Although I respect the diabetes educator and those in the group, cultural differences made me an outsider. For example, in one of the meetings, in a joyous moment, the diabetes educator said, "I know; why don't we bring our favorite recipes and share with the group on how we were able to modify them to fit our diabetic diet." Since I was the only African-American present, this left me out because Hispanics favorite foods are different from mine. Furthermore, as a member of the COGIC subculture, questions of how to reconcile beliefs about living by faith with diabetes education nagged at me. In addition to the support group, my insurance policy provided individual sessions with a diabetes educator, but due to time constraints, I did not feel comfortable discussing all I had in mind about my faith and diabetes.

A theory grounded in the data of the COGIC members combining their faith with diabetes education to construct knowledge that leads to transformation is beneficial to supporters. This understanding frees the leader to dialogue to understand, evaluate, and to identify changes within this subculture of African-American diabetics who believe in living by faith. Subsequently, discourse provides means of critically reflecting upon what Mezirow (1997) calls, "the assumptions upon which our interpretations, beliefs, and habits of mind or points of view are based" (Mezirow, 1997, p. 7). Mezirow (1997) also states that transformative learning involves a process, "Once set, we automatically move from one specific activity (mental or behavioral) to another" (Mezirow, 1997, p. 5). Theoretical knowledge of African-American culture should identify essential factors that help facilitate those changes.

Through reflection on the best means of helping diabetic African-Americans, I concluded I should not ignore the obvious strong subcultural differences within the African-American community, treating all the same. The knowledge that COGIC African-American communities have strong convictions based upon religious differences, with 5.5 million members in America alone, was disconcerting. After reflecting, I concluded the theoretical basis for understanding the subcultural processes of reconciling their faith with diabetes education was the priority. In this way, when developing a support group for African-Americans a theoretical basis exists for dialogue about subcultural differences. This should help prevent marginalization and heighten sensitivity to differences within the African-American community.

Dissertation Road Map

Chapter 1 served three purposes. It revealed the chronic problems of diabetes in the African-American community, established the influences of subcultural religious segregation, and set the background for understanding how one subculture constructs knowledge by combining faith and diabetes education. Initially, the overview demonstrated the devastating effects when African-Americans attempt independent management of this insidious disease. The remainder of the chapter provided literature that established that subcultural needs should have principles of adult education as its basis. They primarily identified problems those outside the culture experience in assisting African-American diabetics without a theory grounded in their data. Furthermore, the African-American culture has limitations in helping itself, without a theory grounded in the data of the subcultures. The chapter also revealed an insider's, or emic view (Fraenkel, Wallen, & Helen H, 2012), of the African-American diabetic culture. The emic view continues with the COGIC subculture since I am an African-American with DM and have privileged knowledge of the COGIC church.

Chapter 2 is a literature review that begins with the reasons this study focuses on African-Americans. The chapter continues by defining type 2 diabetes mellitus. The literature review examines studies of African-Americans suffering from chronic diseases, shows them as adult learners, and acknowledges their subcultural faith and social constructs. The assessment includes a look at the adult learning theories of self-directed learning and self-efficacy and their importance in the African-American subcultures. The chapter continues by giving reasons for choosing grounded theory as the methodology of

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choice for a study of African-Americans suffering from diabetes. Finally, Chapter 2 examines the gaps in the literature concerning African-Americans suffering from DM.

Chapter 3 is the methodology of the study that begins with the researchers' paradigm which includes the importance of symbolic interactionism. The section establishes the Afro-Theistic theoretical framework as an integral part of African-American studies. The chapter discusses qualitative research with a focus on grounded theory as the methodology for this study. Finally, Chapter 3 discusses the methods of data collection and analysis.

Chapter 4 is a detailed and systematic look at the findings of this study. The chapter begins with an establishment of rapport with the participants. Next, the chapter delineates the symbolic interactionism's of actions, interactions, and emotions grounded in the data of the COGIC members' Afro-Theistic data. Through the analysis, categories are discovered and integrated into a theory of how African-Americans in the COGIC subculture combine their Afro-Theistic faith with their knowledge of type 2 diabetes mellitus through their Afro-Theistic subcultures.

Chapter 5 wraps up this study with the key findings, implications, and recommendations. In so doing, the chapter revisits the research questions and summarizes the findings, giving answers to the inquiries. Finally, the chapter briefly discusses the limitations, need for future studies, and recommended actions based on this research.

II.   LITERATURE REVIEW

The purpose of this Chapter is threefold. First, presented is a literature review of Afro-Theistic faith, and the Afro-Theistic constructivism that forms the theoretical framework of the study. Next, the review defines DM, placing it in relationship to adult learning theory and subcultures. Finally, this chapter presents an analysis to establish a rationale for the grounded theory methodology. The chapter begins with the tools used for the literature review, followed by a discussion of the different types of diabetes and the reason for selecting type 2 for this study. The chapter continues with a literature review in three areas of concern to understand African-Americans with DM and identify gaps in knowledge leading to the reduction of current trends. The three topics are the identification of adult learners, the role of subcultures, and theoretical models used to assess data about minorities with chronic diseases that included DM. In addition, literature from African-American religions and Black religious experiences prove valuable in developing the theoretical framework found in Chapter 3.

Method of Search

This literature review has evolved over four years, exploring faith, knowledge, and social constructs of African-Americans with DM. The search included keywords searches through engines such as Google Scholar, governmental agencies, and libraries, both in person and on the Internet. Nevertheless, the greater portion of the resources came from the Texas State University Library system. However, most of the African-American literature was found in the San Antonio library system. The search also required the assistance of librarians through different venues. These venues included several visits to the library to observe the librarians' research methods. Sometimes a

telephone call resolved the search problems, but at times an online chat was the best means of communication since it allowed for interactive searches.

The resources included databases and periodical lists. This review included more than 100 authors from sources that included dissertations, and documented conference papers found in the Education and Resources Information Center (ERIC) database. Also searched were peer-reviewed journal articles, peer-reviewed studies, other conference papers, books and edited book chapters. The bulk of the literature postdated 2007 but continued relevance made it necessary to reference older documents. The findings suggested that DM is the most prevalent disease among, and that African-Americans are among the greatest sufferers of this condition. In addition, it suggested that African-Americans have divisions of subcultures based upon religious practices. However, the dearth of research connecting African-American subcultures to DM caused a broadening of the search to the association with any chronic disease. The search concerning DM included two categories; faith-based support, and methodologies best suited to understand the desperate need to know what is going on in the African-American culture, which has a lower life expectancy (Gaillard, 2007). The following two sections review the literature that discusses Afro-Theism, Afro-Theistic Faith, and Afro-Theistic constructivism in relation to African-Americans.

Afro-Theism

Afro-Theism is the combination of African, meaning of African descent, and theism, meaning having a belief in God. The African-American culture has subcultural divisions based on church denominations or theistic viewpoints. These subcultures are traceable to the divisions in the Protestant church of their association. Historically, these

Protestant churches were divided over the philosophies of two theologians, John Calvin

(1509-1564) and Jacobus Arminius (1560-1609) (Enns, 1989; Ryrie, 1995). Calvinists,

like Baptists, some Methodists, and other fundamentalists, maintain Martin Luther's

(1483-1546) literal interpretation (hermeneutics) of Biblical scriptures. The literal

interpretation emerged as the method of choice during the Reformation (Ramm, 1970; A.

S. Wood, 1995). Arminius, like COGIC and others, including some Methodists, often

unknowingly adapted the Catholic concept of interpreting the Biblical text through

mystical or allegorized means (Ramm, 1970; A. S. Wood, 1995). The attraction to

allegorized Scripture resulted from the development of pietism (edifying). Pietism arose

from "reactions against dogmatic and fanciful" (Ramm, 1970, p. 61) post-Reformation

interpretation of Biblical scriptures.

Today the major divisions in the African-American community are predominantly

from four historically Black churches. The largest are the Baptists (~ 64%), with six

subdivisions, and the Pentecostals (~ 13%), with five subdivisions (Lugo et al., 2008).

These are followed by Methodists (~ 9%), with five subdivisions, and the nonspecific

Protestant church (~ 7%) with no subdivisions (Lugo et al., 2008). Of the approximately

13% Pentecostals, 67% are from the COGIC church. The remaining 7% of historically

Black churches closely affiliate with Baptists or Pentecostals. In a summary of the key

findings in the Lugo et al. (2008) survey, Pew Forum on Religion & Public Life

("Summary of key findings," 2013, p. 8) captures the importance of religion for African-

Americans:

> Of all the major racial and ethnic groups in the United States, black Americans
>
> are the most likely to report a formal religious affiliation. Even among those

blacks who are unaffiliated, three-in-four belong to the "religious unaffiliated"

category (that is, they say that religion is either somewhat or very important in

their lives), compared with slightly more than one-third of the unaffiliated

population overall (p.8).

The religious beliefs of the historically Black churches caused a division based on

the strength of their adherence to Calvinism or Arminianism, but they united in the

uniqueness of Afro-Theism developed during American slavery. Nevertheless, the

divisions created African-American subcultures like the COGIC church in this study. The

subdivisions present additional challenges to resolving the American diabetes epidemic

(ADA, 2011; NDEP, 2011), that are attributable to religious practices, and not addressed

in diabetes education.

Afro-Theistic Faith

Afro-Theistic faith refers to African-Americans who go beyond believing in God

to incorporating theism into their worldview. Eltis'(2008) estimate of over 300 years

since slavery began in North American and lasting for more than 200 years, resulted in an

Afro-Theistic inculcation of faith that compels African-Americans to express it.

Seemingly, the need exists to share their faith, whether in the past, present, in politics, or

socially. Undoubtedly, this faith influences decisions of the COGIC members suffering

from DM. This acknowledgment of faith arose during the Texas State University 50-year

celebration of integration. One woman interrupted the interview flow to let the audience

know that all of them had strong faith and community support that gave them the courage

to do what they did (see Figure 7). Another example of faith emerging was during Phi
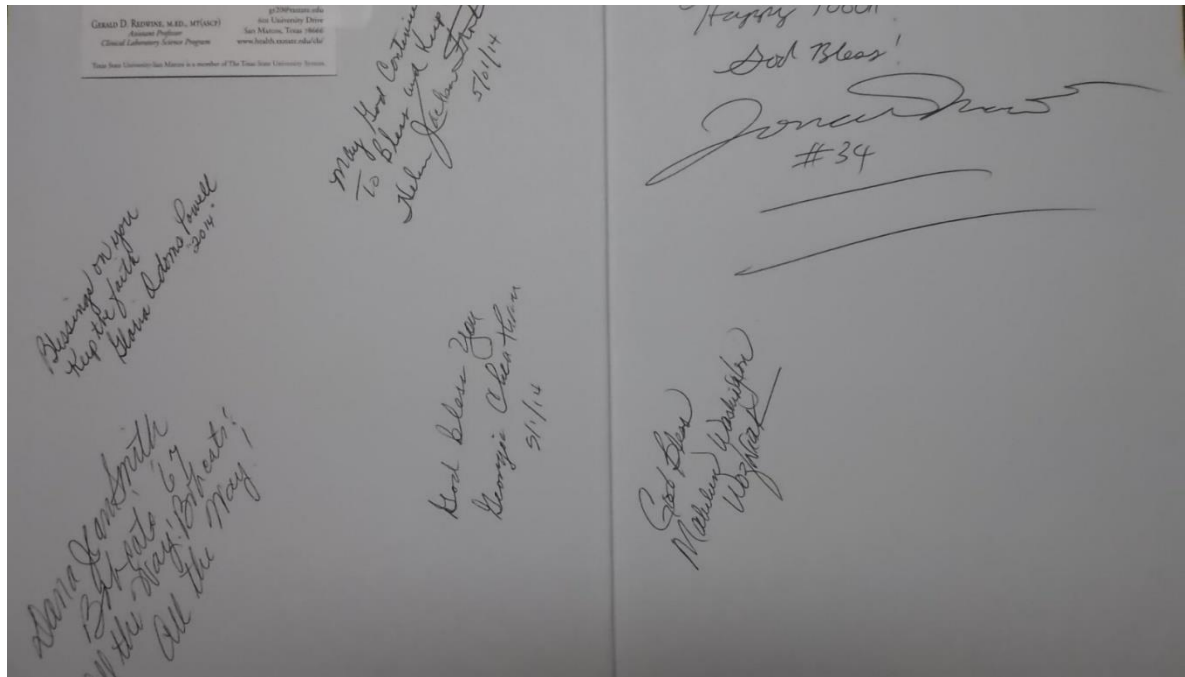
Figure 7. Autographs.

A. Autographs of the first five African-Americans attending Texas State University celebrating 50 years of integration. From left to right and top to bottom: Gloria Odoms Powell, Helen Jackson Franks, Georgia Hoodye Cheatham, Maybelline Washington Wozniak, and Dana Jean Smith.

B. Autographs of the 34th Phi Beta Sigma Fraternity President: Celebrating in San Antonio Texas 100 years. The Honorable Jonathan A. Mason Sr.

Beta Sigma Fraternity 100-year celebr*ation when the speaker, a pastor, felt compelled to make his faith known to the audience (see Figure 7).

All of the African-American religious or social groups have degrees of faith that extends from Afro-Theistic spiritual constructs. Some of them, like the COGIC, piously reject assimilation into the White man's way of somber worship they see as extending from education and wealth (Hurston, 1981). However, Asante (1988) would classify COGIC piety as nothing more than the slave overseer's mentality. In other words, a mentality that believed the slave cannot be as good as their master, and therefore seeks the master's approval to feel accepted. Hurston (1981) also noted that the most affluent

African-Americans became, the more they assimilated into the White man's way of worship, which should also serve as a warning from Asante's perspective.

On the other hand, other African-Americans are faithful to Afrocentric philosophies, are more combative, and also follow Thurman's purported definition of Black Spirituality and Critical Race Theory (Giles, 2010). Therefore, Afro-Theism includes Black Spirituality, which stresses core social values, and Critical Race Theory (CRT) that focus on the ills of majoritarian. It also includes groups that have extremes of pacifism or fanaticism, terms associated with COGIC (Weaver, 2003). Afro-Theism also recognizes other facets of CRT, like *Racial Formation*, a term coined by Omi and Winant, that identifies the hegemony associated with that institution (2006). Afro-Theism also recognizes that African-Americans may defer to any of these depending on the circumstances. However, it also includes groups that strongly object to engaging in temporal (earthly) social practices and have their particular brand of combativeness. Therefore, Afro-Theism acknowledges many African-Americans have strong faiths that transcend temporal order and give priority to their eternal destiny while remaining Afrocentric. The COGIC church is in this group (Whitehead, 2001a), and this adds another facet that distinguishes this subculture, in addition to its allegorical style of interpreting the Bible.

Afro-Theistic faith in relationship to COGIC adult learners with DM focuses on diabetes' educators and clinicians having confidence that these African-Americans will make the right decision, given adequate knowledge and respect for their faith. Therefore, with adequate knowledge and respect, these African-Americans will on their own initiative, obtain additional knowledge to manage their condition (Knowles, 1970).

Knowles (2011) lists characteristics of a democratic philosophy: conviction, faith, precedence, release, mutual trust, openness, attitude, and acceptance (Hansman & Mott, 2010; 1970). Since African-Americans are next to the highest percentage per capita suffering from DM, this study looked for missing elements of democracy in the COGIC subculture related to their faith that hindered self-directed learning.

Without respect for the COGIC religion, Knowles' contrasting factors of paternalism, regimentation, restriction of information, suspicion, and forcing dependence upon authority will prevail. These hegemonic overtones can lead to deficit thinking, a term coined by scholars in the 1960s (Valencia, 1997). An example of deficit thinking that applies to this situation would be to blame COGIC members with diabetes for their condition. Nevertheless, the processes of adult learning also involve social cognition in relationship to Afro-Theism.

Afro-Theistic Constructivism

Afro-Theistic constructivism refers to meaning making through African-American social influences as a means of learnig (education) and survival. Individuals construct meaning based on observations in social settings rather than direct teachings. Historically, African-American adults forbad their children to join in conversations, but overlook them as long as they were quiet. Therefore, African-American children practiced and mastered constructivism (meaning making) early in life without knowing the terminology. The following is an example of a former slave, Amanda Smith (1837-1915):

> Then withal she was an earnest Christian, and had strong faith in God, as did also
> my grandmother. She was deeply pious, and a woman of marvelous faith and

prayer. For the reason stated my parents determined to move from Maryland, and so went to live on a farm owned by John Lowe, and situated on the Baltimore and York turnpike in the State of Pennsylvania.

My father and mother both could read. But I never remember hearing them tell how they were taught. Father was the better reader of the two. Always on Sunday morning after breakfast he would call us children around and read the Bible to us. I never knew him to sit down to a meal, no matter how scant, but what he would ask God's blessing before eating...(A. B. Smith, 1893, pp. 25-26)

Notice, as a child, Mrs. Smith learned by observing and not asking questions. This practice is still common in the African-American culture. Here is another example of Afro-Theistic constructivism in progress through the eyes of an African-American child, and brought to fruition in the following personal excerpt.

My dad, a COGIC preacher, endured many prejudices without retaliation. However, it afforded the opportunity to see the polarity of racism in the 1960s, which likely makes it difficult for African-American diabetics to trust outsiders. For example, as a preacher, he lived what he preached, by maintaining friendship with White people, despite racism. "Colored" and "White" water and restrooms, is etched in memory as the only signs personally observed, paradoxically, at the place of justice; the county courthouse. He maintained friendship with a cook at a hamburger joint but had to eat in a slightly filthy area behind the kitchen. Once, peeping around the corner and questioning why we could not set in the nicer area with the white people, resulted in a quick and forceful tug on the collar and him apologizing to the angry cook. The cook in turn apologized to the white patrons

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who overheard the conversations. The town had a segregated theater, but it did not matter since religious practices had prohibited patronage. There were some good results, like Papa's white friend inviting him to his house for dinner and the memorable experience with the first pork chop. On another occasion, another White man rigged a raffle to make certain Papa's son won a rocking chair.

Finally, the only memory of Jackie Robertson playing baseball is from Papa and his White friend that owned the furniture store in town, listening to baseball games on the radio. Papa, a fan, and an avid baseball player when he was younger, was proudly trying to convince his friend that Robinson was the greatest baseball player. Nevertheless, Papa was complicated. On the one hand, he questioned the desire to work for a White man since he refused, but enjoyed their friendship as an equal. On the contrary, he disagreed with Dr. Martin Luther King's leading of the Civil Rights marches, not because of the cause, but because he was a preacher. For him, the freedom to worship God in his own Black religious way, meant being a good representative of the cause of Christ as the primary concern above any other.

The previous conclusions are from Afro-Theistic constructivism now believed, and used, to make inferences in social gatherings, based on observations without a discussion. Therefore, this Afro-Theistic study acknowledges social cognition is the continual interaction of a three-way relationship between Church of God in Christ (COGIC) members with diabetes, their behavior, and their religious environment that influences change (Bandura, 1989; Davidson & Davidson, 2003). However, based on Black religion,

the changes will include participants' efforts to maintain their African heritage (Washington, 1964).

The social constructs of African-Americans began with slavery that initially imported only young virulent men, who were not fully indoctrinated in the African culture (Frazier, 1963). Furthermore, no more than five could congregate without a White man present, which continued until they were introduced to the White man's religion (Frazier, 1963). These young men never fully gained the experiences of tribal customs, which made it easy to forget most of them. However, once allowed to assemble for religious purposes, the church became the means of all social activities that included music and the birth of Negro Spirituals, but it also sometimes carried secret messages. The "religion of whites and the concern of the slaves were blended to create the Negro spirituals which provided a cover for Negro preachers to lead insurrections and escape" (Washington, 1964). The customs birth out of these assemblies became African-American's own *made in America* way of doing things. This idea of getting away to *do their own thing* is a social construct of the COGIC church.

Afro-Theistic constructivism also dictates the types of foods African-Americans enjoy. For example, Soul Food, which is uniquely African-American, is nothing more than taking whatever edible thing is available and making it taste good. It usually means foods that are fatty, salty, or baked sweets. This way of eating was typical; they called it *making-do*. Making-do was acceptable when resources were scarce, but this is not a sustainable diet today when more resources are available and workplaces are more sedentary.

Finally, this study investigates faith or convictions of the COGIC social group as governing and energizing factors to social interactions and the source that gives meaning to individuals concerning the knowledge about any experiences with chronic diseases. For many African-Americans, the most common source of social interaction is through one of many social groups, primarily churches, followed by other social organizations like fraternities and sororities (Davis, Clark, Carrese, Gary, & Cooper, 2005; Samad, 2013). Faith placed in the teachings of these groups often divides African-Americans into subcultures based on psychological and spiritual principles (Davis et al., 2005). Therefore, this study examines Afro-Theistic constructivism through the COGIC subculture of diabetic members. In the next section, reasons are given for selecting type 2 diabetes mellitus above other kinds of diabetes.

Type 2 Diabetes Mellitus (DM)

DM is not the only kind of diabetes, warranting a brief discussion of the literature involving its classifications, and relevance to African-Americans. Knowledge of diabetes has existed many millennia, as seen with Babylonians and Egyptians. By 1674, scientists made diagnoses by tasting urine for the presence of sugar (Brunzel, 2013). Tasting urine resulted in two forms of diabetes, still applicable today: diabetes insipidus, which produces copious urine without taste, and diabetes mellitus that has copious urine production with a sweet taste. However, in America, the prevalence of DM and its adverse effects have a tremendous negative impact on the economy. According to the American Diabetes Association (ADA), DM has become an epidemic, with its greatest prevalence among minorities in America. In fact, the American Diabetes Association predicts one in three Americans will suffer from DM by 2050 (ADA, 2011). The

prospects are even more distressing for African-Americans and Mexican-Americans (ACS et al., 2011), where predictions have one-in-three developing DM within their lifetime.

These statistics stress the urgency of developing a theory grounded in the data of African-Americans with diabetes since a greater percentage of them have the disease, and their voice is largely missing in extant studies. The theory must begin in a subculture like the COGIC, since most African-Americans use subculture as a coping mechanism (Baumgartner, 2000, 2011; Gaillard, 2007; Two Feathers, 2005; Valencia, 1997). Therefore, this literature review focuses on African-American subcultures, and theoretical aspects of faith, knowledge, and social constructs in confronting diseases, especially DM. Especially notable is literature from researchers who have listened to individuals diagnosed with DM and then identified further needs for research (Two Feathers, 2005).

Grounded theory has been a prevailing means of understanding how to affect change, since it provides an approach from the perspective of those affected by type 2 diabetes mellitus (Corbin & Strauss, 2007; Svenningsson, Hallberg, & Gedda, 2011). However, these studies also indicated that dialogue with patients was the main factor that promoted those life changes (Getz Jeanfreau, 2005). The changes included a reduction in the adverse effects of chronic diseases, such as heart disease, the prevention of DM, and in some cases, the elimination of DM in those with diabetes. Other forms of changes, such as with those irreversibly suffering from HIV (Baumgartner, 2000), came in the form of changes in spiritual outlook. The identification of their changes was primarily through a positive outlook on life and a desire to live it to its fullest. However, the voice

of African-Americans, especially those in subcultural groups, is largely missing in the literature.

Diabetes Mellitus-Adult Learners

The literature selected for analysis covered various diseases in order to collect enough information about faith, knowledge, and social constructs, but the majority was from pre-diabetic and DM patients. Identifying the pre-diabetic and diabetic patients as adult learners also classifies them as self-directed learners, according to Knowles (1970). By self-directed learning, Knowles meant that these adults (or children) become lifelong learners through ongoing inquiry about a subject of interest. Specifically concerning diabetes, sufferers of the disease must remain vigilant and knowledgeable about the insidious nature of the affliction. The literature review supports adult learners, usually middle-aged adults, as being self-directed learners because of necessity since pre-diabetic's, and diabetics' health depends upon their understanding and subsequent actions (Kiawi et al., 2006). Moreover, DM adversely affects many parts of the body (Barouch, 2011), such as the kidneys, the eyes, and extremities (fingers and toes). In addition, complications of obesity, increased body mass index (BMI), abnormal heart cardiographs, and a diminished sex life are possibilities (ADA, 2013b).

Scientists suspect insulin resistance that leads to DM is also a cause of metabolic syndrome, which includes multiple conditions related to diabetes and cardiovascular diseases (Malone, 2011). Among these conditions is obesity, which the ADA (Barouch, 2011) identified as the greatest problem leading to DM. Unfortunately, it occurs during the sedentary middle ages of life. This combination tends to be especially problematic for the African-American (Davis-Smith, 2007; Gaillard, 2007) and Mexican-American

(Melancon et al., 2009) cultures whose diet consists of fatty foods. Researchers like Kiawi et al. (2006) debunk the belief that the poor are vulnerable to DM because they cannot afford healthy food and relegates it to a lack of knowledge, perception that diet and exercise regiments were too hard, and cultural beliefs that undermined means of reducing diabetes. These patients can be viewed as adult learners because a disease invaded their lives, and they must now learn how to manage the disease.

In this respect, diabetic patients are similar to those with other diseases, such as those with methicillin resistant *Staphylococcus* aureus (MRSA) infection (Rohde, 2010), chronic heart disease, or human immunodeficiency virus (HIV) (Courtenay, Merriam, & Reeves, 1998). Although these patients rely on modern medicine for initial survival, research reveals the sustainability of quality life depends upon acquisition and application of knowledge about the disease. While many diseases are acute and unavoidable, according to the research (CDC, 2012b; Davis-Smith, 2007), DM is preventable in many cases.

Surprisingly little research has focused on pre-diabetes, the stage at which DM is still preventable. Since DM is primarily a middle-age disease, there is little research done with those less than 39 years of age. Studies that did include pre-diabetes, such as Evans, Greaves, Winder, Fearn-Smith, and Campbell (2007), were on those over 45 years old, or those least likely to develop DM, like those in Ntiri and Stewart's (2009) study of patients in nursing homes on a regimented diet. However, Kiawi et al. (2006) revealed possibilities of more in-depth studies when they incorporated participants between the age of 15 and 39. There was other research studies on those between the age of 20 and 39, such as Rohde (2010) and Courtenay, Merriam, and Reeves (1998), which were

studies that respected young adults by giving them a voice. Since young adulthood is the time pre-diabetes probably developed, it is necessary to question adults with DM about their knowledge of diabetes during this period of their lives.

Diabetes Mellitus and Adult Learning

The literature review sought studies that emphasize adult learning since those affected by DM are adults with stakes in the disease. Knowles made use of the term andragogy to distinguish characteristics of adult learners from those associated with children, and referred to as pedagogy (1970). A composite definition would describe adults as mutual inquirers with educators in subjects of interest, and as individuals who expect to be shown respect while learning in an environment that maintains freedom of expression without fear of ridicule (Knowles, 1970). Therefore, according to Freire (1998), adult educators are obligated to be joint inquirers, not as more knowledgeable individuals who transfer their knowledge to the learner, as is typically done with children. Furthermore, adults are self-directed learners to the degree they conduct self-evaluations, obtain self-efficacy, and readjust their internal standards of decision-making (Bandura, 1989). While self-directedness initiates lifelong learning, self-efficacy (Knowles, 1970) is the motivation to learn base on perceived belief in that success (Bandura, 1989). Expectations of failure, then easily affect self-efficacy of the adult learner (Bandura, 1989). Adult education, from the research reviewed, included those of varying ages, gender, sexual preference, and persons with various manifestation of diseases, aimed at assessing the degree to which learning occurred. Despite ages varying from 20 to more than 80, the notion that adult learners are self-directed was consistent. Although the greater majority of the adult learners were those affected by medical issues, others

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included in the studies were the caregivers or practitioners who became adult learners to better their abilities as adult educators, even if they did not classify themselves as educators. The models of learning were not necessarily unidirectional or directed at what patients learned alone but at times multidirectional. In other words, the investigator wanted to know what the patient, practitioners, and sometimes themselves, knew or thought about a particular subject. In all cases, the learning methods depended upon the self-directedness of adults.

Researchers promoted self-initiatives through empowerment of the learner (Melancon et al., 2009) as they became aware of the problems entrenched in the culture (Gaillard, 2007). Adult learners' understanding emerged through informal, non-formal, non-accredited formal education, and education in global settings (Academy for Educational Development, 2007; Susan, 2011). The promotion of personal responsibility came through repetitive sessions involving "lifestyle intervention" (Davis-Smith, 2007), as well as "community-based learning and outreach. School feeding and school health programmes [sic], behaviour [sic] change communication (BCC) and information-education-communication (IEC)" (Academy for Educational Development, 2007, p. 18), and self-reliance. Social interactions that facilitated learning were in the form of focus group discussions, church gatherings, neighborhood gatherings, and meetings at clinical facilities. All of the studies above consisted of adult learners with life-threatening medical conditions. The adult learning principles of Knowles (Knowles, 1970), Bandura (Bandura, 1989), and Freire (1998) remained reliable. Minorities, especially African-Americans with diabetes, relied on faith, knowledge, and social constructs as having a

prominent role in their decisions making processes (Gaillard, 2007; Melancon et al., 2009).

Diabetes Mellitus-Subcultural Faith, Knowledge, and Social Constructs

The division of a culture into subcultures requires identifiers that transcend ethnicity. Although subcultures are divisions of a culture, as the name suggests, the most important factor is what the subculture has in common. In the past, Horton (2003) called the poor Whites in Appalachia a subculture of "the biggest gathering of poor White people in the United States, (p. 12)." Still, he considered them kindred to poor African-Americans, Indians, and Chicanos. The Afro-Theistic nature of African-Americans requires the recognition of their subcultural identifiers, faith and social constructs, as filters for their knowledge of DM. The idea of subcultural faith, knowledge, and social constructs builds upon Dewey's (1982) belief that all education comes from social consciousness in two forms, psychological (spirituality and faith) and sociological knowledge. The psychosocial nature of this study attempted to build on previous studies of African-American subcultures and DM.

Available research (Davis-Smith, 2007; Davis et al., 2005; Gaillard, 2007; Wade, 2005) primarily focused their studies on those in cultures most at risk. Therefore, the majority of the literature concerning diabetes also relates to African-Americans and Mexican-Americans, which have the greatest numbers with diabetes. These studies also demonstrated a high correlation between spirituality and diabetes, especially in African-American women (Davis et al., 2005), who mostly adhere to their church culture. Equivalent spiritual mechanisms to cope and live with HIV (Baumgartner, 2000) infections came from partners who shared the experiences of those infected. In this vein,

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emotional support came through self-directed learning in social settings that empowered participants and practitioners to make changes (Baumgartner, 2011; Bricker et al., 2010; Kessler, Dubouloz, Urbanowski, & Egan, 2009). Nevertheless, studies like Gaillard (2007), Davis-Smith (2007), and Davis et al. (2005) agreed that the participants' faith, knowledge, and social constructs were vital parts of their lives when threatened by a disease. This magnifies the demand for a theory grounded in data of how African-American subcultures' faith, knowledge, and social constructs work together. Especially since these factors are more or less in place prior to the onset of the disease.

Diabetes Mellitus and Subcultural Faith

Davis, Clark, Carrese, Gary, and Cooper's (2005) research was a stratified study based upon racial and socioeconomic status. They found African-Americans had strong subcultural factors of psychological and spiritual connections that hindered advocated methods of weight loss. Subcultural bias strongly suggests nonconformity to diabetic standards for healthy living. Meetings took place in gregarious settings, such as churches or sororities, organizations that often shared food and drink, undermining diabetes control. Medically, some foods have positive psychological and biological effects from dietary cholesterol (Zhang, Muldoon, McKeown, & Cuffe, 2005), and in that sense, they help promote subcultural bonding. However, in excess, food contributes to metabolic syndrome that includes insulin resistance, leading to DM (Davis et al., 2005). Therefore, while these social connections develop into strong emotional ties, and strengthen trust and faith, the shared meals potentially further problems associated with diabetes when used in excess. Challenging these paradigms that build faith is irresponsible rhetoric unless it also offers comparable alternatives (Watson, 2002), and is not disrespectful of

these adults. However, faith-based DM studies like that of Wade (2005) give credence to African-American cultures exclusivity as the model to show respect to the participants and enables a fair assessment of their knowledge of diabetes.

Diabetes Mellitus and Subcultural Knowledge

According to some researchers (Gaillard, 2007; Wade, 2005), faith-based African-American cultures are the most effective means of disseminating knowledge of DM, but these acknowledgements stopped short of recognizing the strong subcultural ties to church denominations. Without this acknowledgment, links that connect each subculture to its African-American culture is missing. Nevertheless, Wade (2005) found that knowledge about DM alone in faith-based cultures does not translate into change, but it did increase relative to the participants' educational and socioeconomic status. While offering hope to affluent African-Americans, these findings are compelling reasons for diabetes educators to learn how to package diabetes knowledge to influence and affect the less affluent subcultures of African-Americans. In either case, any diabetes education in the African-American faith-based culture must consider their spiritual life if one expects changes towards diabetes maintenance (Davis et al., 2005). Therefore, the need exists for a theory grounded in data of how diabetes education and faith combine to affect change through the social constructs of African-American subcultures with DM.

Diabetes Mellitus and Subcultural Social Constructs

African-American subcultures developed as a means of survival during post reconstruction resurgence of White supremacy where *Jim Crow* laws, segregation, and Plessy vs. Ferguson *separate but equal* rulings dominated the South (Samad, 2013). As a result, in 1910, 44% of all African-Americans were illiterate, 90% lived in the South with

meager provisions for education, and churches or private organizations supplied most of that education (Samad, 2013). Educationally, African-Americans made do with the available resources. Making-do was my support system in the 1960s. I received my first education from Sunday school, in a church built on land donated by my grandfather, and my first public schooling did not begin until the first grade in a school built on land donated by him. My cousin, a senior citizen, who only had a high school education, was my first grade teacher.

African-Americans' social constructs extended from small networks of church affiliations followed by interdependency on other African-Americans. Similarly, today African-Americans with DM receive support from a few church-based or other private groups with relatively few participants. All of these church-based and social associations produce African-American subcultures with distinctive social constructs (Kasworm et al., 2010) based upon their faith. This understanding is significant when considering that chronic diseases such as DM ultimately depend upon individual changes through self-directed learning (Bandura, 1971). In opposition, strong subcultural groups risk influences of *groupthink* (Beebe & Materson, 2009). For this reason, an understanding of self-directed learning and self-efficacy within the context of subcultural social constructs is necessary.

Subcultural Social Constructs and Self-directed Learning

Self-directed learning is knowledge gathered independent of others to understand the problem, and to make subsequent changes (Bandura, 1989; Knowles, 1970, 1990). Self-efficacy, or the belief in one's ability to accomplish tasks, (Bandura, 1977) is a major component of self-directed learning to manage chronic diseases. Bandura's (1989)

later development of the of Social Cognitive Theory (SCT) emphasized the importance of vicarious learning through symbolic interactionism gained through social constructs. Bandura (1966) developed vicarious learning in SCT from earlier works of observational learning through modeling. He believed learners construct knowledge by observing modeled social behavior. Therefore, Bandura (1966, 1989) emphasized the importance of social constructs in the learning processes. Adult educator Mezirow (1995, 1997), developed the theory of transformative learning which he believed occurred in 10 phases, beginning with a *disorienting dilemma*. For African-Americans suffering from the chronic disease of DM, the disorienting dilemma needs to be one that displaces the status quo of dying, and fosters self-efficacy in diabetes management. Researchers below evaluated self-efficacy, self-directed learning and transformative learning of adults through the venue of subcultural social constructs in making changes in order to cope with chronic diseases.

Baumgartner (2011) found the processes of self-directed learning were different in men and women, but the goal of making changes was the same. For example, in Baumgartner's meta-analysis, men found sources they could access without others while women preferred the emotional support of others as they learned to cope with chronic diseases. Interestingly, women felt empowered by their experience while men did not, and women were more likely to help others in the same condition than were men. The predilection for social construction to make changes in these chronically ill women, and not men, is significant if the same applies to African-American subcultures with chronic diseases, such as DM.

However, caution is warranted when considering that Ntiri and Stewart (2009), who found bias in previous studies concerning transformative learning by not including older African-Americans. They noted, "Published studies pertaining to the application of TL [transformative learning] principles with older African Americans were not found" (Ntiri & Stewart, 2009, p. 102). They found that several factors affected the transformative learning of these elderly African-Americans, who could be seen as a subculture. In addition to the commonality of ethnicity, they were elderly and knew each other within and without a senior citizens home, were in a high risk group for diabetes, and had DM. These commonalities resulted in two noticeable factors to these seniors concerning self-directed and transformative learning. First, the study suggests both male and female elderly African-Americans learn in private settings, similar to the men in Baumgartner's review. Secondly, the familiarity of these African-American diabetic participants with each other in and out of the senior citizens home provided the processes of developing social constructs that led to transformative learning. Gaillard (2007) inferred these these two elements of privacy and social constructs persisted regardless of the ages of African-Americans with DM. He stated, "for African Americans, health and illness are a dynamic entity, governed by body, mind, and soul. Therefore, it is imperative that any adult learning initiatives include the importance of cultural dynamics" (Gaillard, 2007, p. 1). This data mining research included 3,172 African-American women at least 18 years old. Another study by Davis-Smith (2007) also found the social constructive environment of the church was necessary to implement her diabetes prevention plan, and added that it was necessary to include the pastor in all of the steps. Therefore, self-directed learning filters through social groups' expectations

within African-American cultures. Expectations of compliance with social norms are even stronger in African-American subcultures like COGIC, especially considering the post-reconstruction establishment of subcultures where young and old relied on customs for survival. The question remains, how do social constructs in COGIC affect self-directed learning of individuals who greatly depend upon subcultural norms?

Baumgartner's (2011) meta-analysis also found that when it came to chronic diseases the application of knowledge by adults did not differ by age at all, but by aspects of learning and practice. In addition, she found that an individual's acquisition and use of knowledge resulted from self-directed learning. Self-directed learning exhibited three characteristics, condensed here as, self-initiative, with or without social constructs, self-efficacy, with a determination to succeed, and self-directed learning leading to change (Baumgartner, 2011). Her adaptation of Mezirow's 10 phases of transformation is similar to other researchers' adjustments based on their findings. For example, Kessler, Dubouloz, Urbanowski, and Egan (2009) studied the phenomenon of change in stroke victims and did not find that the 10 phases were linear as Mezirow suggested, nor were all phases found in all cases. However, as predicted, the degree of change was reflective of the pervasiveness of the disease, referred to as Mezirow's "frames of reference" (Baumgartner, 2011, p. 9). Mezirow (1997) states, "Frames of reference are the structures of assumptions through which we understand our experiences," (p. 5), but he theorized transformational learning happened upon the disruption of those frames of reference. Baumgartner (2011, p. 9) added, "It involves cognitive, affective, and conative dimensions." Although she did not discuss social constructs in relations to self-initiative learning processes, which is essential in African-American subcultures, other researchers

demonstrated their interaction. For example, research addressing Baumgartner's (2011) first frame of reference (self-initiative), appears in studies with acronyms representing causes in support groups. In essence, social constructs of a subculture directed the adult learner toward transformative learning. Evans et al.'s (2007) study was called WAKEUP, which stood for "Ways of Addressing Knowledge Education and Understanding in Prediabetes." From the beginning, the message was clear that pre-diabetics should "wake up" before they find themselves diabetics. The idea of waking up was not only for the patients, but also the healthcare workers and the diabetes educators these patients relied on to deliver the message.

When Purdie and McCrindle (2002) applied Bandera's views of self-regulation, they implied individuals needed self-initiative. They added, "Thus, the thrust of these models is that individuals can muster for themselves, to a greater or lesser extent, the resources needed to overcome or cope with many of the barriers to good health that exist" (2002, p. 386). Furthermore, self-initiatives apply to more than individuals, as Bricker et al. (2010) reported, participating institutes transformed as they saw, in print, the areas where their facilities needed improvement. These institutes saw immediate and continuous monthly improvements when moved by the social constructs that developed in support groups. A significant factor then is self-directed learning in some ways occurred because of social constructs.

Self-directed learning in Baumgartner's second frame of reference (self-efficacy) also found researchers who observed social constructs that promoted transformational learning in a similar fashion as with self-identity learning. The type of self-efficacy leading to self-regulation does not happen in a vacuum. Sometimes social constructive

processes serve as the motivating factors that lead to changes. For instance, in Purdie and McCrindle's (2002) meta-analysis, they found that older adults needed social constructive support systems to develop self-regulations. In addition, older adults needed an environment (subculture) that included family, friends, and clinicians for support leading to the development of self-efficacy that ultimately resulted in a changed worldview.

Finally, in Baumgartner's third frame of reference (self-directed learning) leading to a worldview change, studies reviewed gave substantial evidence that transformation developed in consequence of social constructs. For example, Davis-Smith (2007), using her lifestyle intervention group, was able to reduce the incidence of diabetes by 58%. In addition, she said:

> Participation rates were high, and the program was successful as demonstrated by weight loss and decrease in fasting glucose tests. Weight loss achieved in the program also appeared to be sustainable on average; the participants maintained a significant amount of weight loss up to 12 months after the program was completed. (Purdie & McCrindle, 2002, p. 444)

So then, self-directed learning conducted within the social constructs of support, conclusively helps in making worldview changes towards coping with chronic diseases like DM. Understanding the role of self-efficacy in this social construct is also a valuable guide to understanding how worldview changes within cultures.

Subcultural Social Constructs and Self-efficacy

The role of subcultural social constructs in self-efficacy is the last area of consideration prior to examining theoretical models of inquiry. Researchers have captured Bandura's use of self-efficacy with terms like "self-confidence" (Stockdale & Brockett, 2011, p. 166; Williams et al., 2012, p. 23), "self-regulatory" (Purdie & McCrindle, 2002, p. 380), and phrases meaning self-control (Taylor, 2010, p. 7). Bandura theorized by saying, "in the proposed model, expectations of personal efficacy are derived from four principal sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states" (Bandura, 1977, p. 191). Bandura inextricably linked these four tenants of self-efficacy with social learning theory in an earlier work (1971, p. 2) that if true, deepens the impact subcultures have on social constructs.

An examination of Bricker et al.'s (2010) research on transformations within institutes serves as an example of how much cultures affect self-efficacy. The study recruited 155 medical practices for several years of learning and exercises geared towards improving the health of chronically ill patients. Institutes collaboratively learned to work with patients, which resulted in various improvements, within and without the healthcare facilities. For example, some institutes discontinued current practices and targeted trajectories for patient improvement through a more holistic approach. They started focusing on neurological damage prevention through prescription of statins, and the "establishment of self-management goals" (Bricker et al., 2010, p. 118) rather than exclusively monitoring the traditional hemoglobin A1c (HbA1c) levels, blood pressure, and cholesterol values for diabetic patients.

Outside the institute, certain caregivers started support groups in the neighborhood. Overall, the patient care in practices reported "persistent improvement" (Bricker et al., 2010, p. 118). One facility felt empowered to try new things because of the training. Many other examples of efficacy developed from the monthly training sessions (Bricker et al., 2010). In this study, multiple practices came together and formed a culture that promoted self-efficacy of the members within the institutes, and their changes became the social construct that influenced chronically ill patients to change.

Finally, self-efficacy, as described by Bandura, has a psychological element called spirituality in crucial circumstances when the possibility of death becomes imminent. Spirituality was particularly evident with HIV patients and their partners, where "social interaction was important in this process of transformation" (Kessler et al., 2009, p. 1057). In general, researchers revealed the initial news of the HIV infection resulted in various responses with differences being personal expectations. In all, three stages became evident with the greatest indication of transformation coming from an internalized satisfaction that they found a purpose for their condition.

A summary of Courtenay et al.'s (1998) phases, reveals an equivalency to Baumgartner's stages of self-directed learning, which led to transformation, namely, exploration and experimentation, consolidation of new meaning, and the stabilization of the new perspective phases. All three processes leading to self-efficacy were dependent upon social constructs where initially HIV patients reflected and often reached what Freire (1998) called conscientization. When they realized they had been living for someone else, the then changed, and lived for themselves. Some use this news as an internal catalyst to help them move on, some turn to God, others claim to have turned

their lives over, some turn to others for support, but for all, these were 'catalytic events.' These catalytic events led to the transformation of patients to having a positive outlook on life. In the literature, this transformation did not change the outcomes of most but did change their perspective to one of personal quality.

Those infected with HIV, and other previously discussed sufferers of chronic diseases, eventually found hope and took advantage of every opportunity because of their faith, knowledge, and subcultural social constructs. Although the individuals became self-directed learners, which led to self-efficacy, neither happened without the influence of social constructs. Largely, African-Americans with DM are missing opportunities, like support groups that have proven to be beneficial. Consequently, the need exists for a theoretical inquiry to explain this absentee phenomenon occurring inside the African-American culture, and the inquiry needs to begin with a subculture containing a substantial social construct. The COGIC subculture has a significant social construct that has survived for over 100 years, and today influences the decisions of over five million African-Americans (Houdmann, 2012).

Grounded Theory

The methodology chosen for this study is grounded theory developed by Glaser and Strauss in 1967. Grounded theory does not compete with other theories but differs in that hypotheses, categories, and finally a theory emerge from the collected data from the participants. In other words, a theory develops grounded in the data from the participants. The advantage of grounded theory is its ability to generate a theory to explain phenomena based upon an in-depth analysis of the empirical information from the participants. When introduced, the originators believed colleagues would only consider grounded theory as a

hypothesis (Glaser & Strauss, 1967). Since then, grounded theory has evolved, and lately has been used for purposes other than generating a theory (Corbin & Strauss, 2007). However, most use grounded theory for its original intent of generating a theory, especially those doing research in the medical field (Corbin & Strauss, 2007). The association between grounded theory and the medical field is the theory's development "was made possible by Public Health Service Research Grant NU-0047 from the Division of Nursing, Bureau of State Services-Community Health" (Glaser & Strauss, 1967, p. ix). This study extensively follows the latest revision of *Techniques and Procedures for Developing Grounded Theory* by Corbin and Strauss (2007). Other supportive works were from Birks and Mills' (2011) means of coding. Also valuable were Charmaz's (2011) diagrams on the grounded theory process and memo writing, and Patton's (2002) viewpoints of building a theory.

Overall, the generation of a theory provided vital information for caregivers to understand their patients better and know how to help them manage chronic diseases. In Taylor's (2010) mixed method study, he assembled a group with similar conditions and used grounded theory methodologies to analyze surveys containing the opinions of health professionals (n=20) and adults (n=12). The theory helped medical personnel gain the confidence of their patients, which enabled them to provide better care. He then surveyed 232 pre-diabetics over three subsequent studies to complete a quantitative study, to optimize the findings in support of diabetes sufferers' needs.

Taylor (2010) and Kessler et al. (2009) used grounded theory methodology in a manner similar to Crotty's (1998) reference to ethnography. He said, "grounded theory can be viewed as a particular form of ethnographic inquiry that, through a series of

carefully planned steps, develops theoretical ideas" (Crotty, 1998, p. 78). In addition, reflecting on Strauss and Corbin's definition, Taylor (2010) stated grounded theory is, "a theory that is derived from data, systematically gathered and analyzed through the research process. The researcher begins with an area of study and allows the theory to emerge from the data" (p. 10). The source of data varied; one was in the form of interviews (Rohde, 2010) while Baumgartner's (2011) meta-analysis built on the research of others. Taylor (2010) modified a previously validated questionnaire called the Godin Leisure-Time Exercise Questionnaire (GLTEQ). All models purposefully included the voice of the patients and sometimes the practitioners. A relevant, but older example utilized focus groups to understand an eclectic mixture of caregivers and those with various chronic diseases, including diabetes (Maine State Dept. of Human Services, 1997). From this report, actions and processes salient to adult education and this study emerged (Charmaz, 2011). The essence of the study is sufferers expressed the need for others to hear them concerning the positive and negative impact of caregivers. Chronic sufferers expressed anxiety about health insurance and health care and the need for caregivers to recognize the importance of their role in living healthy.

<div align="center">**Gaps in Literature**</div>

This review focused on four areas of adult learning about diseases, the adult learners, adult learning, subcultural faith, knowledge, and social constructs, and theoretical models of inquiry. Diabetes is an epidemic in the American population, but it is more prevalent among African-Americans and Mexican-Americans, with pre-diabetes beginning between the ages of 20 and 39. Up to this time, only a small number of

qualitative research studies have included the perspectives of African-American pre-diabetic and diabetic patients, despite their being among the greatest affected per capita.

Furthermore, there are gaps of knowledge in the theoretical assessments of social constructs in African-American subcultures of the diabetic community. The failure to recognize the social influences of subcultures in African-American communities, possibly contributes to the low participation in support groups which have proven to be sources of assistance in diabetes maintenance. Another gap in knowledge is how spirituality influences decisions made concerning diabetes in subcultures of African-Americans with diabetes. A final exposure is the gap in understanding how faith and knowledge evolve through social constructs in African-Americans, especially when death from diabetes becomes an issue. The COGIC emerged as a significant African-American subculture with social constructs of adult learning, faith, and knowledge that influence the decisions of over five million people, or nearly 12% percent (see Table 1) of African-Americans.

However, grounded theory prevailed as a means of providing theory to effect change in the lives of those with various acute and chronic diseases. The voices of both the adult patients and practitioners came in the form of surveys or interviews that led to the construction of new meaning and subsequent transformations through adult learning. Therefore, Chapter 3 evaluates a grounded theory methodology of inquiry to develop a theory out of the collected data of African-Americans in the COGIC diabetic subculture. An understanding of how faith and knowledge merge or change through social constructs is at the heart of the study.

III.   METHODOLOGY

This study aimed to understand an African-American subculture's way of combining their faith-based practices with their knowledge of diabetes mellitus through a grounded theory methodology. By systematically examining data in an Afro-Theistic framework, it was possible to develop a theory relative to the COGIC subculture of African-Americans with DM. This group, with the exception of the smaller numbers of American Indians and Alaskan Natives combined, is the largest group with sufferers of diabetes per capita in America (CDC, 2012a; Ennis et al., 2011; Hixson et al., 2011; Norris et al., 2012; Rastogi et al., 2011). At present, support comes from church-based, short-termed programs facilitated or supervised by pastors since parishioners trust them for guidance in personal matters. Subcultures represent a significant number of African-Americans who live in the duality of social constructs that influence their beliefs and knowledge that originates from outside those social boundaries. Few studies have attempted to understand the African-American perspective of meaning making from their familiarity with DM, and there was no evidence of this investigation from a subcultural viewpoint, which is essential for knowing what is happening (Glesne, 2011). According to Patton (2002), the best means of accessing the meaning making within the context of African-Americans with DM in the COGIC church is through a qualitative study. As a researcher associated with the COGIC church, and an African-American with diabetes, it is important to understand the theoretical framework or lens used in this study. Also important is the researcher's paradigm, and understanding how these factors guided an understanding of the participants.

Theoretical Framework

Based on the literature of African-Americans Churches, this theoretical framework conceptualizes a filter system that African-American COGIC diabetic members use in making changes to manage diabetes. This framework suggests that a commonality of faith and active social constructs exist in all African-American religious groups. Therefore, the theoretical framework guiding this study is Afro-Theism. This includes those who are either passive or fanatical, and those who are radical. The use of Afro-Theism includes African-Americans who assimilate into local religious persuasions of choice and willfully or casually acknowledge their Afrocentric heritage. The name Afro-Theism merely represents an effort to recognize the existence of all forms of religion that are distinctly African-American without having any group *othered*.

Therefore, Afro-Theism acknowledges that Asante's (1988), definition of Afrocentric is valid and originates in Africa. However, he argues from the point of view that connects African-Americans to Africa. Afro-Theism refers to the distinct cultural developments primarily of America slaves influenced by Christianity and other religions in modern times. Afro-Theism includes African-Americans who are not militant and find no reason for relegating Christ as presented in the Holy Bible as the White man's God, especially considering the book descended from Jews and not Europeans. Furthermore, this is a form of intraracial marginalization known as "internalized racism and color-caste hierarchy" (Turner, 1995). This mentality only causes separation and obscures the fact that the first major Christian growth was Afrocentric and not Eurocentric. Gasque (1995) notes that "around AD 300, Christians formed a majority in parts of the providences of Africa and Asia minor." Theologians believe that the "eunuch of great authority under

Candace queen of the Ethiopians" in Acts 8:27 is the one who introduced Christianity to North Africa.

Furthermore, COGIC members do not fit Asante's motif of Afrocentric and would be othered. However, in spite of knowing that COGIC interpretation of the Bible is like the European Arminius, their Pentecostal roots are traceable to Montanus, AD 172, in Asia Minor. This region had a heavy following in Africa, which predates Eurocentric influences (Wright, 1995). Montanists preached asceticism, saw visions, often fasted, prophesied, were intensely religious, believed in speaking-in-tongues, were labeled fanatics but not heretics, were excommunicated for unknown reasons, and more (Wright, 1995, p. 87). Wright states, "Through their oracles they urged Christians to relish persecution: 'Do not hope to die in bed…but as martyrs.' Montanists were 'gloriously martyred' in Gaul and Africa" (p. 87).

Nevertheless, Afro-Theism also infers that African-Americans, who do not subscribe to all of the premises of Afrocentrism, should acknowledge the diaspora. They should also guard against seeing themselves as European creations, or the whip for the White mans' religion, which was inferred by Asante (1988). In this vein, Theologian Franklin lists Afrocentric as one of the seven spiritual traditions in the Black church (Hayes, 2012). It seems that the word then applies to African-Americans in general who try to maintain their brand of African heritage. Meaning, they created a style separate from those of European descent, even if the original positions of African heritage are unknown. Parris explains, "slaves nurtured and promoted in various secret assemblies was undoubtedly subversive if, for no other reason, than the fact that the slaves were

engaged in constructing a means of helping themselves by coopting the religion of the slaveowners [sic]" (Paris, 1995, p. 39).

Noticeably, there are several names throughout this study identifying Americans of African descent, but they reflect the culture of the authors. Hayes noted, "The change in nomenclature…From Negro to colored to Black and Afro-American to Black and finally African American, to identify all persons of African descent in the United States regardless of land of origin or time of arrival on these shores" (2012, p. 186). This same complexity of religion also exists, as shown by Washington (1964). He said, "The religion of the Negro differs from all others in being defensive, reactionary, and lacking in universal or historical appeal" (Washington, 1964, p.235). Asante's efforts to disclose the African identity of the Negro religion is significant and vital to understanding African-Americans and African-Americans understanding themselves. In either case, qualitative studies concerning African-Americans must consider Afro-Theism, which is the theoretical framework of this study.

Researcher's Paradigm

This study reflects a paradigm of Afro-Theistic symbolic interactionism through a constructivist epistemology and logo-centric ontology (Mead, Blumer, Strauss, Glaser, and Corbin). This paradigm is reflective of an African-American pastor, a Medical Laboratory Scientist (MLS), and professor who teaches laboratory sciences, including diabetes, from a quantitative perspective. However, based on current trends, knowledge about DM has not produced a significant change in the way African-Americans manage the disease (CDC, 2012a). Therefore, taking a qualitative approach to interviewing individuals with diabetes gives them space, and helps in the discovery of how they

construct knowledge about the disease from their religious background. Ultimately, knowing how a few apply and construct knowledge will aid others in helping African-Americans make better decisions in preventing or managing diabetes.

Crotty (1998) described Weber's ardent belief that social sciences differ only in terms of interpretivism or understanding. Crotty states, "as Weber sees it, both the natural sciences and the human and social sciences may be concerned at any given time with either the nomothetic or the idiographic" (1998, p. 68). Nomothetic refers to natural laws (nomos, Greek), and idiographic refers to individuals (idios, Greek). It is the individual African-American with diabetes who needs more exposure to those offering help in managing the disease. Needed is exposure through publication, both written and verbal, to help those, including pastors, understand what these individuals with DM believe and know, and what actions follow because of this knowledge. Determining present knowledge and its application results from in-depth analysis of interviews, viewed through the symbolic interactions of this African-American COGIC subculture with DM.

Symbolic Interactionism

Symbolic interactionism afforded the production of any credible and applicable theory (Corbin & Strauss, 2007). In essence, symbolic interactionism is a way to understand individuals who create knowledge through social constructs. Patton (2002) makes note that theorists make a distinction between constructivism and social constructionism. The former refers to individuals meaning making, and the latter indicating meaning forced upon individuals by society. Patton (2002, p. 97) also notes that "It remains to be seen whether this distinction will gain widespread use since the two terms are so difficult to distinguish and easy to confuse.." Without confusion,

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constructivism is the basis of this study while recognizing the significant influence of

meaning making based on prompts from within social groups. Therefore, the

epistemology of this study is constructivism with a logo-centrist ontology. This ontology

is reflective of Derrida's (Prasad, 2007) logo-centrist view that stresses the importance of

words, while acknowledging the contributing factors of social constructs that guide the

development of thoughts and actions. Like Derrida's use of the word logo-centrist in

deconstruction, individuals evaluate and construct new meaning through social

knowledge and empirical means (Bennett & Bell, 2010).

     This qualitative inquiry acknowledges the importance of giving adult learners

respect for their knowledge as expressed in Knowles sixth principle of an adult learner

(Hansman & Mott, 2010; 1970; M. K. Smith, 2002). The motivation to gather knowledge

outside social constructs of African-Americans with DM identifies significant processes

of being self-directed learners. These motivating factors provide points for these adult

learners to evaluate and question prior assumptions (deconstruction) that leads to the

subsequent construction of new meaning. The basis of this development connects to the

social constructs of African-Americans subcultures with diabetes that leads to personal

interpretation and application, in the vein of Mead (Blumer, 1969; Crotty, 1998; Mead &

Morris, 1934). Acting as a redactor of Mead's works, Blumer (1969) identified three

premises of Meads' symbolic interactionism:

     That human beings act toward things on the basis of the meanings that the things

     have for them….that the meaning of such things is derived from, or arises out of,

     the social interaction that one has with one's fellows….that these meanings are

handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (p. 2)

For the African-American COGIC members with diabetes, it means ascertaining two things: 1) the meaning diabetes has for them, and 2) actions taken to resolve the problem. Action taken or not taken results from the significance placed on DM, which comes from the interpretation (understanding) given by COGIC member's faith, knowledge, and social construct. A knowledge of the precipitants symbolic interactionism provides the path to understanding the meanings and actions towards the participants solving problems associated with DM.

Afro-Theistic Symbolic Interactionism

The Afro-Theistic symbolic interactionism is the paradigm that identifies the contexts or circumstances that are the progenitors or initiators of the processes experienced by the COGIC participants. The paradigm is the participant's perceptions as they combined their faith, knowledge, and social constructs concerning DM. The context, as seen in Figure 8, is the core perceptions involved in the participant's decision-making processes. Whereas the context identifies the conditions or associations of those with DM, the resultant processes identify the actions, interactions, and emotions delineated in Chapter 4, emergent categories.

The context leads to the processes within the African-American COGIC subculture of diabetic participants that are chaotic, and demarked with decisions ultimately resulting in living or dying. These processes are psychosocial (Dewey, 1982) in nature and relate to their promotion or distraction from healthy living with DM. Psychosocial, meaning the basis of the findings, is from the participants' individual

psychology or meaning making, with substantial influences from their social constructs. Figure 8 reveals the left to right and top to bottom symmetry of the context and processes of the COGIC members' symbolic interactionism.

Promoters of Health

Mentors and fear occupy the upper half of Figure 8, which made a significant impact in promoting healthy living of those interviewed. However, these perceptions are in opposition to each other with the left and right symmetry. On the left, mentors are the perceived positive social constructs of the COGIC participants. Their make-up is varied and complex; sometimes individuals or those with equivalent social status double as detractors. Nevertheless, when identified as mentors, the participants perceived them as having a positive influence in their lives.

On the upper right half of Figure 8, the participants faced situations that evoked fear, with a negative connotation; participants had mixed perceptions, although overall, the outcomes were positive. For example, when diagnosed with diabetes, the perceptions ranged from disbelief to motivation to fix the problem. In between, were those left frustrated and doubtful. Nevertheless, fear provided the greatest motivation in promoting healthy living. Prescription medicine was also necessary for maintaining the health of the participants, but their knowledge-based perceptions of them were always negative. Therefore, the participants reluctantly took the medication when other solutions would not remediate the adverse effects of DM.
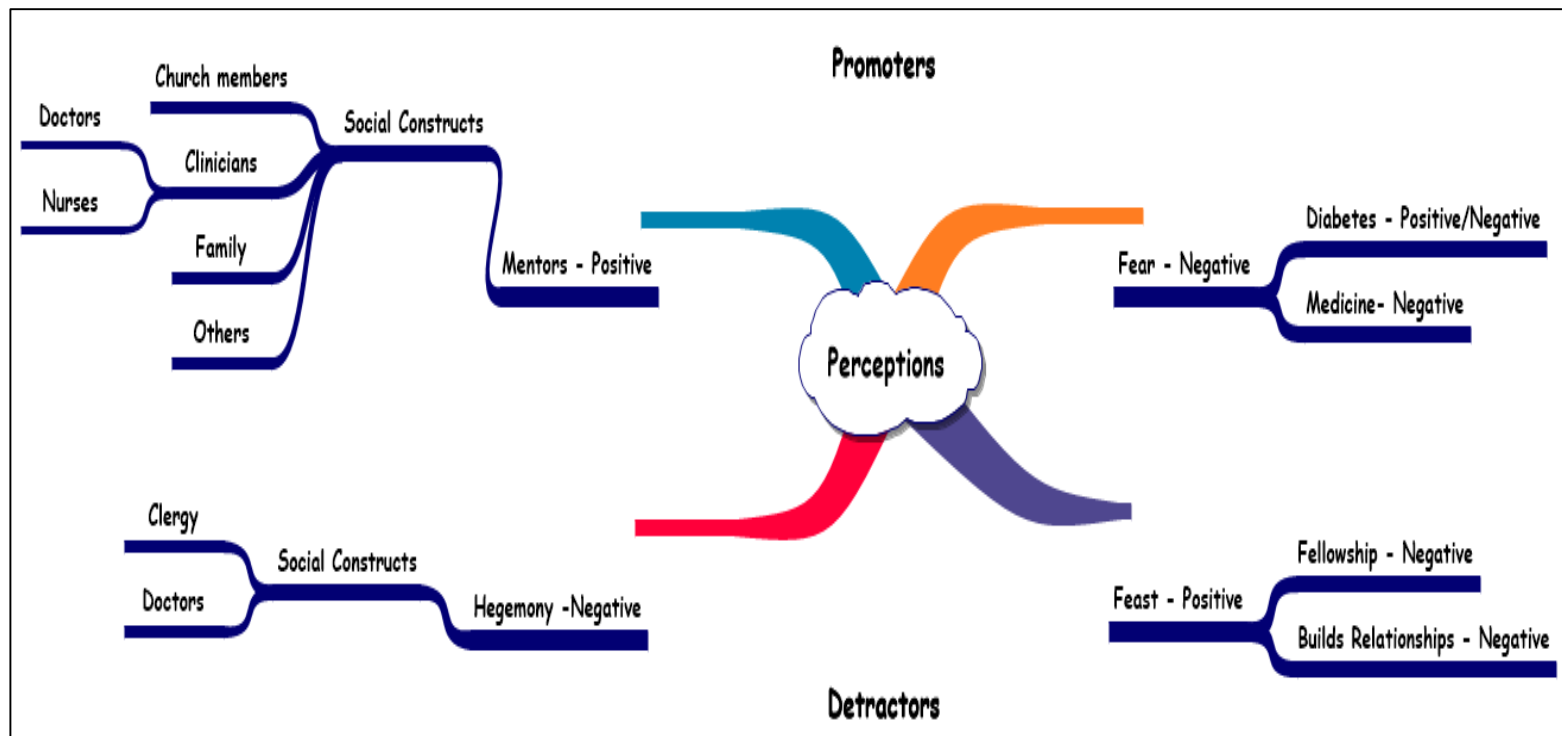
Figure 8: Afro-Theistic Symbolic Interactionism - Context and Process.

Distractors of Health

The distractors from managing DM occupy the lower half of Figure 8, and also have left and right symmetry. To the left are the major distractions felt by the DM participants, which are the hegemonic social relationships. These social constructs necessitated by religious needs or medical needs distracted from problem solving through two agents. Clergy, who dictate the social nature of church events that dominate the social lives of faithful COGIC members by ignorance or will, distract from DM members' health through omission. The pastor of the participants corrected this oversight when he became aware of the need to include church service time to address health issues, following his wife's contraction of DM. Doctors, on the other hand, marginalized the DM participants by failing to let them know what he or she believes is happening. Doctors, by ignorance or will, kept DM participants ignorant by prescribing medicine without providing sufficient information on the drug's effects, alternatives, duration, goals, or knowledge concerning the elimination of medication or DM.

The lower right half of the distractors is the most difficult branch to manage because the social concept of feasting provides a positive image. However, the physiological results are punitive for those with type 2 diabetes. Explicitly stated were the meals following church meetings in celebration or fellowship. Implicit were the strengthening of relationships over shared meals. Nevertheless, the participants admitted that the meals were unhealthy, especially for those with DM. As a result, high-calorie foods put the participants in a tug-of-war between relationships and healthy living. Therefore, the theoretical framework and researcher's paradigm provided the background

for understanding the participants' symbolic interactionism in the process of conducting this qualitative study.

Qualitative Research

Merriam (2009) notes that qualitative research began as a concept with anthropologists and sociologists inquiry of "people's lives, the social and cultural contexts in which they lived, the ways in which they understood their worlds, and so on" (p. 6). Bogdan and Biklen (2007) further claimed these Chicago School socialists used qualitative research to give voice to those marginalized in society. In this study, African-Americans, specifically COGIC members with diabetes, are the ones that need their voice heard. Typically, no hypothesis existed; instead the need was to build a relationship with participants and let the hypothesis "emerge as a study progresses" (Fraenkel et al., 2012, p. 86). Doing so allows this qualitative study to help others assist African-Americans with diabetes combine their subcultural faith-based practices with diabetes education, which increases the opportunities for more support.

By force of will, I constantly reminded myself the ultimate goal is to bring understanding and support to the African-American community of diabetes sufferers. The idea of studying one subculture of African-Americans also follows Cordova's (2011) seventh recommendation to study the "Spiritual culture of one ethnic group of type 2 diabetic patients" (p. 156). Limiting participation to one subculture of African-Americans with DM gives recognition that such divisions exist and equates to ethnic respect as adult learners. Furthermore, an inductive study of one subculture helps track their meaning making based on their knowledge of DM when filtered through their faith-based practices and social constructs. In other words, the exclusivity to African-Americans makes this a

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work that lays the foundation for others to build on. Specifically, the selection of the COGIC subculture gives voice through the interviews of diabetics to discover how their knowledge about diabetes merges with faith through their social constructs. This understanding not only assists this subculture in transforming their lives to manage the disease, but also serves as a model for other African-American subcultures to follow in doing the same. Equally, understanding this subculture helps those outside the culture, assisting us all to reverse the spread of diabetes in the African-American community.

Likewise, this understanding serves as a model to investigate non-African-American cultures with strong beliefs built into their social constructs. The overall objective is to understand how a significantly large subculture in African-American society reconciles its knowledge of DM with its faith-based practices to manage the disease. Therefore, through grounded theory, this qualitative study explains how social constructs of one African-American subculture combines faith and DM knowledge, with the goal of helping to prevent, reverse the effects, or manage diabetes.

Grounded Theory Methodology

This grounded theory study builds upon its current use while keeping the discoverers, Glaser, and Strass' (1967) original understanding as the central focus. Germane to the initial discovery is a focus on description and sample sizes. By description, they meant grounded theory used comparative analysis to generate a theory of processes originating from the data collected. They further declared systematically obtained data made the results of the findings more explainable, interpretable, and increased their applicability (Glaser & Strauss, 1967). In addition, they believed researchers could apply the theory to any sample size, and gave a hospital ward and

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classrooms in schools as examples. Grounded theory builds upon Mead (1934) and

Dewey's belief that action and interaction create knowledge (Corbin & Strauss, 2007).

This concept is the same as symbolic interactionism where the basis of person's action is

upon their interpretation of what they observe, rather than an impulsive reaction.

This study patterns itself after several theorists in their representation. But Corbin

and Strauss' (2007) book primarilly guided the entire process of developing a grounded

theory. Creswell (2007) stated that, "the intent of grounded theory is to move beyond

description and to generate or discover a theory, an abstract analytical schema of a

process" (Creswell, 2007, pp. 62-63). Multiple users of grounded theory as a descriptive

methodology caused Corbin (2007), a fellow researcher with Strauss, to broaden the

definition to Glaser and Stauss'inclusion while developing the theory. They acknowledge

grounded theory as a methodology "in a more generic sense to denote theoretical

construct derived from qualitative analysis of data" (Corbin & Strauss, 2007, p. 1). In

other words, the general definition concedes to the possibility of using the methodology

for means other than building a theory. However, the intent of this study is theory

building from data as defined by Glaser and Strauss (1967) when they fully developed the

theory. Nevertheless, Corbin's (2007) observations guided this study to avoid the

mistakes she noted that some researchers made in calling their methodology grounded

theory when producing rich descriptions or case studies, and not theory. Therefore,

starting with the data collection this study focused on finding theory that connected faith,

knowledge, and the Afro-Theistic social constructs of African-American COGIC

members with DM.

Grounded theory began with inductive reasoning; that is, gaining a general understanding of particular cases by finding patterns in the data leading to the development of categories (Birks & Mills, 2011). Abductive reasoning followed the induction by making unconventional connections between the emerging patterns (Birks & Mills, 2011). Theory appeared grounded in the data through constant comparative and theoretical sampling until data saturation is achieved, as noted by reoccurring processes (Charmaz, 2011; Corbin & Strauss, 2007). A comparative analysis of the data focused on the details (incidents) of the data and evaluating it for multiple meanings. The coding consisted of primary and secondary coding including, axial (memo writing), focused, abstracting, theory building, and finally theoretical sampling to answer questions stimulated along the way. Altogether the data revealed concepts with each iteration of incidents, codes, and compared processes within and across interviews (Birks & Mills, 2011; Charmaz, 2011). The constant comparative methods also included committee members reading excerpts for feedback from their perspective. The comparisons continued until conceptual categories emerged. At this point, theoretical sampling, which relied heavily on the memo writings of the conceptual categories, identified the type of data needed for a particular concept (Charmaz, 2011). Theoretical sampling continued until saturating the abstract categories, which rendered them credible and lucid. Following Birks and Mills' example of using memo as an acronym helped in the discovery of a core category. MEMO, meaning "Mapping research activities; Extracting meaning from the data; Maintaining momentum; and Opening communication" (2011, p. 40) was also used. Comparative analysis continued with abductive reasoning through each step, moving the study toward the abstract where a theory emerged grounded in the

data. The advanced coding consisted of the development and use of diagrams as recommended by Corbin and Strauss (2007). Theoretical integration followed that resulted in "a comprehensive explanation of a process or scheme apparent in relation to particular phenomena" (Birks & Mills, 2011, p. 12).The phenomena in this study is the African-Americans in the COGIC church combining their Afro-Theistic faith and knowledge of type 2 diabetes mellitus with their Afro-Theistic social constructs.

Data Collection

Data collection is the most crucial aspect of this study, because the COGIC members with type 2 diabetes mellitus will not openly discuss private matters with strangers. Therefore, getting to know the participants is the only way to gain their trust in discussing their deepest feelings and thoughts. Since COGIC members are highly social, spending considerable time in multiple church settings, gaining the participants trust by getting to know them starts with establishing rapport with members in their social group, the church, as part of the interview strategy.

Interviews

This study used interviews as the means of collecting data for purposive sampling of DM COGIC members. Conducting interviews of COGIC members required forethought in approaching a people sceptical of outsiders. In the following sections, this process is described in choosing the setting, establishing rapport with the community, and establish rapport with the participants. A digital recorder captured each interview, which was subsequently downloaded directly into a password-protected computer following each session. In order to maintain confidentiality, each participant received a pseudonym. All data collected, including the recording, refer to the

participants by their pseudonym. Participants received assurance of these recordings erasure no later than the anniversary of the completion of this study. Most of the data consisted of an in-depth interview of the participants with semi-structured open questions, supplemented by field notes with observations.

A second factor, based on experience from the mentioned courses and with the literature review, comes in the method of data collection. The participants chose, within reason, the place of the interview as a means of ameliorating the interview interactions (Glesne, 2011). The fifth and final factor for this study is the interview guide. The experience gained in coursework, the literature review, and the theoretical framework, resulted in carefully constructed interview questions (see Appendix C). These questions are an adaptation, by permission, from two sources. The open-ended questions only guided the conversation and were used to stimulate dialog over an area the participants may have missed. However, as a guide, they proved invaluable in obtaining information on the participants' processes of combining their Afro-Theistic faith and the knowledge of DM through their social construct.

Weiler's (2007) interview questions for the study of the socio-culture of Latino migrant workers with type 2 diabetes mellitus served as a source for developing questions concerning diabetes knowledge and social constructs. Cordova's (2011) interview questions for the study of spirituality among Type 2 diabetic mellitus patients served as a source for developing questions concerning diabetes knowledge and faith. The semi-structured questions (Appendix C) provided data from purposive sampling (Birks & Mills, 2011) of five participants, in order to answer the research questions in developing a theory grounded in data of how African-American COGIC diabetic adults'

construct meaning to reconcile their faith with the knowledge of diabetes (Glesne,

2011). These semi-structured questions were flexible and allowed for the probing of

other details in understanding diabetic member's faith, knowledge of diabetes, and the

Afro-Theistic constructs to interpret the data. The occasional use of additional probing

questions (Merriam, 2009) helped illuminate details that clarified the participant's

information.

In summary, the overarching question concerning the COGIC members

construction of knowledge, and processes involving their actions, interactions, and

emotions, guided the generation of the research questions (see Appendix D). In turn, the

research questions adapted from the two previously mentioned sources resulted in the

generation of the interview questions (see Appendix C). Finally, the interview matrix (see

Appendix D) connects the research questions to the discussion questions and suggested

areas of inquiry for processes leading to a grounded theory.

Setting

The participants in this study chose a meeting location that did not compromise

confidentiality, where they felt relaxed with the interview. Interview locations were

selected with the stipulation of having other people nearby, whether in a house, in the

church or other facilities, and with minimum disturbances. Travel distance and time were

short in meeting each participant at the mutually agreed location, due to the modest sizes

of most homes that facilitated a compact community. The interview began with the

reading of a statement (see Appendix C) in order to relax the participants. The statement

also assured them of the importance of the study to sufferers' of DM in the African-

American community. In addition, prior to the interview and choosing a pseudonym, the participants gave their permission to record the session (see Appendix C).

The participants are in a neighborhood that included a COGIC church, and all of them live close to many family members. The church is a close-knit community of Pentecostal believers who are familiar with unique traditions that are generations old. Each community has its story of how their particular place of worship began. Typically, these churches start independently of the mother church and therefore have considerable liberty in the way they conduct their services, with little or no threat from the national organization. Each pastor expects to care for his members until death comes, or he becomes mentally incapable. Therefore, diabetic participants have tremendous trust, first and foremost in their pastors, followed by the ordained elders, and elderly church mothers. All of the participants lived in the neighborhood close to the church of their fellowship.

This study took place in a COGIC community located on the coast, which began among migrant workers through the prayers and organization of one woman. Whites forced these migrant workers to live on the shores until resorts became popular. These African-Americans made the best of the situation, which was a luxury without the expenses. For example, they fished and enjoyed free fresh seafood, in spite of insubstantial living quarters. When the Whites wanted the coastal land, they forced African-Americans to live inland by physically threatening them. In fact, someone burned the house of the last African-American on the coastal side of the railroad track. Once relocated, the close-knit community of relatives lived around the COGIC that most of them attended.

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The African-American community owes its survival to three prominent families who relocated to the area from the Deep South as migrant workers to work in the abundant citrus groves. Two of these families came from an infamous southern county while the other came from the west coast of the state. Several important family members in the neighborhood gained notoriety with their advancement at a U.S. government aviation facility. The notoriety started when the dad of one prominent family gained employment at the agency as a janitor and worked his way up to be an aviation jet propulsion mechanic. This job became a door of opportunity for other family members in successive generations. The children and grandchildren of this former janitor are very gifted at mathematics. However, they do not receive particular attention; in fact, one would think they were of little importance, until neighbors need the help of a tutor with mathematic problems.

Rapport With the Participants' Community.

Choosing the coastal community resulted in a perfect microcosm of the COGIC denomination. Ideal because the majority of its citizens are members of the centrally located COGIC church. In fact, the founding of the community and church began simultaneously when migrant workers in the 1930s and 40s, established both around the time of World War II. A mature lady started the church and conducted services until a COGIC pastor was sent by the church. This humble beginning typifies most COGIC churches, often started in available facilities by inspired individuals, either traveling preachers, local lay members. As is often true for embryonic churches, the building is secondary to the felt need for communal worship. Nevertheless, this church eventually grew into a beautiful edifice, and has trained and nurtured a number of local celebrities.

The musical talent found in this church, and the voice of their choir had sufficient quality to produce a gospel CD. Currently, one of the most talented singers is a former defensive player on a college national championship football team. He is also related to at least one of the participants in this study. The church remains humble and does not promote or publish its celebrity. Outsiders only discovered this information over the course of time in getting to know the people of the community.

The first task in conducting research in the COGIC subculture was to find those willing to talk about their experiences with DM. Participants needed to come from a community typical of COCIC churches. That is, members throughout the United States usually live in the community surrounding their COGIC church. This decision was crucial in finding participants willing to talk especially since most in the COGIC community are suspicious of the motives of outsiders. In fact, this is also an ethnic characteristic as discussed in Chapter 3. Fortunately, several prior visitations to this coastal town helped established an excellent rapport with the citizens in the community.

Additionally, having the first meetings in a preestablished safe space where participants felt free to talk was important. The felt safety did not necessarily guarantee openness, but it provided the space to build trust and respect for one another. In fact, the basis of this trust and respect initially came from mutual love for the family who introduced my wife and I to the community during our first visit several years prior. Having this rapport with the citizens is a lesson learned from Vella's experiences with church authorities in Tanzania (Vella, 2002). It was imperative, as a researcher, to create a safe constructivist environment where mutual learning took place. This constructivist approach began long ago, before visiting this town, shortly after meeting this couple, and

more than 20 years before knowing this approach to learning had a name. We spent many hours in philosophical dialogues around Biblical themes and teachings. On at least one occasion, the dialogue started before sunset and did not end until sunrise. This mutual respect for each other's philosophical knowledge and intellect quickly grew into comfort around, and love for, each other's family. This backdrop provided the comfort and confidence to begin this study in the community of a friend.

Following my proposal defense, while I was considering the question of how to introduce the study to this friend, providence seemingly intervened. My friend's wife (I will call this couple, both of whom are friends, Jason and Jane) accidentally sent an invitation to a function at their church to my wife via email. Not only was Jane surprised and apologetic for sending the invitation, knowing we were hundreds of miles away, she was utterly shocked when she saw our response, "We'll will be there." This invitation was crucial to establishing rapport with the participants.

Rapport With the Participants

Rapport with the participants came in three phases. It began with a diabetes workshop, followed by a general introduction to the study and a packet with contact information for those interested in participating. The third step came when I received, and accepted, an invitation to be a guest speaker at the local COGIC church, prior to meeting with the participants. The opportunity to participate in a diabetes workshop was an unplanned addition to this study. After learning that the real purpose for visiting was diabetes research, Jane was thrilled. Again, with what seems to be providential intervention, she had started monthly health workshops at the local COGIC church because of their pastor's wife's death from DM. However, the workshops had only

addressed relatively nonspecific public health issues in an attempt to raise awareness about diseases and chronic conditions within the community. Jane offered to focus the next workshop on type 2 diabetes mellitus as a way of providing each participant the opportunity to give feedback on a diabetes support session in addition to other experiences with DM.

We worked out the details in order to enhance the research study without altering it. Once again, the hand of providence intervened. The nurse who frequently conducted the workshops was unable to attend the meeting. As a result, Jane asked two COGIC members, both of whom had had inspirational experiences managing DM, to facilitate the meeting. According to the attendees, these facilitators were so awe inspiring Jane regretted not video recording the entire session. Participants also revered the facilitators as mentors on how to manage their DM.

Jane presented general information about the study, and gave each attendee a packet with contact information so they could participate in the study of this COGIC subculture of African-Americans with DM, if they so desired. Of course, there was apprehension, due to the invasive nature of research into private lives, especially for those already skeptical about the idea. Five attendees responded immediately while others took a wait-and-see approach, wanting to see if any negative feedback about the research spread throughout the community. Disguising the participants' data helped protect their identity, especially considering the town is close-knit, with citizens attending the COGIC church having genetic relationships, relationships by marriage, or are long-term friends.

Finally, my participation in speaking engagement at the COGIC church on the Sunday prior to the interviews helped relax the five participants. This engagement

provided an opportunity for the community to develop a sense of comfort with the research, and gave me an opportunity to convey my sincere desire to help African-Americans suffering with DM. Having the participants open, forthright, and relaxed was paramount. Part of the rapport developed through having a shared understanding of language. For example, I have purposefully omitted the term father from this document, replacing it with dad or papa. The COGIC church members avoid using father in reference to a parent because Biblical Scripture forbids using this term for anyone other than *God the Father*. Sharing this kind of commonality about language allowed the interviews to proceed as casual conversation, with mutual understanding, without regard to syntax. In other words, different language would be used with outsiders.

As a result, at times, the participants did not adhere to standard sentence structures. For example, when speaking in the third person, they were giving an opinion of what they though other likeminded COGIC members with DM would say. Their opinion was the first person, but they often used first, second, or third person references in one sentence. Finally, the participants maintained control of the interview, to the point of requesting the deletion of their data should they have changed their mind about doing the interview.

Participants

The individuals in this study elected to participate after an introduction to the study following a diabetes workshop sponsored by Jane (pseudonym). The five COGIC members with DM, briefly introduced below, accepted the invitation presented by Jane to participate in this study. Jane received enough flyers (see Appendix A) for each potential participant. In addition, other acquaintances were available to provide names

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of additional candidates who qualified for the study, if needed. Jane gave the participants instructions and contact information to arrange an anonymous interview by phone. After the phone call, a consent form (see Appendix B) was mailed to each one of them. In addition, we arranged for the interview setting, and conducted the interviews following receipt of the signed consent form. Together, we reviewed the information in the consent form to give the participant a chance to ask questions prior to the interview. The participants were informed of their right to terminate the interview at any time, or the right to selectively not answer certain questions, without jeopardy of losing their stipend. Each participant received a $75 stipend as an incentive with the first interview, and $25 upon request for any follow-up interviews.

Arianna – Arianna is in her late 50s, and is a certified nursing assistant (CNA), which requires a high school diploma or equivalent, and supervised clinical training. Arianna is apathetic towards DM because she is convinced she does not have the disease.

Glenn – Glenn is in his mid-50s. He works as a laborer, that does not require education beyond high school. Glenn is a relatively new member of the Church of God in Christ (COGIC) denomination. Glenn is willing to manage his problems with DM, but he believes doctors think he is ignorant. Because of that, he believes doctors have little interest in him.

Livia – Livia is in her early 60s, and is a retired registered nurse (RN), which requires a bachelor's degree or equivalent. She vacillates between believing she has DM and not believing she has the disease, based on what she thinks are motive-driven, biased test results. Livia is a missionary in the Church of God in Christ (COGIC).

Carlos – Carlos is in his early 50s, and for many years worked as a jet engine mechanic, which required him to have technical training at an aviation maintenance school or equivalent. He serves as a mentor for those who have DM. He is a church elder in the Church of God in Christ (COGIC). An elder in COGIC is one who is an ordained preacher. Carlos is also a talented string instrumentalist.

Nick – Nick is in his mid-50s, and worked for many years as a police officer, which requires Police Academy training or equivalent. Nick serves as a mentor for those with DM. Nick is also a talented minister of music. Nick is well known in the community. He frequents a nearby restaurant, owned by a former NFL player often enough that he receives hugs and kisses from the waitresses. They know his meals, like having fish for breakfast, without him ordering, and the owners personally visit his table.

<div align="center">**Data Analysis**</div>
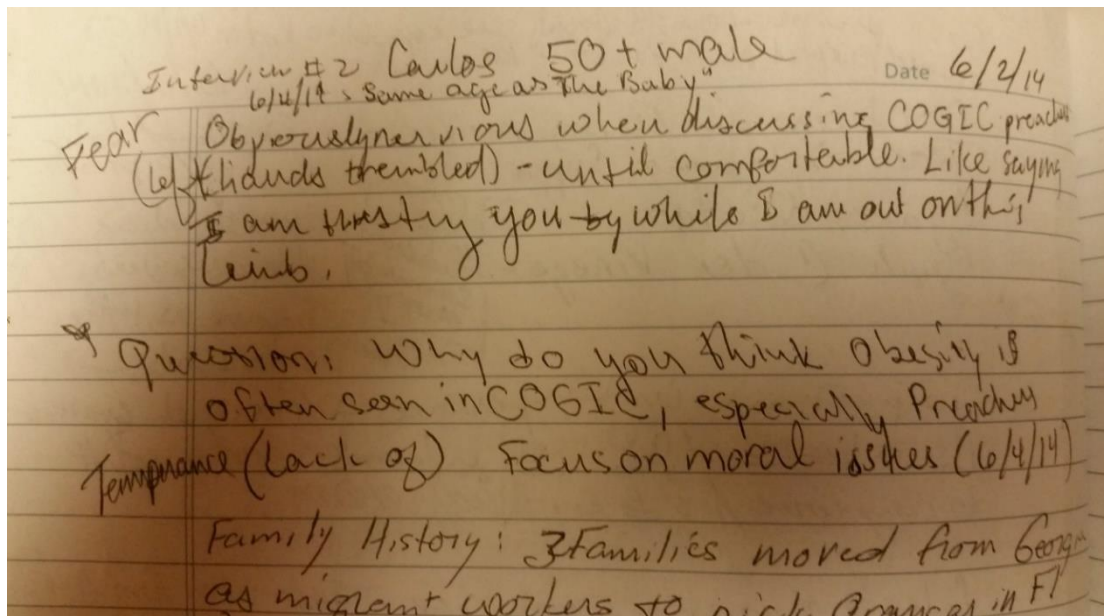
The most crucial part of the data analysis came through trusting the processes of conducting a grounded theory study. As an emerging researcher, spending months analyzing the data without one line written about the findings, required tremendous trust in Corbin and Strauss' (2007) techniques and processes for developing a grounded theory. The motivation to continue following their advice came from seeing the project unfold toward a theory, as the participants spoke, through coding, memo writing, and making diagrams, just as the authors predicted. The data analysis came from the theoretical framework of Afro-Theism. It investigates the symbolic interaction of the COGIC participants with DM in relation to Afro-Theistic faith, knowledge of diabetes, and the Afro-Theistic construct. Therefore, faith, knowledge, and social constructs, assume Afro-Theism, even though it may not be stated explicitly. Interview questions

assisted in the analysis process of generating a credible and trustworthy grounded theory, since they stimulated a response which provided the data. The theory produced applies directly to the COGIC subculture of African-American diabetics. Overall, the designed analysis revealed the actions, interactions, and emotions related to the participants' faith and knowledge of diabetes through their Afro-Theistic constructs.

The development of a theory grounded in the participant's data that captures their actions, interactions and the emotions of this subculture demands trust in the process. Therefore, theory development made it necessary to analyse carefully, using field notes, many diagrams, and many memos to discover the most salient concepts from the small number of participants. Without the use of diagrams, it would have been impossible to identify the central category which is the basis of grounded theory and to know how to integrate the major and minor concepts that subsequently emerged (Corbin & Strauss, 2007). Data analysis would have been impossible without technology such as, MAXQDA 11, which was used to identify, sort, and manage almost 1,600 codes. Through the use of this program statistical relationships were illuminated, and the synchronizing of memos and audios of the transcribed data lessened the labor-intensive processes of data management. Another valuable technology used in conjunction with MAXQDA 11 was Inspiration 9, primarily used to draw diagrams or matrices, which represented actions, interactions, and emotions, with refinements that eventually became concepts in many cases. Finally, Inspiration 9 facilitated additional memo writing that aided in understanding *what is going on here*. The processes of coding, memo writing, and diagramming are treated separately here, but in reality they were interactively created and grew into abstraction.

Field Notes

In the process of developing a grounded theory field notes provided context for the participant's data. For example, Figure 9 records the observation of Carlos, a church elder who appeared nervous, although this was only seen in the trembling of his left thumb. This observation showed that he questioned whether he was doing the right thing by interviewing for this study. It re-emphasized the importance of developing a theory grounded in the participant's data alone. It also revealed his trust that his information served to help COGIC members with diabetes without hurting the church's reputation. Each meeting with a participant included field notes to record observations of the participants' expressions, reactions, moods, emotions, surroundings, and so on, related to DM.

Figure 9: Field Notes.

Coding

It involves interacting with data (analysis) using techniques such as asking

questions about the data, making comparisons between data, and so on, and in

doing so, deriving concepts to stand for those data, then developing those

concepts in terms of their properties and dimensions. (Corbin & Strauss, 2007, p.

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Following the interview and observational field notes, usually came an overnight

transcription of the data. Once transcribed, data were entered into the MAXQDA (see

Figure 10) program for storage, coding, and memo writing, or axial coding, as described

by Corbin and Strauss (2007). The purchase and use of the MAXQDA program made it

easier to follow Corbin and Strauss (2007) who used the same program to demonstrate

the development of a grounded theory. The MAXQDA software allowed the storage of

data, including, coding, compilation of all the transcriptions, observational field notes,

and audio recordings. The software helped organize and catalog the initial and secondary

codes of the participants' data that aided in the development of categories and

subcategories. The easily retrievable and viewable database allowed for constant

comparative analysis of incidences, codes, and categories to one another that led to the

abstraction of the participants' data. Recurring processing and in vivo codes, and

concepts evolved into greater abstractions that resulted in the development of key

categories.
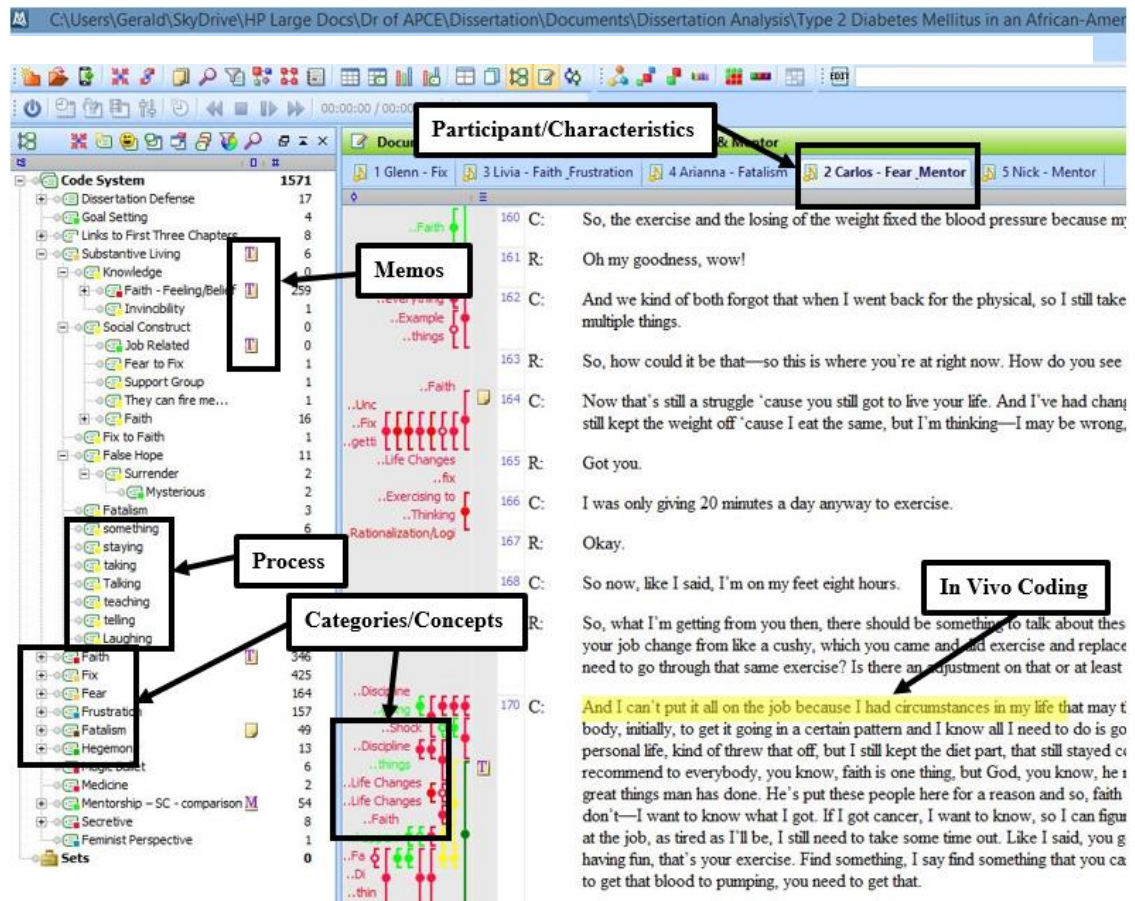
Figure 10. MAXQDA – Coding and Memos.

Memo Writing

Memo writing followed each transcription to capture the impression of what

seemed to be transpiring in relationship to diabetes in the COGIC subculture. Additional

memos in many paragraphs, called axial or intermediate coding (Corbin & Strauss,

2007), helped weave primary and secondary codes together in the process of developing

categories and subcategories. Later, memos reflected thoughts when reading the

transcriptions that further helped identify codes, concepts, and eventually processes. In

the MAXQDA program (see figure 10), these memos are behind folders with and without

letters stamped on them. Those with letters on them came from constant comparative

analysis that focus on incidences leading to abstractions of the data that assisted in

building a theory grounded in the participant's data. The overarching characteristic of

each participant's tab aided the comparative assessment of the data at a glance. Evolving

diagrams such as those seen in figure 11 inspired additional memo writing, such as those

in the same figure, and handwritten memos (not shown). Inevitably handwritten memos

were incorporated into the MAXQDA program. These memos helped to map and track

the theoretical sampling of the participant's data. They continued the abstraction of the

data and the development of a theory grounded in the participant's data.

Diagrams

Diagrams can be valuable tools to integration because integrative diagrams are

abstract visual representations of data (Corbin & Strauss, 2007, p. 107).

The visualization of the symbolic interactionism (see Figure 8) came through

iterations of diagrams and memos developed in an Inspiration 9 program (see Figure 11).

Diagrams aided in identifying concepts, processes, and their relationships to each other.

This mandated time to reflect upon field notes, observations, and thoughts from each

interview through memo writing. However, this process took months of interaction

between data and drawings. The drawings began as simple representation of the data but

grew in abstraction. Some of the diagrams resulted in dead ends because they did not

represent all of the participants. Some drawings merged while others grew into concepts

and processes. Eventually, a grounded theory emerged through continual comparative

analysis, the use of diagrams and the participants meaning making processes involving

the participants' COGIC social constructs. Drawings made the abstractions of an

overarching category that connected to all others readily comprehensible (see Figures 16 and 17).

Credibility and Trustworthiness

The credibility and trustworthiness of the data collected and analyzed came primarily from establishing and maintaining rapport with the participants and their community, similar to Villa (2002). We shared historical ethnic and church backgrounds, in addition to having DM. As a result, participants willingly and passionately spoke concerning their encounters with the disease, which is remarkable for this close-knit community of Pentecostal believers. Their openness to this study extended from trust gained through time spent in the community, speaking to its citizens over the course of several visits, and having a speaking engagement at the COGIC church prior to the interviews. The participants sensed the genuine love shown to the community and gave invitations to consider it home. Therefore, trustworthiness of the study is in the open, and detailed data collected and the subsequent systematic analysis through prescribed means of conducting grounded theory.

Corbin and Strauss (2007) added, credibility or believability comes from detailed descriptions and the manner of gathering data. Therefore, credibility and trustworthiness merged in the data collection and pre-analysis steps involved in triangulating the data. Data triangulation came through a multiplicity of sources. The primary source of triangulation came through the written transcription, and hearing the digital recording of the five interviews.

Memo (Monday 8/4/2014: 7:07)

Furthermore, my dissertation coincides with my diabetes research as a clinical laboratory scientists. As such, I am allotted a certain number of hours for research. As a result, I submitted three research grants following the spring semester, and writing grants are also required for tenure-track, or tenured professors.

Memo (Sunday 7/27/2014: 7:51 AM completion)

Audrey's leaving the Nunnery reminds me of the time that I left COGIC. A very lonely feeling having invested a lifetime into a family tradition, then given the cold shoulder... This has also been a troubling week after our administrative assistant completely lost her composure and went on a tirade against me for all that was troubling her, simply because I would not compromise on the quality of service needed for a new chemistry analyzer. She completely slandered my name and made it totally impossible to work in such an environment. (Friday, the next day at lunch, with no one from CLS or RT around, I felt I needed to defuse the situation, and I asked, "Carmen, are we going to have a problem?" She completely lost it again, as I thought she might, and again hurled insults at me, plus added all the things that was troubling her to it, even more than on Thursday. When I asked, "Carmen, why are you blaming me for all of that?" She then slandered every single faculty, except Tom, starting with me. Before Rod and Tom returned from lunch, we were at least on speaking terms enough for a working relationship.) She claimed that all I ever do is work on my dissertation. She claimed that all I have ever taught was one class while Tom teaches two. She claimed that I was a "golden child," giving every opportunity to finish a Ph D while others pulled my workload. I only caused her to think when I asked, "Then, what was I doing (with my time, if all I do is work on my dissertation) from 2008 to 2010 when I started the Ph. D program.

Truth, I have put in more time on my work than anyone could possibly imagine. Fact is, many times I have worked in my office as early as 2 AM to well after 5 PM, and most times from before 7 AM to the same, on nothing but my work. My day starts at 4 AM and my work for my job starts at home. Most of my weekend is from 6 AM to 5 PM on Saturday, doing work for YSU. Sunday's are the same, other than church. I have continued this since 2008 when I was hired, which was two years prior to starting the Ph D program. When I work on my dissertation it means that I have caught up on the work for my job for that day. The reason I have worked so many hours is that is what it took for me to get up to speed in teaching, realizing that David, Rod, and Tom had much more teaching experience, and they were current in their CLS knowledge at a teaching level. None of that was true for me. When I started the Ph D program, I had gain enough teaching skills to manage my job and grad school. I substituted the time I no longer needed for my job with grad school work, or took away personal time to add more time devoted to teaching and grad school.

However, I owe Rod, who saved my bacon in getting me tenured. I owe David, who I feel that I shortened his tenure or at least overloaded him with my work, because I should have completely taken over chemistry from the beginning...I only hope David can/will stick around long enough to reap the fruit of hiring me.

Gerald

Memo (5 PM, 7/26/2014): Hours after writing this, which was changed from Doctors/gods, I was watching a movie based on a true story, called "The Nun's Story" staring Audrey Hepburn, in 1959. Of the doctor (Peter Finch) that did not believe in God whom Audrey worked alone the side of in the Congo, she stated "No Mother, of course I have not fallen in love with him. I admire him deeply for his skill and selflessness when there is a life to be saved. I think always he is close to God in those unearthly hours when he operates."

Are doctors perceived as the enemy of faith? 7/28/14

Doctors = Prophets

Hegemony

Fear Factor

Two types of fear?

Catalyst

Eat

Flight

Fear = Motivation --->
Like knocking the crust off a red hot iron poker.

Slavery   Desensitization

Desensitization   Life Struggles

Fight

Lose Weight

MEMO: 9/6/14
Weight loss is the major belief to solving the problems of diabetes. Interestingly, only I did not mention weight, and that person is the one I labeled "Fatalism."

Is Death from diabetes the lack of fear? (7/24/14?)

Livia 166 (7/28/14): My dad got out of the hospital, he said God had gave him all the years that he promised. He was going to eat what he wanted and he did just that.

Is this Martyrdom?

Get Knowledge   Needed

Doctors   Knowledge   Inevitability

Fatalism

Temperance   Knowledge   Doctors

Prevention originally- now Fix

Loss of Eyesight

Kidney Damage

Loss of Limbs

Secret

Figure 11: Inspiration 9 – Memos and Early Diagrams.

Field notes recorded relevant observations of each participant and their surroundings during the interview, which complimented the digital recording. The triangulated data continued by having a cross-section of interviewees, from church leaders to lay members, and professionals to laborers, and memo writing. Finally, the data contained enough variances in the cases (Charmaz, 2011) to increase the credibility of how faith, knowledge, and Afro-Theistic constructs converged in the COGIC subculture of African-American diabetic members.

Summary

This chapter began with an explanation of the constructivist epistemology, and logo-centric ontology believed as a philosophy, and continued with a detailed look at the theoretical framework guiding this study. The theoretical framework establishes Afro-Theism as part of the faith, knowledge, and social constructs of the COGIC participants in this study, whether stated or not. The chapter defends qualitative analysis using interviews as the method and grounded theory as a methodology of understanding this African-American subculture of DM sufferers. This study's use of the grounded theory methodology followed other theorists' recommendations to researchers using that methodology.

The data collection and analysis purposed to develop a theory grounded in the data from the participants. The theory generated is with the purpose of increasing support in African-Americans managing DM. Computer programs like MAXQDA and Inspiration 9 aided in identifying concepts and processes of the COGIC participants with DM. Continual comparative analysis of the data and five additional factors helped this qualitative study. Selected pseudonyms purposed to obscure any data that threatens

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participant's confidentiality and helped facilitate openness during the interviews.

Securing the data was accomplished by using a password-protected computer and/or

placing files in a locked file cabinet. Finally, rapport with the participants explains their

open discussions, and systematic analysis of the data assured credible and trustworthy

results.

IV. STUDY FINDINGS

This study purposed to develop a theory grounded in the data of how one subculture of African-Americans combines faith with knowledge and their social constructs to live with and manage their DM. The greater body of research show church-based support groups are the best means of helping African-Americans understand and manage DM, but did not provide a robust reason for the phenomena (Davis-Smith, 2007; Davis et al., 2005; Taylor, 2010). For this reason, the COGIC denomination, a familiar subculture with over 5 million African-American church members, was selected for this study. The theory based findings are indispensable in knowing how to better serve this large populous of African Americans, and elucidate concepts and processes beneficial to others in the severely underrepresented and poorly understood African-American diabetic community. This study's Afro-Theistic grounded theory development begins by giving an in-depth description of the five participants, followed by the emergence of categories, their integration into a theory, and finally a summary of the findings.

The Participants

The thick and rich data of only five individuals provided sufficient information to meet the goals of this study. That is, through data analysis of these individuals major and minor concepts, categories, and the central category necessary in grounded theory, all emerged. Furthermore, each category evolved entirely with data saturation from repeated examples, making it unnecessary to interview more individuals. This evidence provided sufficient understanding of how faith, knowledge, and social constructs worked together for COGIC members with DM.

Arianna

Arianna is a lifelong member in the Church of God in Christ (COGIC) denomination. This means she was born to at least one parent who was a member of the church. Arianna's encounter with diabetes was typical of others in this study diagnosed with DM. She was a middle-aged (early 50s) African-American female when her doctor said she was borderline for DM. This discovery came during a routine physical examination with her primary care physician. Arianna received general warnings that she needed to watch her diet. The doctor did not give her a referral to see a dietician, but directed her to read material on what she should do about her situation instead. In paragraph 106 of her transcript Arianna states, "They might have told me something about the diet. I can't say they didn't give me material, but I didn't read it." Therefore, this "borderline" condition continued in a steady state for more than two years without any change in the stance taken by either Arianna or her doctor. Eventually, based upon laboratory results (i.e. hemoglobin A1c) the doctor proclaimed Arianna had DM.

The uniqueness of Arianna's story is her perspective of the diagnosis. The announcement did not faze Arianna in the slightest because she did not believe that she had DM. In fact, she seemed impertinent about the questions I asked concerning DM. The abrasion did not reflect the interview since previously, and voluntarily, a participant mentioned Arianna's adamant disbelief that a problem existed. She kept rapping her fingers making a "pa-thump, pa-thump, pa-thump" sound while I probed regarding the initial diagnosis of DM, as if to say we might as well move on to other questions. This attitude was not a case of denial, since, in paragraph 28, she gave the reason for her stance, saying, "The numbers say it, but I don't really know if I do [believe it]. I just had

to go by what they say because like I say, I don't feel [painful]; I have never had any symptoms of it—that I'm aware of." The tone of her voice suggested she thought the doctor erroneously forced her to surrender and start taking medicine.

Based on her reply, there were two problems with the diagnosis. First, she did not have any symptoms or evidence to prove that she had diabetes other than laboratory test results. In other words, in Arianna's mind there is a disconnection between laboratory results and indicated diagnosis without physical evidence. When probing for the reason, she felt she needed to have physical symptoms prior to a diagnosis; she revealed that she had many years of experience working around patients with DM. In her estimation, she showed none of the visible signs that she saw with DM patients. In paragraph 62, Arianna gave more insight for her definition of diabetes and proof that she did not have diabetes. She stated:

> We just had a session at church Tuesday, but far as before them, we have family members, church members, family members that are diabetic and I do know people that, you know, have had to take insulin and all this, young, my age or whatever, but I probably should take it more serious than I have, but I guess because last week when I was tested, my blood sugar was okay. I never felt whatever. I do take the pill, although he first started me off with one pill a day and then, I guess the number changed a little, whatever, he changed it to a half in the morning and one at night. Well, I'm just bad about taking medicine. So I really never took that half in the morning, maybe a couple of times. So, I'm still taking the one at night.

In her estimate, a person with diabetes (young or old) takes insulin, or at the very least has an elevated blood glucose (sugar) level. She believed the home glucose test was the best indicator of her status, or at least as good as the hemoglobin A1c test the doctor (according to Arianna) used to confirm his diagnosis. She reasoned that a glucose reading within normal ranges, even with periodic testing was proof that she did not need medicine (pills) for diabetes, at least not the dosage prescribed by her doctor. Medicine then is the second problem expressed by those interviewed, a general distrust and fear that the medication caused more harm than good.

Finally, Arianna's belief about her diabetes status presented a conundrum in connecting her faith with diabetes. However, after unraveling the mystery, it provided a valuable link with the comments of other participants. Her responses also helped make a connection between the following seemingly indifferent response to doctors concerning the prevention of diabetes and a later diagnosis of cancer. Regarding the instructions for diabetes prevention, she stated in paragraph 100:

> Watch my diet, exercise, blah, blah, blah, blah, but when I work, I walk, they say walking ain't the same, but I walk pretty much of my day. I work 8 hours, and I know I'm working at least 6 or more of them hours and by the time I get home, I don't even want to go walking."

However, her attitude completely changed towards a diagnosis of cancer based on laboratory results without symptoms. She stated in paragraph 44. , "Now, [in] actuality, as far as going to my primary physician, it's been awhile since I've [not] seen him because I came up with the issue in…where I had cancer." She completely dismissed the

fact that she had DM and focused on the cancer that she considered a more pressing matter.

Glenn

Unlike the other participants, Glenn, an African-American male in his mid-50s, is a relatively new member in the Church of God in Christ (COGIC) denomination. Church affiliation means that he recently became a born-again Christian, also known as receiving salvation or the new birth. COGIC associates real members as those professing new birth. Although a person can have their name added to the membership roster, full-fledged membership comes through conversion to Christianity. One of the marquee songs for the church declares:

> This is the church……Of God……In Christ…(Vamped and repeated)…Oh, you can't join in……You got to be born (drawn out) in……this is the church……Of God……In Christ…(Then repeated).

This mindset is noteworthy and significant because new members are usually long-term holdouts to conversion because they understand the church's position that conversion is a wholehearted and lifetime commitment to obedience to Christ in every phase of life. Prior to commitment, holdouts believe the denomination is too restrictive for the lifestyle they desire to live. However, after conversion, a wholehearted belief (faith) resonates with all that new converts say and do. Glenn reveals his wholeheartedness as he laments his past wayward actions and celebrates his new conversion in paragraph 128. Glenn stated, "…but I ain't been too long got in the church myself and I thank God for it, but I was out there, it was like, in the world, big time, big time, big time, you know."

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This submissive attitude of finally being willing to listen to others carries over into his attitude towards his diagnosis with DM. Glenn displayed an attitude of learning, was unassuming, and willing to obey any instructions, but exposed many gaps resulting from insufficient instructions. Gaps in knowledge are evident from the beginning of the interview. Glenn began in paragraph 4 stating:

> Well, I know a little about diabetes. I don't know much. I've just been diagnosed with diabetes and here in the last year, the doctors was telling me I was at borderline, so here in the last six months he put me on metformin, and he had me to check my, he —gave me some papers to check my diabetes. So, I've been ranging sometime—97, 125, in that area, might go up to 130, then it will go down to 100, like that. I wasn't sure. I assumed it wasn't the normal range for it to be in.

Glenn only received two morsels of information about diabetes from his doctor: he unmistakably knew that he was borderline for diabetes for approximately one year, after which he acknowledged his status changed to DM. However, the doctor made his diagnosis based on lab results without any physical symptoms, with instructions to take some medicine and check his glucose without long-term goals or purpose other than keeping his glucose readings low. Glenn did not receive a reason for the onset of diabetes nor how to prevent it while he was borderline. Glenn did not appear overweight nor did he indicate that the doctors thought he had a problem with obesity. Glenn was aware of the connection between DM and obesity as indicated in paragraph 128 when he said, "…I told them it's going to be hard for the saints to losing some weight because we always eating."

By all indications, the attitude toward Glenn's DM was mundane as another person with diabetes and therefore undeserving of viable knowledge. This treatment is evident from paragraph 4 above that said, "…he —gave me some papers to check my diabetes," and expected Glenn to figure out how to take his glucose reading without a demonstration. Glenn surmised it was the color of his skin and in paragraph 248 he noted the difference when he said, "…him in the next room, taking his time with people staying in there a long time…he [is] a different color, you know what I'm saying?" Over the years, Glenn had noticed the doctor spent more time with his White clients than with him. Glenn's proof that some White people generally assumed that because he was Black he was also ignorant, came when he decided to test his theory. Since his doctor did not demonstrate how to use the glucose meter, he took it to a local Walgreens pharmacist. In paragraph 212, he stated:

> Just like when I got the machine, nobody showed me, so I came home and I said, it's easy to do once you do it, but had never used it before, you know what I'm saying? So I got here and I went back up to the store about eight miles and I took it in there and said yall show me how to us it, so I can make sure this, and that. They say, "Oh it's easy [in a mocking voice]...I said, "show me," then when he got it and do it, and he couldn't really do it right then himself, you know what I'm saying?

Glenn demonstrated his sincere desire to learn and asked if he could demonstrate what he had learned. I recorded this field note, "During voluntary glucose testing Glenn did not clean his finger, in fact, after reading the meter, he sucked the blood to stop the

bleeding." 'Glenn's willingness to learn was not matched by his doctor's willingness to teach, as noted in another field note.

Glenn was searching for answers – – – I gave him as little as possible to prevent me from interfering with the research questions. He absorbed all of my information and used it to improve his knowledge of diabetes mellitus.

Glenn's frustration was heartfelt by the blatant void in instructions to someone willing to fix the problem. Another field note records a major reason to believe Glenn's sincerity.

He [Glenn] spoke with tears in his eyes… When he said, "I know you know," I am certain he [Glenn] was referring to my uncontrollable tears the day before. My tears were a reference to Jesus being nailed to the cross in a skit [performed by church youths on Sunday at the local COGIC church]. It was emotional because two days prior we had an awards ceremony for Kathleen Aguero, one of our students in the Clinical Laboratory Science program, who was killed in a car accident over spring break. Plus, I had a brother [who] died a few weeks prior to that, and an Uncle who was a Bishop in the COGIC church who died prior to that. A tough year for me... At Kathleen's ceremony, Dr. Rohde said he could not see how I could hold back the tears. I said, [it] was a sense of duty as a minister. But, just before I spoke as a guest speaker on Sunday following the ceremony, I had a long moment of tears.

Glenn opened his heart in helping me to understand the genuineness one may have in learning to manage DM, the frustrations one may encounter, and the sense of futility when this void in knowledge remains vacant. Glenn was one of the attendees at

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the support session instituted by Jane. From this meeting, paragraph 32 showed his attentiveness to details and proved his willingness to learn, saying:

And I know like—you know, you learn more as you go, like we had a session at the church the other night and Brother…was talking about it 'cause he's a diabetic, but he said he's not now 'cause he eat the right things and stuff, he's saying.

Glenn, apparently moved by what he learned at the meeting, helped validate the importance of this study and confirm his willingness to fix the problem. Further proof of his desire to learn is demonstrated when he changed doctors. In paragraph 240 after finally changing doctors, he stated:

But the doctor that I have now…he do set down and talk to me like you talking to me and had to tell him, man I sure appreciate you telling me that, but you know, the doctor that I had years before that, you know that doctor ...I tell you what the doctor I got now stayed in that room with me longer the first time, longer than my other doctor did, three to four years.

Hearing Glenn's story evoked several questions, "What is the doctor's responsibility in educating potential DM patients about their condition?" What is the goal of medication? How possible is it for DM patients to stop needing diabetes medicine? What does diabetes management mean? Regardless, Glenn's interview added valuable information to this study in knowing how faith, knowledge, and social constructs worked together in the COGIC subculture.

Livia

Livia is a mature lifelong member in the Church of God in Christ (COGIC) denomination. Like most participants, her family can trace their membership back to the founder and even the formation of the COGIC church. Livia is a vibrant, mature African-American female who is active within the denomination. She retired from the medical field and serves as a sounding board for many within the community concerning spiritual and health issues. Livia conscientiously influences family members and community members with admonishments to maintain a healthy lifestyle. Perhaps this is the reason Livia expressed the most surprise, embarrassment, and frustration after being informed that she had DM. Her diagnosis came later in life and a few years after retirement. In paragraph 12 Livia stated:

> I was diagnosed, which was kind of discouraging, I was diagnosed April of last year and that's something I said would never happen to me and I was diagnosed. I did some routine lab work and when it came back, my blood sugar I think was like 150, but my hemoglobin A1c was 8 point something and I'm like, you've got to be kidding me.

Like others in this study, Livia did not exhibit noticeable physical ailment or symptoms of DM. Instead, like others, her doctor's decision resulted from laboratory tests. Unlike the other participants, Livia had a greater understanding of the cause of diseases and the significance doctors placed on laboratory tests. For example, in paragraph 4, she described diabetes in this manner, "Well, I know it's dealing with your pancreas and insulin." Therefore, paragraph 12 above exhibits her understanding that the diagnoses of diabetes comes from the combination of laboratory tests. She did not lack

knowledge of DM and had cared for diabetic patients. In fact, her knowledge of DM is the primary source of her frustration.

Livia believes part of the problem is the test results doctors rely on to make their diagnosis. She stated in paragraph 115:

> Well too to me and this is the way I feel, the range back when I started, I started working July 21st, 1980, I was a fresh graduate…and the range that they had for your blood sugars was a lot higher then, than now. They keep lowering the blood sugar levels. So if they keep lowering the blood sugar levels, everybody in this world going to be a diabetic.

The word "lowering" evoked the thought that the current numbers did not consider ethnic variations of African-Americans, and the authorities could manipulate numbers to include everyone at will. For certain, Glenn would come to this conclusion from a community leader like Livia. Especially considering that he said in paragraph 272, "One time, they did have me thinking just white people couldn't get it, diseases like diabetes and high blood pressure" Furthermore, as a laboratory scientist and African-American with diabetes, her comments were sobering and previously not considered. Coincidentally, her education in the medical field coincided with mine as a medical technician in the U.S. Air Force. Consequently, I promised to search old references to verify her claim. Livia's claim was right. Experts lowered the results that indicated DM based upon a fasting glucose test from 149 to 129 mg/dL.

As further proof, Livia, as did all participants, made a comparison of their status with a family member, primarily in the form of an ancestor. In paragraph 167, Livia said of her dad:

It makes me wonder 'cause like my dad was diagnosed at 70-something years old as a diabetic. There is no way that was true and the only reason, the only time my dad's blood sugar went up, and that's how you knew he was sick. When he had his—he had I think it was a triple bypass or a quadruple—anyway, he had a bypass surgery and his blood sugar went up and so they said of course, he was diabetic and they were going to put him on medicine, whatever. My dad got out of the hospital; he said God had gave him all the years that he promised. He was going to eat what he wanted, and he did just that. My dad didn't have bad hemoglobin A1c, so what gives with that? And he always was a guy who loved fresh—he liked his peas and his beans and his okra, he loved his bacon, he loved his squash, he loved his grits, he loved his eggs, his fried corn.

Livia used her dad in his old age as an example to prove that the diagnoses of diabetes will happen to anyone because the numbers that indicated DM had changed. She claimed her dad did not have diabetes for several reasons. His blood glucose (sugar) became elevated when he had heart problems. In other words, she considered that his elevated glucose served to warn him of his heart condition. In her logic, diabetes would have been evident prior to his old age. She also noted that in all of her dad's laboratory tests, only the less reliable one met the condition for diabetes. She surmised that since the more reliable hemoglobin A1c was in the reference range for non-diabetic individuals the doctor made the wrong diagnosis. She used his diet of unprocessed foods as another reason to question the doctor's decision. Furthermore, her dad did not believe he had diabetes, or at least the diagnosis was not currently relevant. His attitude toward the diagnosis of diabetes gave a clear example of how COGIC members weave faith into

their decision-making processes. In her dad's case, he thought God had given him a meaningful life, and he decided to live the remainder of his life in a manner substantive to him without the restrictions of doctors.

However, Livia admitted obesity was a problem within her COGIC community, and she admitted to having a weight problem. Therefore, she worked hard to eliminate the weight through diet and exercise, but knee problems that developed thwarted her efforts. Consequently, Livia believes there should be a speedy cure for those testing positive for diabetes with weight being the only physical evidence that a problem exists. For this reason, Livia states in paragraph 58:

> 65 pounds and I felt real good about myself and these years went on and you
> know, the weight came back up. So, it's just kind of disheartening because
> everybody say do this and do that and it's not like I don't want to, but if I'm in
> pain, then to me it's not an option and I just feel like I should have a quick fix, do
> you know what I mean?

The prompting to lose weight came from her doctors. In paragraph 58, she said of them, "Well, lose weight, lose weight, I hear that 24/7 and you know, get my eating under control, about eating the right things." However, one of the things that added to her problems was the socialization during and after events at the church. In paragraph 109 she said, "Church folks like to eat. We like to eat and especially if you go to a service, like a conventional whatever, I don't care what time of night you get out, you going to eat something." The reason for not curtailing the eating when a problem exists extends from the fact that it did not immediately worsen the effects of DM. She said in paragraph 149, "because we feel good or whatever, we just keep doing what we're doing, we just keep

eating and keep eating the sweets and keep eating because we don't feel anything."

Celebratory eating is a common and predictable attitude considering the ethnic

background related to the uncertainty of life. In other words, prejudice and poverty

threatened their parents and their early childhood in the South. As a result, they

celebrated with immediate gratification of community feasts, and it has become a way of

living.

Carlos

Carlos is a middle aged African-American male with a lifelong membership in the

Church of God in Christ (COGIC) denomination. His family also traces their heritage

back to the church founder and the formation of the COGIC church. He and his family

are active church leaders locally, within their state, and nationally. Carlos' diagnoses of

DM came after many years of warning. When he was younger, the doctors informed him

that based upon his family history he was a good candidate for DM. Carlos stated in

paragraph 10:

> Well, with me, my doctor, every year I take a physical. I've been doing that
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> since…I kept that going and then the jobs I've had somewhat demanded that you
>
> take a physical, so I've always done that. And every year, the doctor would ask
>
> me about my family and I would answer questionnaires, what have you and when
>
> I let them know that my two brothers at that time had it and pretty much, the
>
> doctor would always tell me, at some point, you probably going to contract it as
>
> well.
>
> In paragraph 12 Carlos continued:

So, that would always be in the back of my mind, but at the time, I was kind of

young. You know, I was kind of young, so I'm like, yeah, sure, you know. He

would always say; you're alright, watch it a little bit, though that number is up a

little bit high, but you're fine. So every year I went like that.

Each year it seemed that Carlos inched closer to the predicted status of DM. It

seemed that regardless the warnings to watch his weight and maintain a healthy diet,

Carlos drifted toward self-fulfilled prophecy. Not until paragraph 201, did Carlos reveal

that feeling, saying, "So he wasn't a cheerleader, pretty much prophesied that one day, of

course, he was right." Carlos needed help but received negative predictions instead.

Those in the COGIC denomination are people of faith and sensitive to predictions, which

they consciously or unconsciously translate into prophecy from trustworthy individuals.

Carlos' innocuous "always be in the back of my mind" statement in paragraph 12 is

significant. Although COGIC members are not ignorant or naïve, they have a high

capacity to tolerate those in authority. Often quoted is the Biblical passage that says,

"Touch not my anointed and do not my prophet harm." Furthermore, from the church's

origin those proclaiming to be working on behalf of God have precedence over

educational status. Carlos reveals this reverence to doctors concerning diabetes in

paragraph 170:

Faith is one thing, but God, you know, he made doctors for a reason. We're made

in the image of God. God is creative and so; a part of God is in us and so, I mean,

look at man. Look at all the great things man has done.

It is notable that Carlos contrasts his faith with the doctor's diagnosis. Therefore, in his estimate, doctors command the same respect as church authorities, each being part of God's creation.

In paragraph 12 above, Carlos mentioned another significant factor that affected his decisions following the general warning about the possibility of DM, "youth." Youth was also a factor with Nick, the final participant, which connects him to Carlos. However, in Carlos' case, youth led to a cursory acknowledgement of the possibility without action. Therefore, a general warning left room for Carlos to interpret or make a decision on the best course of action that invariably resulted in only slight dietary modifications. Atypically, Carlos did not like sweets; his ancestral heritage was the desire for meat and potatoes instead. In paragraph 20 he states, "Well, sweets and stuff never bothered me, but when you start talking about starches and potatoes, you know, I grew up on that, so I give up your drink as a habit, but I can't give up potatoes. I grew up with that stuff, so." Like every participant except Arianna, Carlos admitted that the weight was a contributing factor to DM. Moreover, he admitted that his continual weight gain mirrored the advancement of his condition towards DM.

Carlos' mantra concerning DM is "FEAR." Not until the doctor mentioned that he had diabetes did his attitude change from inactivity to fixing the problem. The initiating factor was fear as stated in paragraph 173:

My doctor's encouraged me. He tell me I got diabetes that's encouragement. That's what motivates me, the fear of having diabetes motivates me. People are different; they may need a coach, somebody to motivate them, but I don't need it.

I need the fear. I'm a Pentecostal boy. I initially got saved because of fire

insurance.

During the interview, Carlos reveals the source of that evoked within him when

the doctor announced that he had DM. He reflected upon ancestors who died of type 2

diabetes mellitus. Carlos reflected upon the Pentecostal origins of the COGIC

denomination style of preaching during his childhood rearing. Outsiders call these "Fire

and Brimstone" messages. COGIC preachers are notorious for preaching that one must

come to a believing faith in Jesus Christ, or they will spend eternity in hell where there

are only fire and brimstone that produces weeping and gnashing of teeth. This message

was to everyone, children included. Even today COGIC do not believe in "children's

church," where the message is toned down. These words produce powerful incentives for

youth to live a righteous life and avoid all the trappings that could lead to death.

Therefore, children understand there are only one of two choices, right or wrong. Right

may be called "do not's." DO NOT: curse, lie, steal, cheat, dance, go to clubs, smoke

cigarettes, drink alcohol, or commit immoral acts. And, God forbid overt sins, such as

rape and murder. Wrong is just the opposite. As a result, these are common characteristic

beliefs of any COGIC member. Ironically, this preaching has the same effect as Orthodox

Muslims preaching has on its youth. However, notice Carlos said he "initially" converted

to Christendom because of "fire insurance." Although the fear drove him to obedience,

but Biblical scholarship keeps him obedient. Therefore, Carlos' so-called "Fear Factor"

motivated him to change his health habits and eliminate the threats of DM, and listed the

loss of limbs, eyesight and kidney failure as the factors.

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However, earlier Carlos also identified another type of fear, that is, the lack of diabetes education. In paragraph 150, Carlos states:

So our pastor has allowed, since we have healthcare professionals here in the church and as a matter of fact his daughter is one and so he's allowed different ones to come in and kind of educate the people and that's all it is, is we need education because where there is a lack of education, there's going to be fear.

In other words, he believed that through education, fear could motivate those threatened with DM into preventive or better management of the disease. He also identifies another authority figure prominent in the diabetes education and management formula. That is, those in leadership positions, especially pastors, whom parishioners look to for guidance. Unfortunately, it took the death of the pastors' wife for him to start addressing health issues of other church members. Fortunately, through his wisdom and care for the members he allows the church to have one health awareness session per month to address health issues of the members.

Nick

Nick is also a middle aged African-American male with a lifelong membership in the Church of God in Christ (COGIC) denomination. Like others, his family also traces their heritage back to the church founder and the formation of the COGIC church. Nick is a zealous and talented church member and celebrated leader. However, Nick's story is the most different of all participants. Unlike others, his development of DM came at the relatively early age of 37 years old. Unlike the other participants, Nick developed preconditions that forced him to seek medical help.

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Ironically, on-the-job benefits may have triggered the onset of diabetes. In paragraph 16 he stated, "I would go to the 7-11 we could drink all drinks for free." Over time, as stated in paragraph 4, Nick said, "I started experiencing some things going on with me I felt wasn't right. I was urinating a lot at night." As a result, he attempted to quench his thirst by drinking his favorite orange flavored Slurpee's, which created a vicious cycle of drinking and urinating. Finally, he stated in paragraph 6:

> Excessively thirsty throughout the day. And very, after sleeping at night, waking up several times to urinate. While I was at work, I was finding myself falling asleep. Couldn't stay awake. That went on for some time, and I knew something was going on with me. I went to the doctor and told me I was a diabetic and my blood sugar was like 500.

Excessive thirst and urination are classic symptoms of the two types of diabetes, insipidus, and mellitus (see Chapter 2). Excessive sleepiness is also another common symptom of DM. The 500 mg/dL glucose reading is dangerously close to resulting in a coma. Prior to seeking help from his doctor, in paragraph 22 Nick stated:

> I would drink one and a couple hours later I was so thirsty again, go back and drink another one. I was like I can't stay awake. Sometimes I have to go park somewhere I know no one's at just to try to take a nap. Try to wake up and pretty much the same thing again. Then in church, I started noticing when I really, man this is wrong, something wrong. I would see people's silhouette, but I couldn't see their mouth moving or their eyes, it affected my vision.

The final straw seemed to have been his blurred vision while at the COGIC church that finally sent him to the hospital. Eye problems are also classic symptoms of

DM, which could result from stress, as with my mother or elevated glucose (sugar), as with Nick. As a result, Nick's doctor insisted that she give him an insulin shot to bring down the glucose reading.

Interestingly and significantly, despite all the symptoms, Nick delayed going to the doctor because he compared his condition to his dad. He stated in paragraph 28:

> Yes, and that's what made me really go to the doctor. I thought I could tolerate the peeing and sleeping but after it got to where I couldn't see, I had to have a doctor check on me 'cause some symptoms I didn't experience. My dad was a Type-2 Diabetic. And I remember used to say he smelled fruit, and I had never, I don't smell that. And I got afraid when I couldn't see far. They brought it down. They put me on Glucophage.

Like with Carlos, fear was the determining factor that overrode all of Nick's inhibitions to see his doctor. Only Nick lived in denial, but he based his decision on his knowledge about diabetes, which he suspected, but did not have what he deemed as the essential symptoms experienced by his dad with DM. The fruity smell of urine is another classic experience by those with uncontrolled diabetes.

This fruity smell is the smell of ketones that results from the body utilizing lipids or fat as an energy source. All body cells, especially the brain, need glucose (sugar) for energy. If cells in the human body do not receive the energy needed to function, as in the case of DM, the body will convert fat into glucose. This conversion will result in the production of ketones as a metabolic byproduct and disposed of through urination. In reality, patients with DM, like Nick, have enough glucose, they do not have the insulin that instructs the cells to open and let the glucose enter. The cell does not know it, so the

nervous system thinks it is starving and utilizes the fat that is available to produce the sugar it must have. However, increased ketones can lead to the body becoming too acidic, called acidosis, which can also kill those with DM.

Unlike Carlos, fear did not force Nick to take the necessary steps to manage DM properly. Other obstacles arose as seen in paragraph 30:

Which is known as metformin also. When I first taking that, it got sick to my stomach; I got sick to my stomach. But uh, I got passed it, but I still eat...I didn't still cut out things I shouldn't eat. It controlled it for a period of time. Then I got worse 'cause I feel like I'm invincible, I can live with this stuff. It ain't affecting me like that. So I continued to eat some things I knew I shouldn't have been.

Nick is not living in denial, as with Carlo, who lived in imminent danger of DM. Nick's youth seems to make him feel he could manage DM with a pill. In reality, he admitted that he made his decisions based upon his desire for sweets. In paragraph 30, Nick only mentioned one problem with DM medicine, but later he, like the other participants, expressed other reasons to avoid taking it. It took two years (age 39) before Nick finally had enough of the medication.

Therefore, it took both time and youth to create a desire to eliminate DM and not merely manage it. He began by mastering balanced dieting, exercising, and living with the disease. However, this mastering took place in stages over time. He began by exercising. When asked how he knew to calisthenics, he based it upon common knowledge that exercise is what we need, but admitted his that doctor tried to teach him. In paragraph 48, he said, "She tried to teach me but you know being young like I was, it was really going in one ear, out the other." His doctor was an African-American who also

sent him to a dietitian, but Nick was determined to do things his way. By his admittance, the doctor did all the right things, but in paragraph 52 he attributed the problem to him being, "Young and felt like I could do what I want." However, at some point Nick grew weary of taking the medication and decided he would stop taking it. He did so by finally modifying his diet to exclude sugar.

Over the course of time, by eliminating the sugar, exercising, monitoring his glucose readings, and without taking the medication, things were good for three years. His diet came from one recommended by his brother of eating certain foods (non-sweets) six times a day. It worked so well that his glucose was consistently average that he reduced check-in to one per month, and finally he stopped monitoring his glucose altogether. However, after three years, he reverted to his old habits of eating sweets, and the symptoms of diabetes returned.

Nick had a new job and his new doctor, a White male, put him back on Glucophage and added an additional medication called Actos. Nick knew the doctor from an injury the doctor repaired some years ago. While in the hospital, Nick heard the doctor's name mentioned several times over the intercom and decided he must be a good doctor because of his popularity.

Nevertheless, he became alarmed at the weight gain and did research on the medication via the Internet. He discovered the new medication Actos would cause weight gain and stopped taking it. As a result, he lost the weight. The doctor decided to try some natural means of controlling the diabetes, which he suggested to Nick. The doctor also mentions that Nick had developed high cholesterol, which alarmed Nick more than his

physician. Nick had learned to educate himself about his health. Therefore, in paragraph 123 he said:

> Red yeast rice, something natural you can take that should help you lower it. So I started taking that but when I walked out of his office, I was like cholesterol. I didn't know much about it but sounds like I'd been eating too much fatty foods.

Nick had learned to counter negative laboratory results by doing the thing that would make those reports positive. Nick said in paragraph 125, "So I decided well I am gonna do something different. I'm going to cut out beef and pork and stick with chicken, fish, and turkey." As a result, Nick stated in paragraph 127:

> So that was nine years ago this past March. So I quit eating beef and pork. I went back three months later, and I had also stopped taking the red yeast rice he put me on. And I went back to him three months later to do blood work, and he looked at me and said what're you doing? I said what're you talking about? He said if I would ask 100 people their cholesterol levels, I would doubt one would be better than yours.

Although Nick became self-educated about controlling his cholesterol levels, he did not control his sugar intake through the same educational means. In fact, Nick completely relapsed into the same detrimental habits of increased sugar intake, and not monitoring glucose levels, which resulted in worse medical conditions than before. Now middle-aged, Nick had the same excuse as he did when he was younger; that is, he thought he was invincible. As a result, his friendly doctor gave him more medication, for a total of three, including insulin. This doctor retired and the White female doctor that replaced him looked at Nick's results and said in paragraph 55:

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Oh my god! She said you're a candidate for a heart attack or stroke. The A1c is

13. And she looked at me, she said, you gotta do insulin. I want you to make an

appointment with endocrinologist.

It took these frightening statements to get Nick's attention and him reflecting on

his dad dying at the age of 63 from diabetes complication. He said in paragraph 183:

My oldest brother is on insulin, and he's about four years and a couple months

older than me. And I'm looking like my older brother's health is worse as my

dad's was when he was his age."

Finally, fear drove Nick to change in his dietary habits from eating sweets. He also states

in paragraph 201:

I was like I'm going to change my diet. When I go there [to the endocrinologist],

these numbers are going to change. So I went to the organics section looking at

some things I can start eating, and there was a white lady that was there and she

picked up, she said, "have you ever tried this stuff?" I said, what is it? She said

agave nectar. I said no, what is it for? She said I substitute it for sugar.

Nick purportedly utilizes this sugar substitute and eats what he researched and

found to be friendly fruit, and the doctor recommended complex carbs. With these

changes, Nick is finally seeing expected results and reducing the medications. He states

in lines 265-267:

So I started eating oatmeal with blueberries, friendly fruit, adding it in there. I

would put a tablespoon of this and make it a little sweeter. So my next

appointment with her was in April. I went to see her in April, and she did blood

work and got it back, and she almost jumped out of her chair. I'm so happy for

you. You lost 27 pounds, and your A1c is 6.

Nick is currently in this status, and he serves as a mentor in the community and

especially his family. Nick is also suffering from a crippling bone-to-bone contact in his

knees that prevents him from exercising, so his control of diabetes is strictly dietary. He

continues to search for remedies to alleviate the pain in his knees, but manages DM

despite this problem through regimented diet.

Part I: Emergent Categories

The emergent categories are an expansion upon the symbolic interactions in

chapter 3 (Figure 8) that introduced the contexts as the progenitors of chaotic processes.

In so doing, concepts emerge replete with examples given by the most salient actions,

interactions, and emotions of the participants with respect to DM. Some of these

examples appeared with the introduction of those interviewed. More of these examples

appear throughout the remainder of this chapter.

Symbolic interactionism identified the context leading to the chaotic nature of

processes of the African-American COGIC participants with DM whose knowledge-

based decisions were matters of living and dying. However, in the chaos, five categories

emerged that capture the results of these actions, interactions, and emotions. Although the

five categories emerged in a non-linear chaotic manner, each has a ranking with a bias

towards living or dying. On the other hand, these five categories tend not to be stable and

tumble or ascend into another category with a certain degree of predictability based upon

further action, interactions, and emotions that extend from circumstances, events, or

situations that first landed the participants into a category. Based upon the interviews, the

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processes of living and dying are psychosocial (Dewey, 1982) in nature and link to the participants' faith, knowledge, and social constructs.

Fear

Fear emerged as the dominant category that provokes action toward resolving the myriad problems with DM in COGIC members. However, fear does not always result in positive actions or any action at all. Nevertheless, fear is a major factor that is diverse and complex. Therefore, it necessitated several diagrams to evaluate its impact on the axis of living and dying.

Catalyst

In one scenario, fear acts as a catalyst resulting in one of the two reactions depending on the context leading to the participants' perception or interpretation as seen in Figure 12. Initially, some participants were not concerned over the news of DM because of desensitization that extended from anesthetizing historical conditioning or personal struggles. For example, in paragraph 209, Carlos states, "It seems like we don't get serious about something until they tell you, you could die from it or something." His conclusion about COGIC members is a reflection of both the church's heritage and the ethnic plight of African-Americans living in the South. Chapter 1 discusses the history of both and explains the necessity of a greater fear to disorient the catatonic response to lesser threats, including DM. In other words, the participants can only respond to a limited number of problems, and only immediate threats to living resulting from the adverse effects of DM, provide motivation to change. This lack of motivation is the frustration Livia expressed of her husband in paragraph 62. She said, "my husband just,

he won't take his blood sugar, and his blood sugar will be 300…it just irks me when it gets too high. Then he'll take it."

In addition, participants revealed that current struggles with problems have the same anesthetizing effects on the response from those with DM in the COGIC church. For example, Arianna states in paragraph 44, "Now, actuality, as far as going to my primary physician, it's been awhile since I've seen him because I came up with the issue…where I had cancer." Overwhelmed, Arianna focused on her most immediate concern with cancer and disregarded DM altogether. Other participants to a lesser degree had similar responses when overwhelmed with problems. Livia stated in paragraph 50, "but because I'm bone to bone with my knee, and everybody said, well you should exercise, but when you're hurting every day, that's really not an option. So, I know I need to; I probably should force myself." Livia states that she does not exercise because of her debilitating knee problems. However, she also admitted that she was capable of doing more. Ultimately, Livia, like Arianna, focused on the more pressing problem, her knees, and to a lesser degree on her DM.

Regardless the reason for the desensitization, it took the perception of frighten news to move the participants from lethargy to a decision concerning DM. However, as a catalyst, fear, evoked one of the two actions taken by the COGIC members with DM, each depended on perceptions. As previously noted, only the announcement of DM struck the fear necessary for Carlos to change by dieting and exercising. On the other hand, Nick, had all the classic symptoms of DM due to uncontrolled diabetes. However, he did not reach the status of fear until his doctor said he was a candidate for a heart attack or a stroke.

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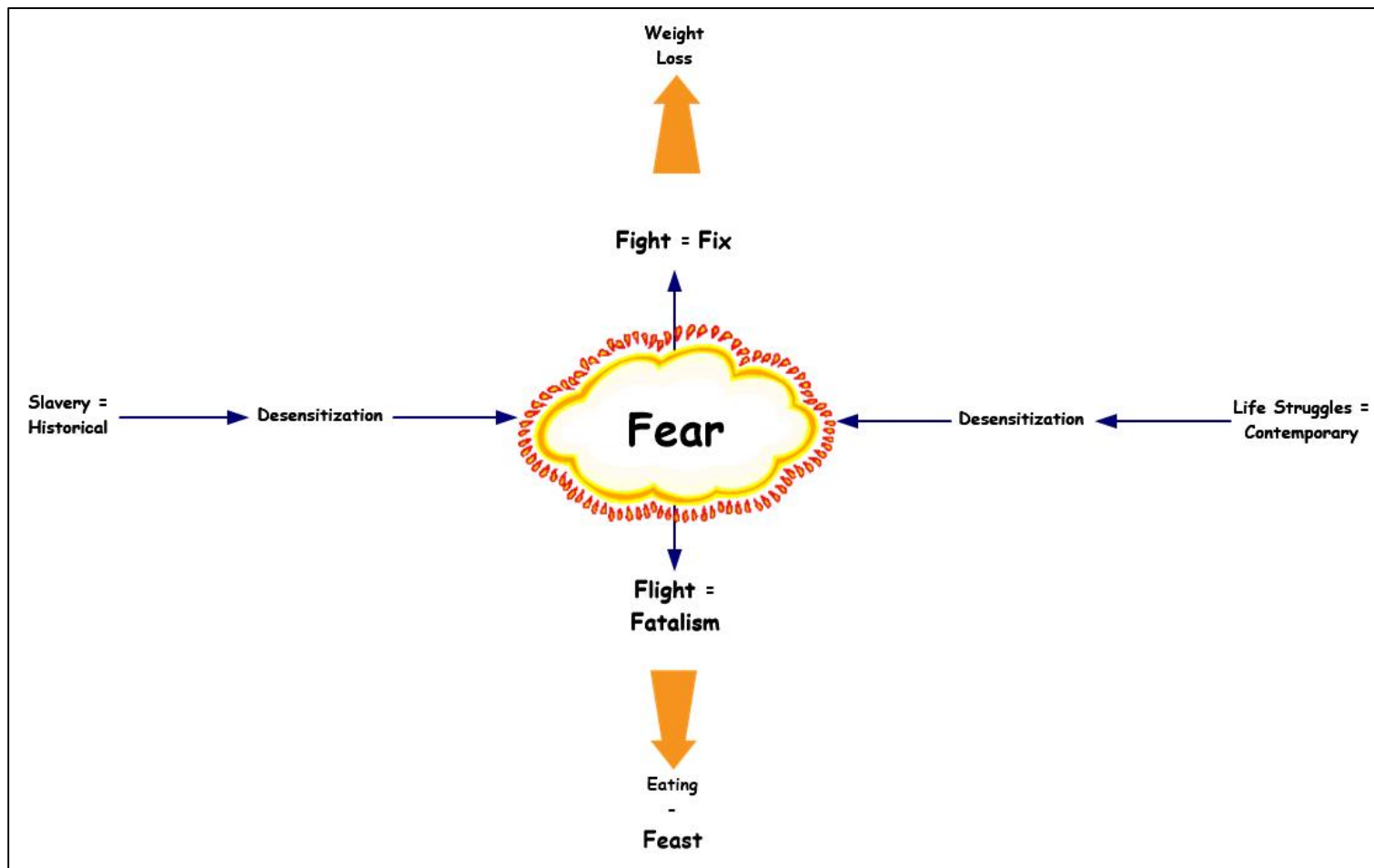
Figure 12. FEAR - The Catalyst.

In both cases, when the fight or flight responses arose from enough fear, both chose to fight by fixing the problem. The participants gave other examples of those in the COGIC with DM who chose the flight option of fatalism by continuing to eat foods detrimental to their health. The best example comes from Livia's dad. About him she said, "My dad got out of the hospital; he said God had gave him all the years that he promised. He was going to eat what he wanted, and he did just that." Nick had a similar experience with his dad. He said, "Yeah, he'd get out of the hospital, continuing to eat like he was, he'd revert back to what he was doing, he's back on insulin, back on pills and ultimately it took him out."

Factors

The participants mentioned, or had experience with, factors that evoked fear enough to make final decisions concerning their status that resulted in the catalytic reaction of fixes or fatalism, see Figure 13. Carlos said, "You can lose your limbs, lose your eyesight and kidney damage." Concerning a DM medication, Nick said it "Could cause weight gain." Similarly, Glenn said, "I've heard that medicine would mess you up if you be on it long, so that's why I want to get off of it if you can, you know, but I could do what I want to do what I can to get off of it." In each case, the impending threat produced sufficient fear in the participants to attempt to fix the problem. However, fear did not always translate into solving the problem as seen in the next section.
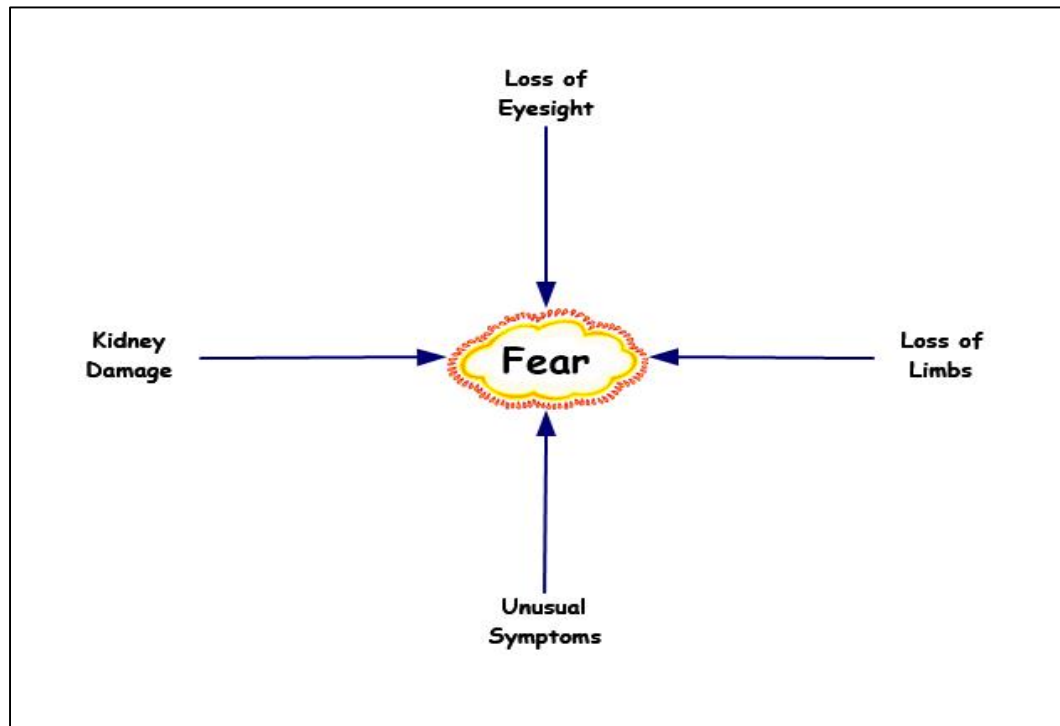
Figure 13. Fear Factors.

Affectivity

Although the fear factors previously mentioned had a predictable reaction of solving or fixing the problem, there were certain factors that had the opposite effect, as seen in Figure 14. Once understood, these impacts also have a certain degree of predictability. An essential ingredient was whether the participant felt like their object of the fear provided a reason to hope for improvement. The occasions mentioned in the previous "Factors" section came with avenues to escape the dreaded conditions. In other words, the causation of fear came with hope, despite the shock, and the participant would attempt to fix the problem. However, when overwhelmed a fatalistic sense of

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hopelessness developed. For example, in paragraph 150, Carlos gave a scenario containing COGIC African-Americans' perception of hopelessness when he said:

Figure 14. FEAR Affectivity.

You know, we burying them too early, so this is one of the ways we do it here at this church is periodically, like my wife happened to be over what we call…and she's had hospice directors that have came in and talked 'cause it's taboo in the black community, hospice is death and not realizing that these people can help you.

The obvious conclusion is that COGIC African-Americans with DM think that visits from hospice are a sign that death is soon to follow. This demarcation is a signal to prepare mentally for the inevitable death. This would likely explain the thoughts of my mother-in-law, who died within a year after hospice visitations began. This mental preparation was the idea of Livia concerning her dad in paragraph 167 saying, "God had gave him all the years that he promised. He was going to eat what he wanted, and he did just that." Her dad, a COGIC member with DM, took a fatalistic view because of his age.

This case gives another factor, age that caused these with DM to take a fatalistic course concerning health care. For example, when Livia talked of her dad's decision, she

spoke in a tone of voice that suggested an admiration for some noble act. In fact, this sense of nobility in choosing an avenue of defiance or escape, increased as the participants aged. In paragraph 113, Livia discloses her feeling that many diseases experienced in her church in the elderly population, including diabetes, extend from exaggerated claims from the medical profession. She stated:

> And it's just to me, just from growing up in this church, I seen more—and this is back when my mom was probably my age, I seen more diabetes now than I've ever seen in my life. I didn't see this when I was a little girl running around in the church and my mom was my age. You didn't see, I see more sickness now than I've ever seen in my life. And if it ain't diabetes, it's still all connected with—it really comes together, the hypertension, the diabetes, the sleep apnea and you have a stroke, heart disease, it's just all in there.

Livia followed this statement in paragraph 115 and stated, "They keep lowering the blood sugar levels. So if they keep lowering the blood sugar levels, everybody in this world going to be a diabetic." Therefore, her defiance is an act of faith or belief that DM and other diseases are the results of the medical community having ulterior motives for declaring that elderly people have these diseases. In other words, even though Livia is part of the medical community, she does not trust everything the medical community has to say, especially to the elderly.

Another ingredient that results in fatalism is simply an urge to continue eating familiar enjoyable foods when the symptoms of DM are not approaching death. Livia's husband is a typical example, she said in paragraph 64, "trying to be the perfect wife or whatever and you can see the disgust on his face, no fried chicken, do you know what I

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mean?" As stated earlier, Nick also exhibited this type of defiance up to the point of his doctor declaring he was a candidate for a heart attack or stroke. In Nick's case, youth and a sense of invincibility led to fatalism. In summary, fear factors leads to fixes, but the feeling of hopelessness, age, distrust, and a desire for comfort foods led to fatalistic views.

Social Constructs and Knowledge

Mentors. Mentors played a vital role in the decision-making processes of managing DM within the COGIC members' community. Those decisions resulted in three categories, Fix, Faith, or Fatalism. As seen in Figure 15, participants chose to listen to those within their social constructs who shared in their experience or who had encounters with DM. They used them as models, or as an assist in living with the condition. The first persons given the social status of respect based on their knowledge or experience with DM were the ancestors of the participants.

Ancestors. In Glenn's case, his experience with DM began as a child as he stated in paragraph 266. "Grandmother gets shot, shooting herself in the thigh, and I didn't know what it was all about, you know what I'm saying?" In paragraph 182, Carlos presented several ancestral models of learning:

He was probably old enough to be her daddy, but she died in her early 60s because she was overweight and so to me, that could have been prevented. My dad was active. I had an uncle; he died in his early 60s, overweight. Him and my dad had similar jobs. They both came from…to…as migrant workers. My dad was older than he was, but then they got a job at the…and they started out as janitors, both of them, both of them being janitors. My dad became a diesel

mechanic and then I think he became an electrician. And so, they went from

working hard, to hardly working at all, but when my dad comes home, always in

the garden. After I get home from school, I hurry up and get out of the house,

before he got home, or I'm going to be working. But then when my uncle come

home, get on the TV or get on the couch watching TV, "man ain't doing nothing."

I got real life examples here. [Emphasis added] My dad kept active, and he died

when he was 85. Couch potato, he dies when he is 63.

Even as I reflect upon my mother's encounter with DM, so did all but one of the

responders refer or make comparisons to their parents. Glenn stated in paragraph 222, "I

seen it with my grandmother and some others and stuff, they're talking about oh, if you

get your foot cut, don't get your foot cut if you have diabetes." Livia in paragraph 167,

"It makes me wonder 'cause like my dad was diagnosed at 70-something years old as a

diabetic." Carlos in paragraph 177 and 182, "My dad's aunt…she was a diabetic, and she

was overweight and my dad, on the other hand, he always stayed busy." Finally, in

paragraph 181, Nick stated, "I saw my dad die from complications of diabetes." As a

reminder, this connection to the past relates to Chapter 2s discussion of the COGIC

beginning and the post-reconstruction establishment of African-American subcultures.

Family. Closely related to the ancestors were family members with DM who

influence the decisions of the participants. These family members consisted of the

participant's spouse and siblings. Although most of these have DM, all of them served as

mentors in the participants' decisions concerning the disease.

Spouse. Already mentioned are Livia's concerns, frustration, and admiration of her husband who also suffers from type 2 diabetes mellitus. She also revealed her husband's dependence upon her for his meals. This kind of dependency was a common theme among men with DM. Somehow the expression of love and respect for one another came through the meals prepared by the wife and enjoyed by the husband. Livia stated of her dad in paragraph 167, "he said God had gave him all the years that he promised. He was going to eat what he wanted, and he did just that." Carlos dependent upon his non-diabetic wife's empathy in managing DM and stated in paragraph 54:

> I'm not turning it down, so she was part of the problem, so now I've got to change her. My thing was again; I wasn't going to the dietitian or anything like that. I just said, well what I want to do is, during the week, I just want to eat vegetables and then I eat meat or what have you and I said on the weekend, I eat my starches and that's how I did it."

Although Carlos realized his wife's meals were detrimental to his health, he continued to eat them. He displayed his dependence upon her to help manage his DM by altering the preparation of their meals. Livia expresses this recognition of her husband's dependence upon her by stating in paragraph 85, "And my sweet stuff…I don't make a habit of doing that because of my husband, more so than me. I worry more so about him." Livia specifically identifies the hindrance to change as the foods they ate. She stated in paragraph 153:
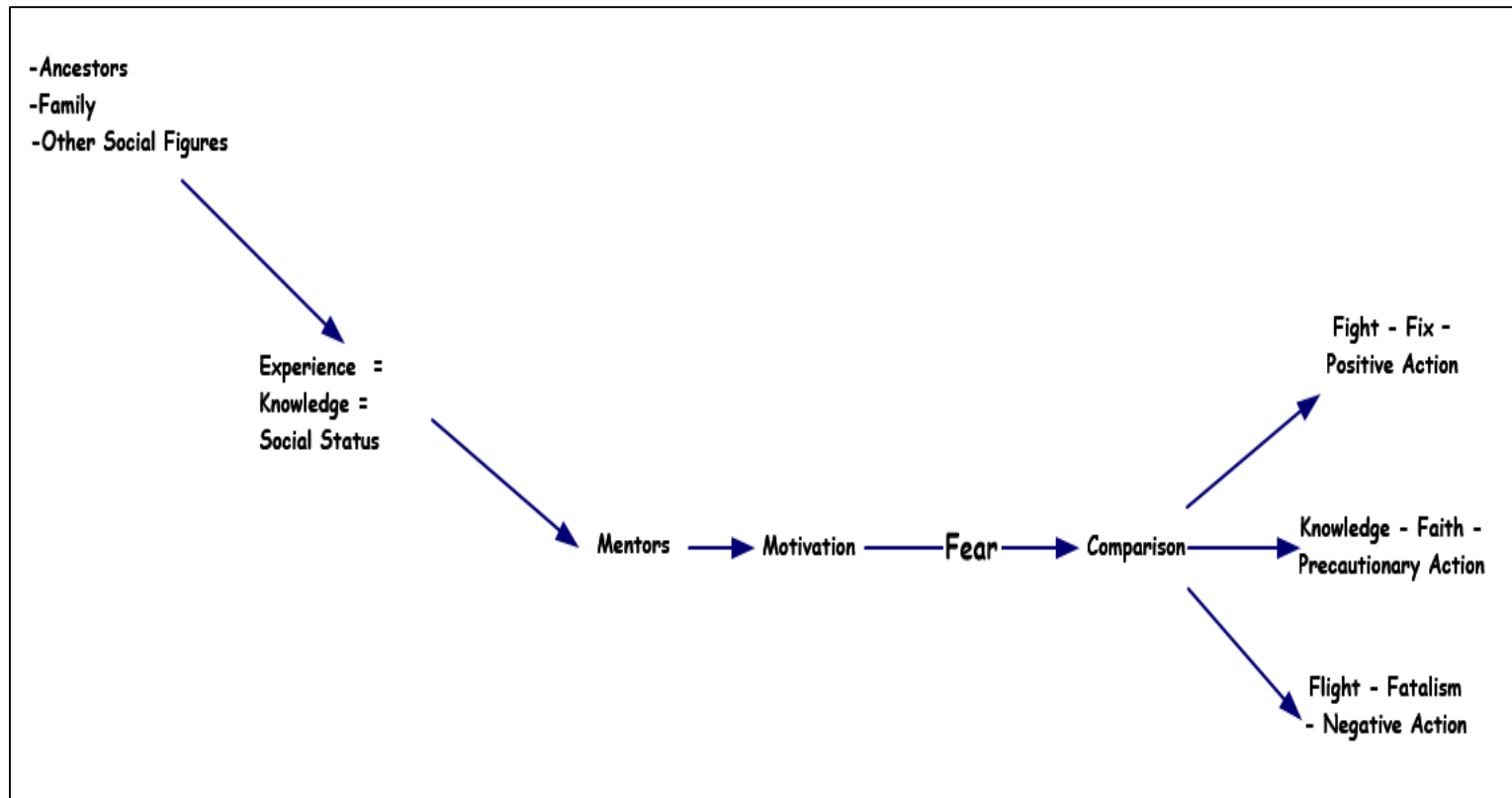
Figure 15. Afro-Theistic Change Agents.

I know after Tuesday night, we had the thing on diabetes and then, so I went back

and told my husband how good the—I call it the little seminar, was. And I really

wish he had been here, and I said, okay, I made up my mind, you will not get

bacon or sausage or grits or eggs this morning.

The meals eaten together by husband and wife are clearly expressions of love for one

another, which relates changing to divorcing one another. However, Livia's attendance at

a DM support group session expressed the need for both spouses in the COGIC

community to attend and the motivation it gives to make changes without threatening that

relationship.

Siblings. In paragraph 350, Nick mentioned several family members that he used

as examples in his decision-making processes concerning DM.

I've seen it in my family; I've seen it with me, and I've seen where if you get

control of it, you can turn some things around. If you're way too late, I'm not

sure you can turn it around. If you look at my brother and his condition…I went

to see him a couple weeks ago and literally his feet; they look like a football.

Livia in paragraph 32 stated:

I just felt like, my two brothers, they was diagnosed first and then my sister was

diagnosed and I would get on her and get on her and I'm like, because I was fine,

just like sleep apnea, I was diagnosed with sleep apnea and I'm like, I don't have

it. It's not going to happen to me, but next thing you know, they say I have sleep

apnea and I have diabetes and—but, you know, even with that, like I said, I never

had a low reaction. I know what a low reaction is 'cause my husband is a diabetic,

one of the worst kind and so they put me on Metformin. They said 1,000

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milligrams and I told them at that time; I said I'm not taking that, not taking

1,000. I said I'll take 500, so that's pretty much what I've been taking.

In paragraph 184, Carlos stated, "I knew my two brothers had it, but I got a sister and

she's real secretive, she don't tell her business, but she want to know all your business

and come to find out, she had it." These individuals use their siblings as an example to

motivate each other as seen in the next example. In paragraph 309 through 311, Nick

stated, "And the whole while my dad would say you're digging your grave one fork at a

time. He would say that about himself. And that's what he did. I shared that with my

brother and sister now."

Other social figures. Responders also used athletes, pastors, doctors, and church

members in the decision-making process concerning diabetes management. For example,

Carlos developed a dietary plan that worked for him based upon an athlete he heard on

television and used him as a mentor. In paragraph 54 through 58, Carlos states:

I cut that out, and I start drinking a lot of water…I got this from just watching TV,

when Shaquille O'Neal lost all that weight…He had said, when they ask him how

he lost the weight, he say he started eating more, so that got my attention…I want

that, this will work for me and what he was saying, your body is like a car and

you got to keep gas in the car and what we do and this is what I was guilty of.

Okay, I might eat breakfast and I can eat nothing till lunch, so I'm getting hungry,

so at lunch you eat more than you should and then when you eat lunch, by the

time you get home, dinner you have ate nothing between lunch and dinner. You

get home and again, you pig out some more and that end up hurting you and what

you're supposed to do, eat some snacks in between and so you never get hungry.

So, what I start doing there, I would take some fruit or whatever, I eat my

breakfast before I leave. Maybe 2 or 3 hours later, I get me some fruit and lunch

time come, in between lunch and dinner, get me some more—you know,

something, nothing with sugar, nothing like that, something just to keep me from

being hungry and then at night, same thing, fruit or something and I did that.

The participants also listen to, and trust, their pastor to a degree in matters

concerning their health. In paragraph 134, Glenn stated I listen to the church and listen to

the pastor and stuff." In paragraph 84, Arianna stated, "But like, when the pastor asked us

to fast not long ago, I didn't fast the full length of time he said, but I did fast some." In

paragraph 150, Carlos stated, "So our pastor has allowed, since we have healthcare

professionals here in the church and as a matter of fact his daughter is one and so he's

allowed different ones to come in and kind of educate the people…"

Finally, the participants listen to their doctors and other Christians who stressed

the need to make changes. For example, in paragraph 350, in continuation of Nick's

statement in the last section. He stated, "I heard Dr. Peter saying that diabetic medication,

when you start taking it; it starts affecting your organs, your body, your lungs, brain,

heart, kidneys… when I go back, [I want] for him to tell me get off it." Concerning

Christians, Carlos concluded that all should model healthy living. He stated in paragraph

78:

We as Christians, we need to be an example, we need to do the best, we need to

be the best we can be and so we don't make the name of Christ, where they say

well those Christians, you know, I don't want to be like that, I won't, you know

go in those workplaces or a place, be the best I can be.

Outcomes: Fix, Fatalism, or Faith

The participants used ancestors, family members, and others from their social constructs to make decisions concerning DM. These individuals provided experience that produced knowledge and gave them social status deemed worthy of the participants' attention. Therefore, these individuals served as mentors and provided motivation to make a decision. This motivation resulted from fear as discussed in previous sections. However, the results of the decisions were not unilateral or ubiquitous because the participants use mentors to make comparisons prior to selecting a course of action. In other words, the participants sometimes changed categories based on additional comparison and fears.

Fix. Through comparative measures, the participants made one of the three decisions concerning their DM. Although the fear of catastrophe was the primary reason COGIC members with DM chose the positive action of fixing the problem, their health was not always the main concern. For example, Nick stated in paragraph 193, "It made me change my life and my family, my son's, my wife, my granddaughter, hope that she doesn't. There's generations that are diabetic in my family." In other words, his motivation was reversing the effects and trends exhibited in his family now and in the future. Howbeit, most feared the ravaging effects of DM on their bodies as seen in previous examples. Presented earlier were cases where Carlos feared the adverse impact of diabetes on his body and even death that motivated him to diet and exercise to fix his problems with DM.

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Fatalism. In opposition to positive action, negative action or fatalism, resulted from comparisons, and a conclusion that the evidence refuted the notion of DM. The participants are not living in denial; rather they conduct an independent study and compare the results with their knowledge of DM. When the evidence did not match their concept of DM, the participants' decided to dismiss the doctors' claim and that decision became absolute. Seemingly, in defiance, they continued their usual dietary and exercise routine.

In Arianna's case, she seldom monitored her glucose, took the recommended medication dosages or read information about diabetes, because she did not believe she had diabetes. In paragraphs 40 and 42, she said, "Well, when I was checking it, the numbers always looking pretty good to me, so…I just stopped." Daily monitoring of blood glucose levels is the only certain way of knowing when diabetes is not under control, which leads to the severe complications of diabetes.

She goes on to say in paragraph 22, "Some people, I guess maybe it depends on whatever. I've never had symptoms that I know of, you know or anything." Here, Arianna admits that she made her decisions based on her knowledge of symptoms exhibited by diabetes sufferers. Likewise, Nick drew a similar conclusion in paragraph 28. He said, "And I remember [dad] used to say he smelled fruit and I had never [Nick demonstrates the action of sniffing that he did when he was peeing, and then said] I don't smell that." As a result, and similar to other incidences of fatalism exhibited by the participants, Nick dismissed the warning signs and continued without altering his diet and exercise routine.

Faith. The final response to comparisons made with mentors was faith based on participants who surmised that their health was equivalent to other individuals. As a result, and unlike the fatalistic approach, these individuals proceeded with caution and remained alert for more information or knowledge to make adjustments. Beliefs concerning the participants' status with DM was a factor for Fix and Fatalism. However, beliefs based on the participants knowledge of healthy individuals, and remaining alert to ideas, produced a different category, called Faith that resulted in precautionary action. The participants were not in denial, and in fact, they were willing to concede to having diabetes. The problem was the doctors' diagnosis did not match their perception of DM, based on their current knowledge of the disease and with comparisons made with their mentors. In paragraph 181, Livia stated, "I have a friend …she's not big at all…everybody can't be a diabetic…I just don't believe that." Livia's reasoned that should doctors' conclusion that her weight was the deciding factor; then why does her African-American friend have the same diagnosis. In other words, the doctor apparently left out some vital information to her understanding of DM. Furthermore, based on her knowledge of diabetes from a nursing background, the indicative numbers for diabetes are lower than in the past.

As a result, Livia exhibited disbelief and frustration with her diagnosis and did not take the recommended dosage of medication, based upon her knowledge of their adverse effects. Livia continued to learn in order to make the best decisions on how to proceed in managing her glucose readings. However, Livia had a limit to her inactivity based upon her fear of the worst-case scenario. She believed things could progress to the point of no return, which is a code for imminent death. She stated in paragraph 151, "Don't feel an

effect, you know, we're not using losing eyesight, we still can see, we still got our legs, so we feel like whatever, but then, when that sucker-punch hit us, then we may have a massive stroke that can't be reversed." Consequently, Livia admitted that regardless of her view of having DM, she took action to prevent the onset of a "sucker-punch" that she believed led to death.

Therefore, the participants' belief about their DM status based on a comparison to mentors resulted in positive action, negative action, or precautionary action. In each case, fear and knowledge were deciding factors in response to the diagnosis of diabetes. In summary, fear and disbeliefs concerning the participants' status with DM emerged as factors that produced the Fix and Fatalism categories. Whereas, faith based on knowledge of healthy individuals resulted in precautionary action by making comparisons to mentors.

Dualism: doctors or pastors. Doctors and pastors, as mentors in the social interactions of the participants, emerged as having significant roles that helped or hindered the participant decisions concerning diabetes management. Each contributed in differing ways to the participant's fixing or taking fatalistic approaches to the management of his or her DM. Albeit, the doctors' interactions with the participants, had the most direct impact on the decisions made towards diabetes management, while pastors had the most indirect effect.

The ultimate responses were polarized in the action of fixing the problem or for various reasons, taking a fatalistic approach that results in negative or no action towards' reducing the effects of DM. Along the way, Fear, Faith, and Frustration were also solidified as categories while surrendering and solutions emerged as processes. Although

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Figure 15 depicts linear processes, in reality, they were more complicated and only completely revealed when considering the entire social constructs of the participants concerning DM, as seen in the next Part II. In addition, the participants' knowledge of DM did not emerge as a category, but as an intricate part of their social constructs and interactions. Figure 16 depicts doctors and pastors interactions with the participants that produce one of the two results. Howbeit, the means of getting to each are fragile, complex, and sometimes involved the same individual.

Doctors. Two clear examples, as mentioned in Chapter 3 (see Figure 8), under symbolic interactionism, are the medical and church ministers, or doctors and pastors. Depending on the perception of the participants, either could cause a participant to fix or neglect their problems with DM. The participants viewed doctor's role in a similar manner as their pastor, as one sent from God. For example, Carlos stated in paragraph 170:

> We're made in the image of God. God is creative and so; a part of God is in us
> and so, I mean, look at man. Look at all the great things man has done. He's put
> these people [doctors] here for a reason and so, faith is one thing but man, don't
> be stupid. You know what I'm saying? Go see the doctor.

Carlos argues that COGIC individuals with diabetes should overcome their fear of the news from doctors and let them use their gifts of healing in managing DM. Thus, Carlos revealed his and COGIC members perception of the dual role of physicians. On the one hand, they feared the hegemonic announcement of doom. More accurately, participants viewed doctors' specific role as one holding a ministerial office similar to that of a prophet. COGIC members understand prophets in the Bible as those able to

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predict the future and give advice on avoiding pending doom. On the other hand, participants welcomed doctors in mentoring and a caring role of healing.

Carlos clearly states the felt hegemony and callous prophecy of doctors in paragraph 195 and 201, saying:

> My primary care physician, he wasn't too—what's the word I'm looking for? He really wasn't a good cheerleader because all the time he was telling me well, you going to get it…So he wasn't a cheerleader, pretty much prophesied that one day, of course, he was right.

Nick revealed the patronizing tone of his doctor in paragraph 147, stating, "He'd be like well your blood sugar went up a little bit, but I'm sure you'll bring it down. I was good with it." In both cases, the doctor minimized Carlos and Nick's concerns for their condition. The doctor lessened the participants' belief about the seriousness of their diabetes and served to frustrate their efforts against DM. This minimizing created a domino effect included surrendering to conditions as seen in their fatalistic lapse in dietary and exercise discipline. As expected, their diabetes worsened.
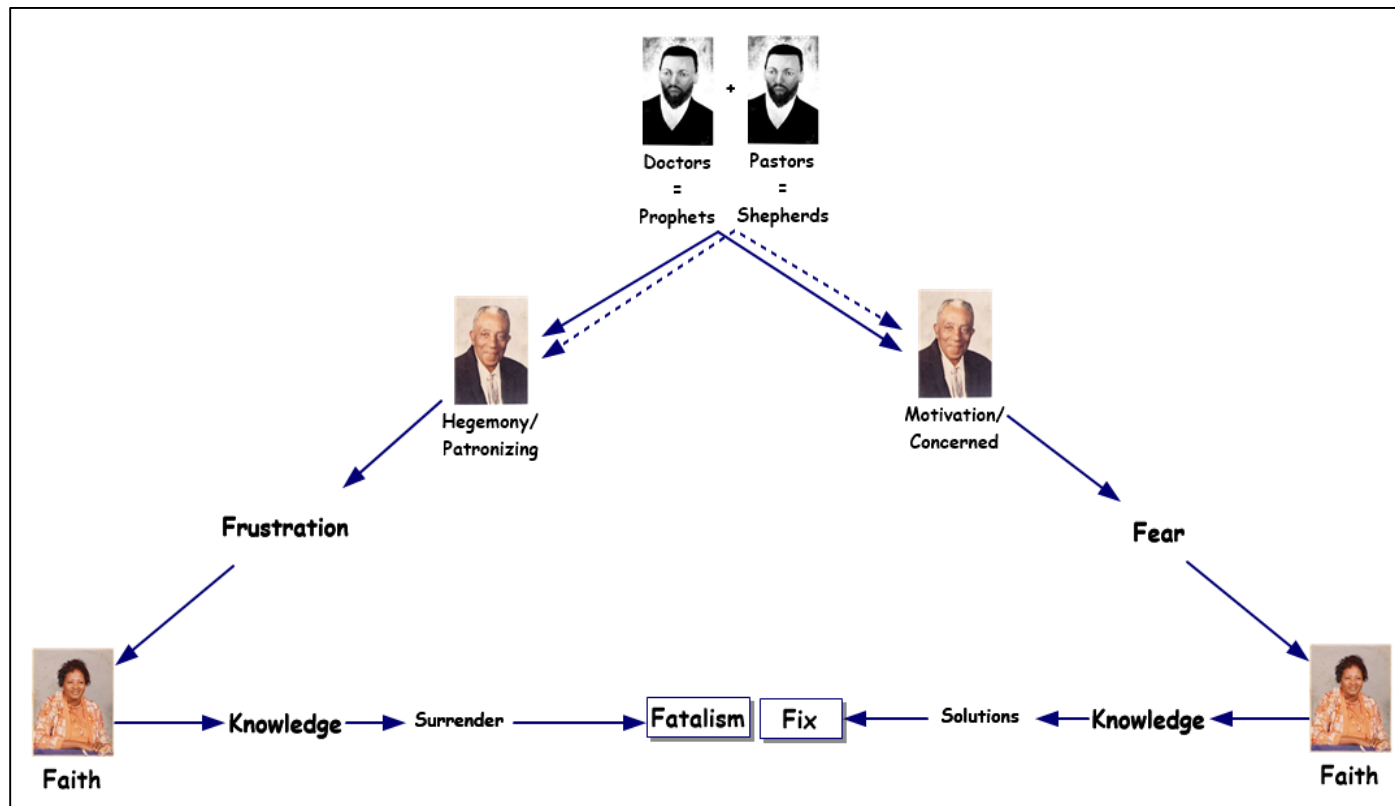
Figure 16. Dualistic Afro-Theistic Faith, Knowledge, and Social Constructs.

Conversely, the participants perceived doctors as mentors when they show them respect. In paragraph 240, Glenn expresses this felt respect to his new doctor when he stated:

But the doctor that I have now…he do set down and talk to me like you talking to me and had to tell him, man I sure appreciate you telling me that, but you know, the doctor that I had years before that, you know that doctor ...I tell you what the doctor I got now stayed in that room with me longer the first time, longer than my other doctor did, three to four years.

In paragraph 203, Carlos perceived his doctor's respect when he was forthright with "fear factors." He stated:

And again, especially with people who have grown up in Church of God and Christ, Holiness churches, a lot of times to me, probably the better motivation tactic is the fear factor. So, maybe they start showing people look, this is what can happen to you. You can lose your limbs, lose your eyesight and kidney damage 'cause I know when I was a kid, as a matter of fact, diabetes, that was a term that came later. In fact, when I was a kid, it was sugar. I'm like, that didn't sound too bad to me, sounds pretty sweet, you know what I'm saying? So it's no fear. Our culture, you know, I mean back then they preached fire and brimstone, it's fear factor.

In Nick's case, the fear factor came in paragraph 55, when his doctor said, "Oh my god! She said you're a candidate for a heart attack or stroke." Ironically, the fear factors are also prophetic, but the perception of the blunt messages was one of respect from a mentor or someone concerned about the participants' health. In a cascade, fear alerted the

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participants to the imminent danger from DM, and with this understanding, the participants work on solutions to fix their problems.

In addition, the participants were sensitive to hegemonic incidences that resembled prejudice. Glenn mentioned his perception of his first doctor in paragraph 244:

He wasn't only doing me like that, and I don't know whether, a lot of blacks I talked to he was turning them around real quick. My uncle was going to him, going to him regular, come to find out my uncle had emphysema…[his] sister…had told him…you need to change your doctor because that doctor ain't listening. Come to find out, my uncle had all kinds of diseases and stuff and died.

The disrespect Glenn felt from his doctor hindered his ability to manage his diabetes, not because he did not trust his doctor, and he did not, but because his doctor withheld vital information. Glenn continually asked questions during the interview to fill in missing knowledge. Therefore, Glenn could not avoid fatalism with his first doctor because the physician withheld knowledge. As seen in paragraph 272, Glenn said, "One time, they [doctors] did have me thinking just white people couldn't get it, diseases like diabetes and high blood pressure." Glenn did not have a problem with white doctors as seen in paragraph 240 (above); the problem was his observation of the doctor's attitude towards him. Nick appreciated having an African-American physician, but ultimately, the perception of the participants towards their doctors made the difference in managing DM. Nick demonstrated the importance of the message delivery over the race of the physician by connecting paragraphs 36 and 48:

I just always knew it [exercise]was good for you, and she had told me, the doctor, she was an African doctor and she told me exercise would help lower it [blood

glucose]…She tried to teach me, but you know being young like I was, it was really going in one ear, out the other.

Notice, Nick respected the doctor but ultimately ignored her instructions. On the other hand, the white female doctor in paragraph 55 (above) entirely commanded his attention with her shocking announcement of imminent danger. Finally, the respect and forthrightness from doctors that the participants are accustomed to from messages in their African-American COGIC churches makes their belief about DM an Afro-Theistic belief or faith.

Pastors. Pastors' dual roles were less apparent because concern and mentoring dominated their position, but the participants revealed the existence of hegemony. As Sheppard's lead flocks of sheep, the title of pastor assumes role modeling and special care for the members of their congregation. Unexpectedly, the participants identified a hegemonic side to this leadership that leads their flock to a fatalistic approach to managing DM.

Glenn hinted at this hegemony in paragraph 138, "You know what I'm saying? I give them [pastors] respect and stuff, you understand what I'm saying, but I know they can tell me to have faith in this and that, but they've got to have it too." Glenn, a new member of the COGIC church, had not learned the aforementioned code phrase, "Touch not my anointed and do not my prophet in a harm" for not pointing out the obvious. Perhaps his newness as a member in the COGIC church also explain his uninhibited view of doctors' failures. In fact, only one other participant dared, though reverently, point out the hegemonic side of the COGIC ministry, and that was another minister. In paragraph 124 through 132, Carlos stated:

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I think a lot of church, where ministers go, they won't touch their stuff because

you noticed in our church, the preachers are the biggest, they're some of the

biggest…obese people in the church. Most people don't preach on their self. You

know, it's not necessarily right. You stay away from subjects like that; it's going

to make you look bad…and so how do I preach on temperance when I'm on the

pulpit weighing 269 pounds? I'm not messing with that subject.

Therefore, this hegemonic process is by way of omission. As a result, COGIC members

are not receiving the customary "fire and brimstone" messages against diabetes. This

omission results in fatalism for members with DM for the same reasons Glenn in the

previous section experienced it from his doctor who withheld vital information. This

indirect impact may be worse than the direct effects of physicians, because of the

multiple weekly interactions with participants with DM with their pastors. By

implication, pastors, especially obese ones who through omission of messages on the

contribution of obesity to DM, will lead members into the same fatalistic condition.

Part II: Integrated Theory

Five categories have emerged in capturing the actions, interactions, and emotions

that resulted from the social constructs of the African-American COGIC members with

DM. Integrated in this section, are these five categories into a theoretical explanation

grounded in the data from the participant's processes of actions, interactions, and

emotions that extends from one core theme. This core idea necessarily connects to each

concept and explains the knowledge-based decisions made concerning living and dying

with DM emerged from hypothesis made through inductive reasoning. The evaluation of

data, especially the knowledge-based decision-making incidences, revealed a desire for

the participants to have a substantive life, whether it meant a shorter life or longer one became secondary. Substantive Living, the core category, is the participants' goal of having and doing the things they enjoyed after years of cultivating those behaviors. Therefore, faith, knowledge, and social constructs concerning DM produced the actions, interactions, and emotions as the participants' defined or redefined their meaning of Substantive Living.

Figure 17 is the composite matrix that evolved with each discovery of five categories. Faith, Fear, Fix, Frustration, and Fatalism are the major categories that emerged from the participants' data and the diagram illustrate the conditions and the mitigating consequences. In the shape of a cross is the axis of actions and emotions with Faith serving as a hub. Fear and Frustration identify the emotions; Fix and Fatalism are the actions, and Faith is what the participants believe about DM that moved them towards one of the four directions. Furthermore, similar to the symbolic interactionism of Figure 8, there also exist left to right and top to bottom symmetry in the figure.

Similar to symbolic interactionism in Chapter 3 (see Figure 8), the top half contains the more positive and the bottom half is the more negative categories and processes in the figure. Ultimately, the top reveals processes of solutions and complexities to living, and the bottom is that of the participants' surrendering to dying. Also similar to symbolic interactionism, the top half represents positive actions, and the bottom half are the negative ones. The left half expresses the emotion of Fear, and the right hand represents the emotion of Frustration.

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Fix

1   Solutions   2

Complexities

Fear   ◄····Sensitization····►   Faith   ◄····Suspicion····►   Frustration

Fighting

3   Surrender   4

Homegoing

Fatalism
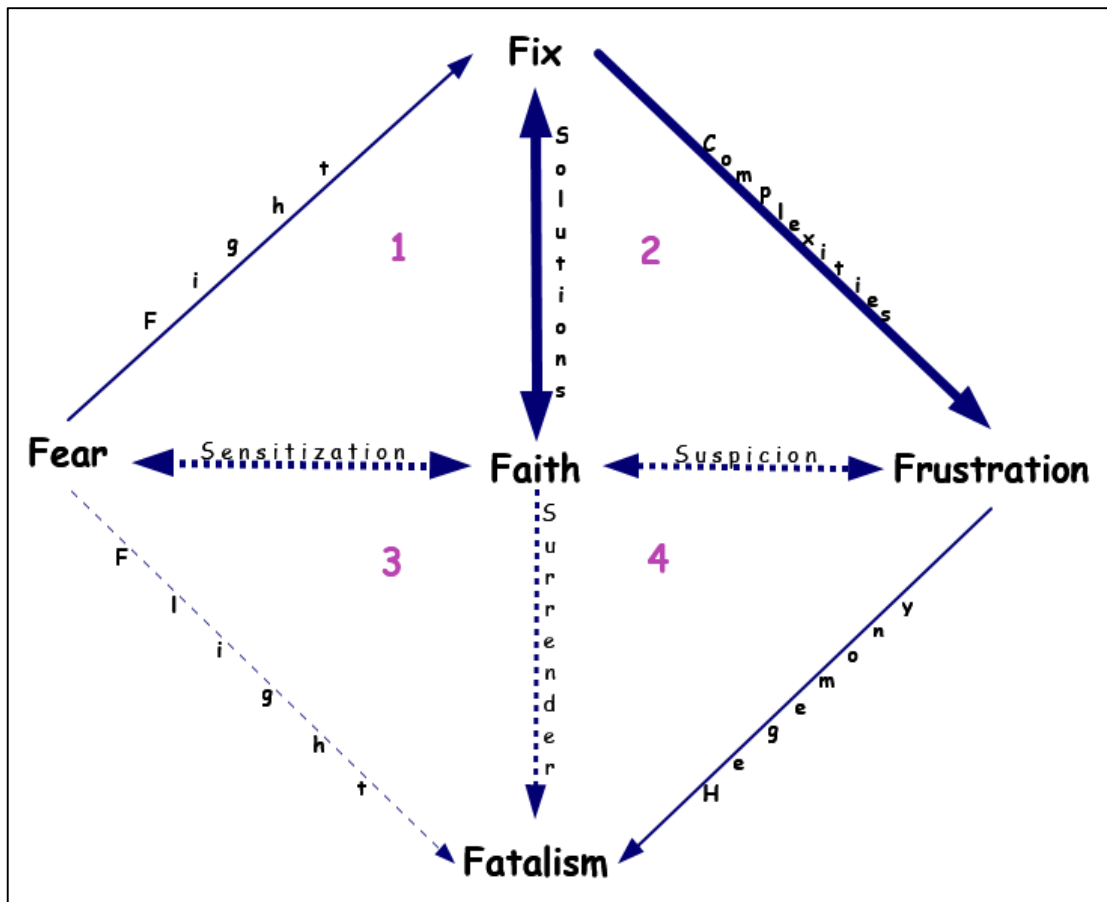
Figure 17. Afro-Theistic Substantive Living.

In addition, there are four quadrants (see Figure 17 and Figure 18); the first quadrant is a triangle that has the best outcomes in managing diabetes and the best chance to experience self-efficacy. Although the second quadrant equates to diabetes management, the participants are disgruntled and less determined to continue their regiments. Participant, or the examples they use that are in the third quadrant "give-in" to harmful habits through self-will. On the other hand, those in the fourth quadrant, discouraged by hegemonic overtones, "give-up" and stop trying to manage their diabetes.

Category Strength		Total	
Quadrant 1	Most Positive	1212	4088
Quadrant 2	Less Positive	1206	
Quadrant 3	Less Negative	838	
Quadrant 4	Most Negative	832	
Process Strength		Total	Percentage
Quadrant 2	Less Positive	275	689	17%
Quadrant 1	Most Positive	241	
Quadrant 4	Most Negative	92	
Quadrant 3	Less Negative	81	

Figure 18. Code Triangulated Significance.

Each of these categories (Figure 17) has connecting processes that vary in significance in terms of quantity and the degree and direction of influence. Interestingly, the number of codes for the processes or actions of the participants (Figure 18) equally countered those of their respective category but only at a rate of 17%.

The statistics seem to suggest that the actions that are more harmful temper the most optimistic status of the participants. In other words, the best scenario for living with diabetes (Quadrant 1) had the worst actions (Quadrant 2) against it. Conversely, the slightly worse (Quadrant 2) situation in managing DM had the most constructive counteraction (Quadrant 1) by the participants. The balance meant that the closely related, in term of numbers, Quadrant 3 followed by Quadrant 4, adverse scenarios for living with DM, also had polar opposite actions. Howbeit, the negative scenarios only occur at approximately half the time as the constructive ones.

The triangulated significance of the codes reveals a certain balance that helps explain the complexities in understanding how African-Americans in the COGIC church manage their diabetes. In the following sections through the identity of 1,423 of the 1,571

codes, and elucidated through memos and the presented diagrams, five categories and

their process emerged from the participants' data. The additional 143 remains unspecified

to prevent forcing data into categories or compartments. The order of presentation begins

with the dominant concept, Faith and culminates with the overarching category,

Substantive Living.

Faith

Faith located in the center of the theoretical model (Figure 17), stands for the

symbolic interactionism or the perception of the participants concerning DM. This

symbolic interaction expands on the perceptions leading to promotion and distractions of

health in Figure 8, now identifiable as faith (belief) about diabetes. The codes connecting

faith to DM is an extraction from data relating to the participant's beliefs about diabetes,

actions, interactions, and emotions concerning the disease. Nonetheless, Faith is the most

prominent and complex category of the five. In an attempt to define faith, surprisingly,

the participants did not think faith and diabetes had any relationship. In fact, the

suggestion seemed repugnant and astonishing to them. Asking the participants for a

definition surprised all except Arianna, who denied having diabetes based on her

understanding. However, she volunteered for this study on the basis that she had diabetes

according to the doctor's estimate. Therefore, her definition of faith related to DM is a

matter of believing or not believing she has the disease. In fact, all of the participants,

except Carlos, expressed doubt about having diabetes at some point.

Most sobering was the irritation with the request to define faith in relationship to

diabetes, which required careful analysis of the data to uncover the definition. For

example, Carlos said in paragraph 170, "Faith is one thing but man, don't be stupid."

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Here, Carlos views faith in one Biblical sense of expecting God to bring about the desired results. When he said, don't be stupid," he meant God had given those with diabetes the ability to take action. Therefore, claiming to be waiting for Him to do it based on having faith is stupid. Notwithstanding, he did not claim faith and diabetes were mutually exclusive; rather faith must not exclude the participant's ability to take action. Nick had a similar reaction in paragraphs 303 and 305, but gave clarification to the type of faith suitable for COGIC members with DM. He said:

> God put some responsibility on us. Just because we have faith doesn't say I still can eat a quart or pint of ice cream…Sometimes I think we're ignorant and in denial that I can beat this on faith, when God is daily giving you an understanding, this isn't good for you; don't eat it."

Nick equates faith and diabetes with absurdity when expecting God to take care of the diabetes sufferer's responsibilities. However, he stated that the type of faith COGIC members (the subject) with diabetes needed is one that combines it with restraint, responsibility and intelligence.

In paragraph 103, Livia also shows her strong objection to the notion of an association between faith and diabetes. However, she left reason to believe her objection resulted from the novelty of the idea. She stated, "I guess I haven't. I don't really—I don't think I have because like I say, I just really feel like this wouldn't happen to me, and I don't think I associate the two together." She concluded that since she did not believe she had diabetes there was no reason to consider her faith. Howbeit, she left room for the possibility of another definition for faith when she said, "I don't think I associate the two together." On the other hand, Glenn in paragraph 144 clearly understood the

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multiple meanings of faith when he asked, "What faith you're talking about." Based on his question, he surmised that the definition of faith varied based on the context or the circumstance of application. Earlier in paragraph 134, Glenn showed the same objections that others had when thinking of faith as placing the responsibility of managing DM on God. He said:

> No, but common sense tells you that you should have faith and rely on God and you apply yourself to it, God is only going to do so much, you've got to do something too. I listen to the church and listen to the pastor and stuff, but then I got common sense for myself, you know, to understand the Bible as much as I can and try to and you know, I ask questions if I don't understand something, you know.

Glenn states that faith in the context of DM is a collaborative effort between God and COGIC members with diabetes. In managing the diabetes, those affected by the disease can only expect God to do the things beyond their capability. However, most of the responsibilities belong to the one suffering from diabetes, and their faith should be such that it is active, advisable, teachable, practical, and searches for answers. In paragraph 138, Glenn associate's faith concerning diabetes with doing what knowledge about diabetes instructs him and the ones preaching about faith to do when he said:

> You know what I'm saying? I give them respect and stuff, you understand what I'm saying, but I know they can tell me to have faith in this and that, but they've got to have it too.

Therefore, in Glenn's estimate of faith, based upon paragraph 138, it is doing what knowledge, which he called common sense in paragraph 134, instructs one to do.

Ironically, even Livia's belief about her diabetes status is part of the participants' definition of faith.

Ultimately, the data revealed three components to the definition of faith about DM. Initially, the participants' beliefs about diabetes dominated the definition, because every participant had beliefs and doubts about having diabetes. Next, each took actions or made decisions based on knowledge about DM. Furthermore, more than one expressed the belief that God expected them to take responsibility and manage their diabetes. Meaning, faith is the participants' beliefs about diabetes linked with their emotions, actions taken, if any, based on multiple sources of knowledge from social constructs and God's help. A more concise composite definition of faith from the participants is, "COGIC members with DM responding with knowledge based on their beliefs about diabetes and relying on God for circumstances beyond their control." Additionally, Faith emerged as the hub that connected to all other categories in both degree and direction. In terms of quantity, 44% of the 1,423 codes (Figure 19) for the five categories belong to Faith. In terms of direction, the next four sections speaks of faith's influence on the other four categories. Although the Faith of the participants influences each of the categories, the primary direction is the actions and emotions towards it.

Finally, all concepts have two components, social constructs and knowledge seen in Part I, which identifies the contexts and the basis of the processes or actions of those with DM. Statistically, nearly 75% of the overwhelming number of codes (621) relates to Faith or the participants' quest to understand what a diagnosis of diabetes meant. The fundamental belief is that the cause and cure of diabetes lie in the gain and loss of weight. Typical is Carlos remarks in paragraph 184, stating:

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And I look at my brothers, they all overweight. You know, some of my family has

Titles	Faith	Fix	Fear	Frustration	Fatalism	Row Totals
Nick	83	191	86	14	13	387
Carlos	78	115	27	22	14	256
Livia	84	61	27	62	14	248
Glenn	86	56	22	52	8	224
Arianna	15	2	2	8	0	27
Subtotal – Category Codes	346	425	164	158	49	1142
Substantive Living Relationships	275	1	1	1	3	281
Totals	621	426	165	159	52	**1423**
Category Percentages	44%	30%	12%	11%	4%	

Intra-Category	Code Ranges	Percentage
Faith	621	
Faith to fix.	65	10%
Faith to fear.	38	6%
Faith to fatalism.	32	5%
Faith to frustration.	31	5%
Fix	426	
Fix to faith.	111	26%
Fix to frustration.	63	15%
Fear	165	
Fear to fix.	24	15%
Fear to fatalism.	8	5%
Fear to faith.	3	2%
Frustration	159	
Frustration to fatalism.	24	15%
Frustration to faith.	5	3%
Fatalism	52	

Processes Total	
404	
Faith and Fix Percentage	
176	44%
Fix and Frustration Percentage	
63	16%
Faith and Fear Percentage	
41	10%
Faith and Frustration Percentage	
36	9%
Faith and Fatalism Percentage	
32	8%
Fear and Fixed Percentage	
24	6%
Frustration and Fatalism Percentage	
24	6%
Fear and Fatalism Percentage	
8	2%

Figure 19. Afro-Theistic Category and Processes Code Statistics.

it, but it may be genetics or what have you, but to me, I mean he was—now I'm

bigger than I should be, but I'm moving and I don't think it's a coincidence that

the exercise and the loss of the weight, that now I don't have it.

Carlos denotes the reliance on his family's history to make comparisons for

understanding his condition. As discussed in Part I, ancestral history, which is part of the

family, is the primary source of knowledge about diabetes that influences the participants' belief or faith concerning their condition. The next source of this knowledge is their clinicians, as in paragraph 50 of Livia. She states, "Well, lose weight, lose weight, I hear that 24/7 and you know, get my eating under control." Combining these cases corresponds to the participants' means of understanding DM through the triangulation of data, using their circumstance and two other references, and then concludes that the primary problem is weight.

Faith to fix. The significant influence of Faith (see Figure 19) upon another category was through the process called solutions. It purposed to "Fix" a problem (see Figure 17) experienced by those with DM. Coding revealed that these influences came through social constructs and the knowledge of the participants.

Social constructs. A typical example of Faith influencing a Fix through social constructs is Glenn in paragraph 206. He states:

> Like what you saying about a second opinion, that would be good too, you know, instead of just telling you, say hey—even they have classes you go to and like telling you, showing you what you should eat or whatever, you know, stuff like that too, you know.

In the cited case, Glenn acknowledges the benefit of gaining knowledge through the social construct of diabetes education classes. Notice his recent rant against hegemonic overtones and the preference of demonstration, through support groups, for example.

Knowledge. In paragraphs 291 through 299, Nick was motivated to change or fix his problems with diabetes through his ancestral and familial knowledge. He stated:

Certain things what changed me was thinking about my dad did insulin, my

brother who will be 58 tomorrow; he's in worst shape than my father was…he got

edema. Yeah, its big, he's in the hospital now going on three months. Yeah, his

legs are turning dark. But, he was one who decided, ate what he wanted. I'd

watch my father go in the hospital with complications of diabetes. Within a

month they took him off insulin and took him off pills 'cause he was eating what

they told him.

Nick expressed a variety of emotions and concerns, which led to different codes, among

them is he Fixed his problem with diabetes based on this knowledge.

Faith to fear. Faith's influence upon the action of Fear ranks second behind that

of fixing the problem (see Figure 19) for those with DM through processes of

sensitization. Sensitization is becoming aware through social constructs, knowledge or

experience that results in Fear. The means of sensitization resulting in Fear is from

knowledge that changes a belief related to DM and incites fear.

Social constructs. In terms of social constructs, Faith connects to Fear through

processes of sensitization. Being sensitized is the exposure to, in this case, causes of fear

by those of the participants social construct. In paragraphs 121 through 125, Nick

demonstrates how social constructs and knowledge work together. He states:

Yeah, he told me, he said I don't want to alarm you, but I noticed that your

cholesterol levels are going up. So we'll continue to do blood work. He said I

want to try to do something natural first, so he recommended red yeast rice.

Red yeast rice, something natural you can take that should help you lower it. So I

started taking that but when I walked out of his office, I was like cholesterol. I

didn't know much about it but sounds like I'd been eating too much fatty foods.

Yeah. So I decided well I am gonna do something different. I'm going to cut out

beef and pork and stick with chicken, fish, and turkey.

In this case, the social construct concerning DM, is a doctor who sensitizes or made Nick

aware of natural approaches to managing diabetes. However, the doctor elicited fear

when he mentioned cholesterol. After reflecting on his knowledge of dietary intakes,

Nick surmised that the primary sources of cholesterol was certain meats, which he

decided to exclude from his diet.

Another case is Livia it in paragraph 151, who states:

My daughter say I'm a hypochondriac, which I'm not, but I know, I wake up one

morning, like 146! She say, there you go, my blood sugar's up, but I want to stay

like that because I want to be aware, okay, you know what you have, you know

you need to leave that alone.

Livia used her social construct (family) to motivate her to stay fearful through the

sensitization or daily readings of her glucose levels.

Knowledge. The case of Nick above demonstrated the interaction of social

constructs with knowledge, making it difficult to separate them. Nevertheless, after

beginning the interview with Carlos showed the Faith to Fear connection to the process of

sensitization in paragraph 8. He stated:

As far as I know and it has something to do with your blood, the sugar level in

your blood and I do, just by seeing some of my family members who suffer with

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it, I know it has some adverse effects of the disease and my own self, I know that

your diet, especially with type 2 diabetes, has a lot to do with it, but I don't

pretend know a great deal about it, but I just know that it's something I don't

want.

Although Carlos does not claim to be an expert on diabetes, he demonstrated the

continual building of knowledge that keeps him sensitize enough to fear DM.

Faith to fatalism. Another effect that Faith can have is the production of fatalistic

actions by those with DM. Completing the process came through surrendering to

conditions fatalistic to those with DM. The process of surrendering also came through

social constructs and the knowledge of those suffering from DM.

Social constructs. The best illustration of a social construct resulting in fatalism

through processes of surrendering came through Carlos's experiment in paragraph 134

and 140. He stated:

I give a workshop here every year and so I remember doing a workshop on it and

I kind of set them up a little bit and I can't exactly remember how…one of my

ways of getting people here, I always offer a free dinner. So, after the workshop,

after you get the teaching, you get a free meal…And so I had already did some

preliminary stuff at the beginning and then my next line was, I had this

smorgasbord place [only PowerPoint]. That's where we are on Sunday. This is

what, we leave church, we done told to do this and not do that and that's where

we would go and we eat, they say all you can eat, we get our money's worth, but

then we go back and preach against the cigarette smoking, the snuff and all this,

but the doctor has told you not to do certain things, yet you go and do it. Now

how out of control are you? So that was my opportunity to shock them because, at

time, I hadn't been through this, and that's what the Lord was dealing me with.

You can't control your flesh, see how hypocritical you're being. You know,

cigarette smokers inhale, you just as bad.

Many codes came from these paragraphs where Carlos demonstrates the necessity of

shock or fear to motivate COGIC members with DM. Among the codes came the

overwhelming temptation to surrender to the self-destructive behavior of overeating

through the influences of social constructs.

Knowledge. Combining statements from paragraph 6 and 62 reveals Arianna's

fatalistic processes of surrendering to DM through her knowledge. She states:

Well, not at first, I guess because they tried, he said to watch my diet or whatever.

Well, I don't know because like I say, they said I was on the borderline. So then

when they got past the borderline, I guess, they put me on the Metformin...So I

really never took that half in the morning, maybe a couple of times.

The paragraph above juxtaposes Arianna's disbelief that she has diabetes based on her

knowledge with the clinicians' knowledge. Since she did not believe (Faith) she had

diabetes, she took a fatalistic approach by modifying or completely ignoring her doctors'

advice.

Faith to frustration. As mentioned in the Faith to Fear section, another emotion

experienced by those with DM is Frustration. In this section, the route is from Faith-to-

Frustration through the process of suspicion. The Faith to Frustration path exhibited the

same two origins, social constructs and knowledge as in previous intra-categorical

connections, except the process is suspicion.

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Social constructs. In paragraphs 70 through 76 Livia states:

But she said I went from 6.8 to 6.9, but still back up. Why are you fussing at me

for a point? I said ma'am; I'm a nurse. I know…I guess she was a medical

assistant.

Notice, Livia became suspicious of the claims from a medical assistant's diminutive

remarks based on her knowledge of hemoglobin A1c readings. Livia perceives the

condescending remarks as being hegemonic and frustrating, which led to her pushing

back with her knowledge. Later comments suggest that the pushback did not extend from

retaliation, but the consequences of the effects it had upon her faith or belief about her

condition with which she must live.

Knowledge. Livia also gives an excellent example of Faith leading to Frustration

based on her understanding. In paragraph 12, She states:

I was diagnosed, which was kind of discouraging, I was diagnosed April of last

year and that's something I said would never happen to me and I was diagnosed. I

did some routine lab work and when it came back, my blood sugar I think was

like 150, but my hemoglobin A1c was 8 point something and I'm like, you've got

to be kidding me.

Seemingly, irrefutable data interrupted Livia's faith or belief, concerning her status with

diabetes. Later, Livia again pushes back with her knowledge of the disease versus the

diagnoses made based on data. The pushback is Livia's way of clarifying the facts in

order to make intelligible or informed decisions about living with DM. Nevertheless, at

this point, knowledge from the data frustrates her faith.

Fix

The participants with DM overwhelmingly focused on fixing their problems (426 codes), once understood, as found in the category of Faith. Fixes resulted almost three times more from Faith than Fear. Of the two causes, Fixes only reciprocated with a response to one; that is, Faith. However, Fixes had two possible responses, with the overwhelming majority building the participant's Faith or understanding their condition, and to a much less degree, it elicited the emotion of Frustration.

Fix to faith. The process of the participants with DM from Fix to Faith came through finding solutions, which is the same process from Faith to Fixing the problem. The only difference is the generating source.

Social constructs. Carlos demonstrated a solution the women in the church found in managing their health in a community setting. He stated in paragraph 50:

The ladies actually used…this area right here on the other side of this wall used to be the dining room before we build this big dining room, so the ladies started using, a certain night of the week, they would come and do aerobics…

Carlos continued in paragraphs 285 through 291

One thing…that is different now is most of the time when they cook now, they try to make something for, they think about the diabetics. I think it started with the old first lady – she was diabetic, really bad…She started making people more alert about it. [She would say] You all don't want what I got here, so they started doing classes on it. Started to do stuff, cooking a different way for diabetics.

In these paragraphs, the community got involved in combating the adverse effects of health problems, especially diabetes. In paragraph 50, Livia states, "if I could implement

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the exercise, I probably would do better." Although she is physically unable, she believes that exercising is the solution to her problems with diabetes. In other words, based on her experiences, the ability to use the exercising facilities her church made available to the community, gave her reason to believe in the possibility of managing and eliminating problems with DM.

Knowledge. In paragraph 160, Carlos' doctor validated his knowledge base decision to exercise and lose weight. Carlos implemented a plan to fix his problems based on information gained over the years that suggested his array of problems had connections to dieting and exercising. He said:

> So, the exercise and the losing of the weight fixed the blood pressure because my doctor said, when you come in for your physical, we'll monitor that. If this checks out, we'll take you off blood pressure medication.

The doctors' surprise revealed that he had given up on the belief that diet and exercise would help Carlos after years of warning. In effect, the doctor indicated that dieting and exercising was a secondary plan to issuing medication to solve problems Carlos experienced. Nevertheless, through the process of dieting and exercising Carlos found a solution that increased his faith that he could eliminate DM. In this case, the increase in faith experienced by Carlos, and validated by his doctor, is equivalent to self-efficacy.

Through self-directed learning, Nick eventually reached his goal of managing diabetes mellitus without medication despite his limited ability to exercise because of problems with his knees. As a result, he is a mentor greatly admired in his community. In paragraph 333, he said:

I try to share what works for me. We just had a class…and…called and asked, if

I'd come out and…could come in and talked about diabetes. So I shared with

them what worked, worked for me. And I said I guarantee that if you would [do

that repetitively], if you're a Type-2 Diabetic, you don't have to be on medication.

You can beat it, but you have to discipline yourself, and I told them about the

complex carbs. I got a whole list of them. Eat more complex carbs.

Nick demonstrates self-assured faith that others can "beat" diabetes by following his

example of modifying their diet, and in so doing, they will maintain weight control and

eliminate the need for DM medication. Therefore, Nick's self-directed learning resulted

in him fixing his problems with DM, strengthened his faith, and gave him confidence to

help others. This self-efficacy took considerable time and effort, as he learned from the

literature, mentors, and experience.

      Fix to frustration. A little over one-half of the participants with DM codes

extending from the action of "Fix," led to the emotion of Frustration through complicated

processes. In other words, complicated processes frustrated the participants. Through

both social constructs and their knowledge of DM, they desired simple solutions or less

complicated solutions.

      Social constructs. In paragraph 58, Livia, who suffers from knee problems,

strongly desires simple solutions in managing her DM. She states:

65 pounds and I felt real good about myself, and these years went on and you

know, the weight came back up. So, it's just kind of disheartening because

everybody say do this and do that and it's not like I don't want to, but if I'm in

pain, then to me it's not an option and I just feel like I should have a quick fix, do

you know what I mean? I say, now everybody else; they have these surgeries or whatever, but nobody say, well ____I'm going to sign you up, you need the surgery. No, ___ need to get out and walk 24/7 and it really gets to me because you know, I know I can, and if I make myself get out and walk, but then there is the part that say, I dont wan-a-be in pain. I don't take pain medicine; I don't take pain medicine. I've been given pain medicine, but I have a high tolerance to pain, I'd rather deal with the pain than be an addict.

Livia expresses frustration in not being able to do as others, but also from the lack of solutions for those with a handicap in managing DM and associated complications. She gives proof that she would exercise if she could by the fact that she lost 65 pounds prior to her knee problems. She also feels frustration from the seeming lack of concern of doctors about the medication that she believes organs the bargains in her body. The best phrase she had to simplify the matter is "quick fix."

Knowledge. In paragraphs 141 and 143, Nick demonstrates the Frustration from Fixes based upon knowledge gained through experience. He states:

Yeah, now you're talking 50. It started getting worse, I had to pee so much at night I would get a milk jug, and I would pee in the milk jug and go back to sleep, wake up again, pee again. I had to go dump that thing before the night was done. I was peeing that much…So then I decided well I quit taking Actos 'cause then I was, I'm skipping but it was making me fat, I quit taking Actos and the Glyburide.

Nick learned that managing DM could not happen with medication alone. He learned that he needed to take diabetes medication, and alter his diet. In addition, he learned that

certain medications worked against him losing weight, thereby, complicating his management of DM. Therefore, through experience Nick gained knowledge that led to frustration.

Paragraphs 141 and 143 are more complicated than the presented Fix to Frustration aspect. In addition, a poor solution in the doctor's choice of medicines added to Nick's mistrust of DM medication. Therefore, the Fix, medication, caused a change in perception, Faith, concerning proper DM management. Then there is Faith-to-Fear sensitization process that resulted in a Fear-to-Fix the problem through the process of flight by discontinuing the medication that caused the weight gain.

Fear

In Part I, Fear is thoroughly discussed in its significant role to help those with DM manage the disease through their social constructs. However, the number of codes (165) is a distant third behind Faith and Fixes in managing or eliminating DM (see Figure 19). The emotion of Fear had one of the three processes that produced an action or changed the participant's perception (faith) of DM. Fear had a unidirectional relationship between the "action" categories (Fix or Fatalism) and a bidirectional relationship to the symbolic interaction (faith) of the participant.

Fear to fix. In cases where participants with DM experienced the emotion of Fear, "Fixing" the problem through processes of flight from the circumstance that caused the fear was three times the likely the outcome. The process that bridges Fear flows in one direction in the form of fight that Fixes the problem as opposed to becoming a victim of diabetes. Fighting the problem came through means of the participants' social constructs and their knowledge.

Social constructs. In paragraph 203, Carlos emphatically tells what he believes COGIC diabetes sufferers in need from the social construct of their church. He said:

> And again, especially with people who have grown up in Church of God and Christ, Holiness churches, a lot of times to me, probably the better motivation tactic is the fear factor. So, maybe they start showing people look, this is what can happen to you. You can lose your limbs, lose your eyesight and kidney damage 'cause I know when I was a kid, as a matter of fact, diabetes, that was a term that came later. In fact, when I was a kid, it was sugar. I'm like, that didn't sound too bad to me, sounds pretty sweet, you know what I'm saying?

Carlos believes that preachers should use the same tactics COGIC members are accustomed to hearing to motivate them to avoid hell at all cost. That is, give them the "Fear Factor" concerning type 2 diabetes mellitus.

Knowledge. In paragraph 48, Carlos also demonstrated how knowledge about DM motivates participants to fight or resists circumstances that add to the problems of diabetes. He said:

> Now, I got scared a little bit, you know. So, I ain't going out like this, so I got serious, even though I was tired coming home from the long drive, I would come home, I'd go exercise first. We have an actual gym here in the church and so—but I made a plan.

Carlos proclaimed that a full knowledge of DM gained through years of seeing his family suffer from the diabetes caused him to develop a plan to fight back and Fix the problem.

Fear to fatalism. Only 5% of the time did the participants with DM experience Fear that led to Fatalism. As seen in Part I, fear is the catalyst that elicited one of the

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three responses. The most popular was the familiar "fight or flight" processes. The Fear to Fatalism process is the flight from the problem as seen in only eight cases equally divided between social constructs and the knowledge of those with DM.

Social constructs. In paragraph 189 Livia said:

So, my fear for her is it going to really sock it to her because she won't check hers and so I just feel like if I could just get a grip, maybe I could help all of us, you know as far as, maybe trying to be creative, but it's hard at my age, trying to be creative with a meals.

Within the social constructs of Livia, she expresses a desire to help loved ones by creating meals that those with DM would appreciate. Her lament indicates that despite her fear of diabetes that she passes on to family members, they flee or ignore the warnings by continually eating meals that will lead to their demise.

Knowledge. In paragraph 149, Livia said:

The Burger King did it. It wasn't the grits because I've seen patients in the hospital, and they give grits. It's just the portion and so a lot of times, we, because we feel good or whatever, we just keep doing what we're doing, we just keep eating and keep eating the sweets and keep eating because we don't feel anything and then one thing I've seen about diabetes, when it give you that sucker punch, there ain't no returning, it can't be reversed and that's what I see a lot with us as church people. You know, we go and we still eat the wrong thing.

Livia expresses frustration with those whom she loves, her husband and church members with DM that continued to eat unhealthy meals with the knowledge of a looming "sucker

punch." Like Livia, other participants feared the worst-case scenario, but unlike Livia, some continued to eat unhealthy meals that will cause diabetes complications.

Fear to faith. Surprisingly fewer codes of those with DM related to the effects of Fear on Faith than Faith on Fear. In fact, the three codes were more than twelve times less, and two concerned the social constructs and the other, the knowledge of those with DM. The knowledge is the same as seen in Figure 15, and called precautionary action. In other words, the participants reacted to fear based on knowledge that change their perception (faith).

Social constructs. In one example, Glenn in paragraphs 222 stated:

But I didn't know what diabetes was. I seen it with my grandmother and some others and stuff, they're talking about oh, if you get your foot cut, don't get your foot cut if you have diabetes. Don't stub your toe. It's hard for you to heal if you get diabetes and I'm going to tell you one thing, before I even got diagnosed with it, if I get a little cut or bruise on me, I will try and watch it to see how fast it heals and a few times I heal real quick and I said shoot, I'm in good shape, you know, but I haven't got cut lately where I check it out.

Glenn revealed that his primary source of knowledge about diabetes came from fragmented teaching and observation of his ancestors struggling with the effects of diabetes. Glenn's sensitization through Fear caused him to monitor the healing of his injuries as an indicator of his diabetes status. In other words, if he healed normally, in his estimate he believed he did not have diabetes or his case was not severe.

Knowledge. Paragraph 62 of Arianna shows the only case related to knowledge that changes the participant's perception because of fear. She said:

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> Well I'm just bad about taking medicine. So I really never took that half in the
> morning, maybe a couple of times. So, I'm still taking the one at night.

Arianna did not believe she had diabetes, and she was afraid of medications given to those with DM. However, her knowledge concerning the adverse effects of DM on diabetic patients changed her perception (faith) and caused her to take precaution by taking a portion of the medication.

Frustration

The number of codes related to frustration experienced by those with DM is slightly less but comparable to the number associated with Fear. Both Frustration and Fear are the two emotions expressed by the participants concerning DM that has a similar low number of coded processes in comparison to the number of codes in the category. However, like the "Fix" category, Frustration only has two processes that influence separate concepts.

Frustration to fatalism. The participants with DM experienced frustration through processes with hegemonic overtones causing them to give up on trying doing things associated with managing DM. These examples are from participants who followed poor examples or felt less appreciated through hegemonic acts through the omission of statements or hegemonic statements, respectively. In either case, hegemonic processes led to fatalistic approaches to the participants' management of diabetes.

Social constructs. Frustration to Fatalism occurred primarily through the participants social constructs of doctors. However, the most influential examples were from the social constructs of the church leadership. None of the codes related to the church leadership in terms of knowledge. This fact is reasonable considering education or

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understanding usually followed the experiences within the social construct, and the hegemony of the leaders extended from the omission of information. In fact, it took a church leader's confession to make the information known.

Preacher's omission. In paragraph 185, Carlos reveals the hegemony of leadership based on the omission of information. He states, "You know the COGIC we'll send you to hell on almost anything, we skip that part, cause the preacher is overweight." Since the participants were reverent and followed the examples of those in church leadership positions, Carlos surmised the increased obesity in the church members reflects them mimicking the governance behind the pulpits. According to Carlos, preachers avoid the subject of weight because it is self-reflective of said destructiveness. Therefore, through omission COGIC church leaders through hegemony lead the members into a fatalistic approach to managing diabetes.

In paragraph 144 through 146, Carlos reveals his knowledge of preachers who through hegemonic practices hinders progress by continuing dated practices. He states:

> You've got to allow the younger generation to—because they've got fresh ideas. They've got more information at their disposal than the older generation. They getting it from the social media, they getting it from the websites and the leadership of the church, for the most part, as you know, they've been around, they hold onto their position, I mean forever, until they die.

Doctor's hegemony. In paragraph 270, Glenn's doctor promoted fatalism through hegemonic overtones. Glenn states:

Cause I know when I was about 14 or 15, I went to the doctor, me and a white

boy and it was like a summer job or something, we was taking a physical for or

something. Even then, my blood pressure was high, and you know, I could hear

him saying, most black people got high blood pressure. It's like, it's normal for

black people to have high blood pressure anyway, like it's no big deal, like they

going to have high blood pressure, but white people have it too, just as much as

black people.

The doctor made Glenn feel as though he should give up because black people will

predictably have high blood pressure. In paragraph 248, Glenn added, "They make you

feel bad sometime, you know and people like that you got looking over your body, you

know, putting your life in their hands." Glenn expresses his sense of frustration through

hegemonic processes that pushed him towards fatalism, at least in thought, to avoid being

at the mercy of the perpetrator, his doctor.

For reasons previously mentioned, codes revealing the frustration of the

participants followed by fatalism did not come through church leadership. Only two

codes appeared, and both extended from doctors. In paragraph 56, Livia stated:

But, you know, I go to these doctors, I go to a cardiologist, I've been

going to one for years because I have palpitations, which they really can't

explain why I have them and I don't have them all the time, but I do have

them, so haven't had a heart attack or nothing like that, but every time I

go, he's preaching to me about my weight and like I do want to lose

weight, I have done it. When I first retired in 2008, I was walking, and I

lost 65 pounds.

Livia is frustrated with the doctors' continual insistence that she loses weight without considering her history. She explained that her previous loss of 65 pounds, prior to her handicap, did not prevent the onset of diabetes. She explained in paragraph 58, "everybody say do this and do that, which includes doctors, are not working with her to find means of exercising with her handicap. Furthermore, they have not explained the seemingly greater problem of palpation that relates to her heart condition. She reduces the doctors' efforts to matters of "preaching," which is another way of saying hegemonic. Because of the doctors' insensitivity, Livia takes a fatalistic approach to managing her diabetes by making little effort to exercise.

Frustration to faith. The Frustration-to-Faith process of those with DM is the same suspicion seen with the Faith to Frustration connection. The number of codes between Frustration and Faith is equally low at five from either direction. However, the participants are five times more likely to have occurrences of frustrations leading to fatalism than from the frustration to a weakening of their faith.

Social constructs-doctor's deficit thinking. Only two codes emerge related to the social constructs of the participants with diabetes. Both codes came from Glenn's data, and in paragraph 272, he said:

> One time, they did have me thinking just white people couldn't get it, diseases like diabetes and high blood pressure. Like I said, I was illiterate; you know what I'm saying? And just illiterate till not long ago really, but you know, and I hear a lot of white people saying, oh, this or that, back in the day, but now sometime I go to the doctor or whatever and white people is in there with diabetes and all that, they got it too, you know what I'm saying?

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By listening, Glenn accumulated enough knowledge to refute misleading claims from doctors who gave him the impression that diabetes and other diseases were African-American diseases. Glenn admitted that his doctor's deficit thinking affected his faith for years. Therefore, for years Glenn blamed his ethnicity for his problem with diabetes. In fact, he wondered if he had diabetes because he was not overweight, and his glucose readings were normal. As a result, Glenn could take one of the two routes to fatalism. Through processes of surrendering, or the hegemony of his doctor, if he had not changed primary care physicians. He expresses this belief (faith) in paragraph 240, when he said of his new doctor, "he do set down and talk to me like you talking to me...I tell you what the doctor I got now stayed in that room with me longer the first time, longer than my other doctor did, three to four years." The differences in Glenn's faith or belief about diabetes before and after his new doctor are obvious. His questioning his status comes from years of remaining silent in the presence of a physician whose job it is to inform patients. His reluctance to ask the new doctor questions about his condition that he asked during the interview apparently extends from at least three years of oppression due to deficit thinking.

Knowledge. Nick's paragraphs 120 through 125 overlaps with codes from Fear to Faith in social constructs, and fear, in Frustration to Faith through the suspicion processes, yet both exist. He states in paragraph 123 and 125:

> So I started taking that but when I walked out of his office, I was like cholesterol. I didn't know much about it but sounds like I'd been eating too much fatty foods…So I decided well I am gonna do something different. I'm going to cut out beef and pork and stick with chicken, fish, and turkey.

The prompting word was "cholesterol," which elicited fear because of another disease, but also stored knowledge that connected it to dietary intake. Notice, the doctor did not suggest a connection, but his statements made Nick suspicious or question the proposed cure. Based on his knowledge, Nick believed, or had faith enough to make an informed decision in managing the new condition that further complicated his diabetes.

Fatalism

Fatalism is the last major category that emerged to explain a connecting set of data from the participants with DM. However, the number of codes is less than one-third of the closest category, Frustration (see Figure 17). Another significant difference based on the participants' data are all associated processes were towards Fatalism, never outward. Interestingly, the accumulation of codes in each category far exceeded existing ones, and most codes appear in concepts through undisclosed means, but Fatalism had no exit. As a result, the 52 codes of data related to Fatalism divides almost evenly between the participants' social constructs and their knowledge of DM. They have no alternative to carrying out the fatalistic behavior once the process towards Fatalism begins. As previously discussed, an additional number of codes came to Fatalism from Fear, by methods of flight, Faith, by processes of surrendering and a significant number by Frustration, by processes of hegemony. However, it is important to note that Fatalism is an action carried out by COGIC members with DM every time the code appears, and almost 45% appeared without a detected process.

Social Constructs. In paragraph 114, Carlos shows the willingness of some COGIC members with diabetes to surrender to old eating habits even with the doctors warning. He said:

But the doctor done told you, you know, to stop eating sweets and stuff, but they

keep doing it. To me, we just as sick as the guy that's smoking the cigarette and

right on the package it says it cause cancer. But the doctor, what are we doing?

We doing the same thing.

Carlos' reference to cigarettes is an example of a killer habit repugnant to COGIC

members (and drinking alcohol), and preached against. At the same time, some with DM

ignore warning from doctors and die because they refuse to repress eating certain foods.

Livia's paragraph 167 is perhaps the best example that connects Fatalism to the social

constructs of the COGIC members with DM through the process of surrendering (see also

Part I, affectivity). She said, in part:

My dad got out of the hospital; he said God had gave him all the years that he

promised. He was going to eat what he wanted, and he did just that. My dad

didn't have bad hemoglobin A1c, so what gives with that?

Livia's dad expressed satisfaction with the length of time he lived, took the fatalistic

approach of ignoring all dietary precautions, and enjoyed the remainder of his life. Livia

gave the impression that she admired the stance that he took and seemed to entertain the

idea for her future. The theory is likely, since she thought the doctors made an incorrect

diagnosis of her dad's condition and also questioned the doctor's diagnosis of her having

diabetes. In addition, she has a physical handicap that prevents her from exercising.

Therefore, the accumulation of frustrations that affects her faith or belief about her DM

status could conceivably result in her fatalistically surrendering like her dad.

Knowledge. In paragraph 299, Nick gave the example of a COGIC member with

diabetes who took a fatalistic approach to managing his diabetes. He said, "Yeah, he'd

get out of the hospital, continuing to eat like he was, he'd revert back to what he was

doing, he's back on insulin, back on pills and ultimately it took him out." Even though

his dad knew the consequences, if, for no other reason than his experience, he elected to

continue with his destructive eating habits until his death.

Substantive Living (SL)

The overarching theoretical explanation gluing the discovered categories of those

with DM through codes, memos, and diagrams is their quest for Substantive Living (SL).

Through careful inductive analysis, categories emerged, but it took deductive analysis by

rethinking schematics and data to discover the goals of the participants and the mentors

that influence their decision concerning DM. The abstraction of the data revealed that the

primary objective of the participants is to live a substantive life. As defined earlier,

"Substantive Living, the core category, is the participants' goal of having and doing the

things they enjoyed after years of cultivating those behaviors." COGIC church members

live highly structured and restricted lives, but relish the customs of their heritage. Many

customs involve familiar ethnic foods enjoyed in private and social settings. Type 2

diabetes mellitus interrupts these customs, and every decision made by the participants

reflects their desire to live meaningful lives, which are lives close to their norms.

Nevertheless, the abstraction of the core category necessitated a continual abstract

view of the diagrams and memos developed from the participant's data. The evolution of

the comprehensive matrix of Figure 17 produced two unplanned visual effects. The first

is the formation of a cross in the middle with Faith connecting to the other major

concepts. Though surprising, it seemed fitting for the subculture of African-Americans

with DM in the COGIC church. Most surprising is the pyramid that emerged after

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considering the familiarity of the Figure 17 matrix that out of the participants' data. That

is, considering the prominence of Faith because of its significantly greater number of

codes, elicited the thought of elevating it above the others. From a bird's eye view this

restructuring produced the startling awareness that a pyramid has the shape of the cross in

the middle. Furthermore, the resulting three-dimensional model in Figure 20 of a pyramid

better illustrates and simplifies a complex theory of how the COGIC subculture of

African-Americans with DM integrate faith, knowledge, and their social constructs.
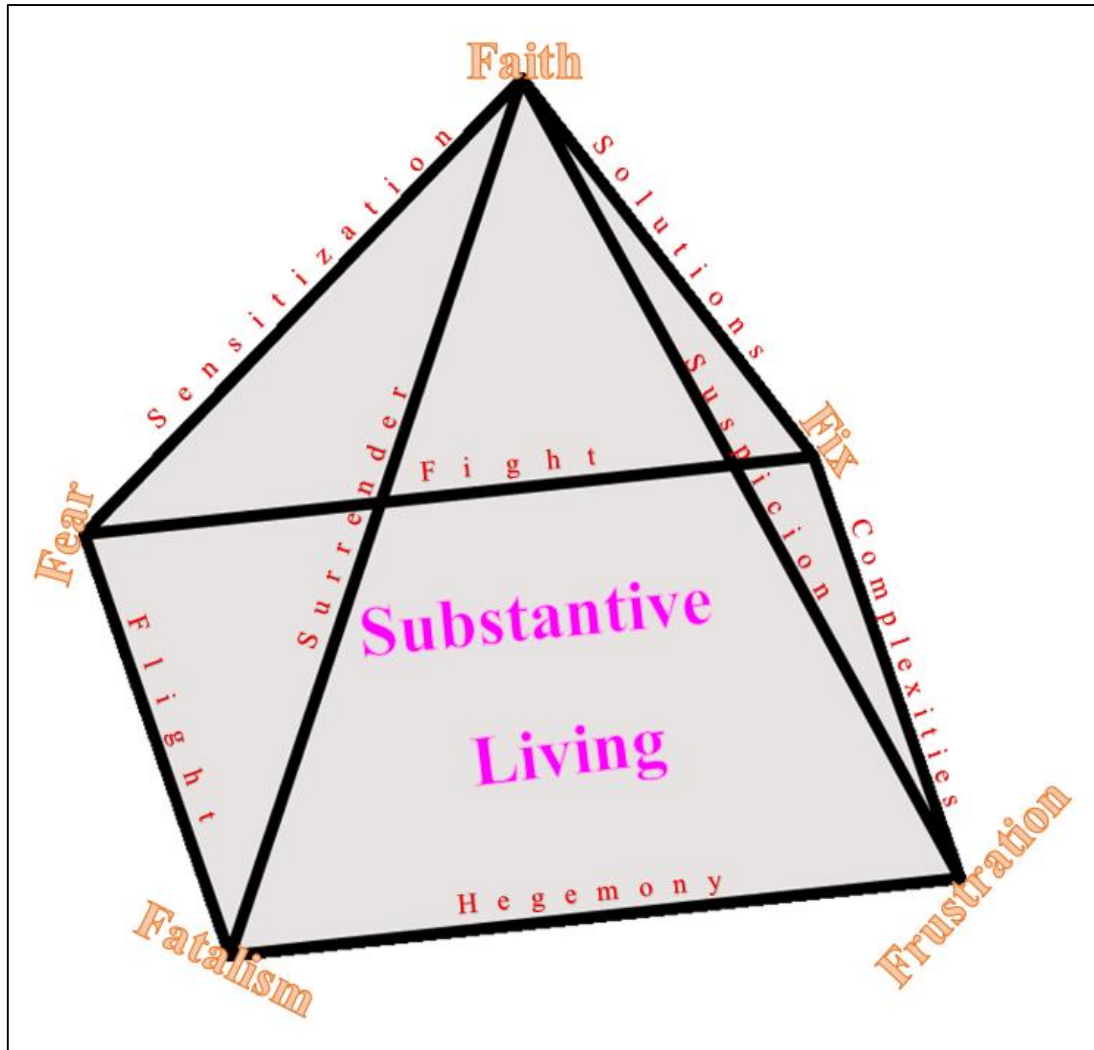
Figure 20. Afro-Theistic Theory in 3D.

The elevation of Faith memic not only its greater percentage of codes, but also the difficulty of other categories to affect changes in it. Conversely, the participant's' Faith could easily affect changes in the others. In other words, based on the participants' statistics in Figure 19, change is more probable when going downhill as opposed to uphill. However, there is one exception; there are more Fix to Faith (uphill) codes than Faith to Fix. The increased numbers reflects the significantly greater number of codes for Nick and Carlos in the "Fix" category of Figure 19, while the other three participants had

a greater number in the "Faith" concept. Interestingly, although slightly less, the number of codes for Nick and Carlos (see Figure 19) in the Faith category were comparable to the other participants. Therefore, the primary source of the increased numbers in the "Fix" category for these two are the results of increased efforts to fix their problems with DM. Their data reflects this finding since the Fix to Faith route obtained by the process of finding solutions took years of knowledge gained through literature, mentors, and experience. However, they became the only two whose data rewards them with the self-efficacy status. Conceptually the difficulty in achieving self-efficacy reflects the difficulties of the average American to climb the pyramid Khafre in Egypt. For most, it would take years of changing habits to save the monies in order to afford the trip, obtain permission, overcome fears of heights, and become physically fit.

Additionally, a look at the total number of codes in each category (see Figure 19) reflects the participants' efforts to fix their problem, mainly because of Nick and Carlos, and ranks second to that of Faith. Therefore, theoretically, the proactive action of the category Fix rightfully belongs to the North, and the reactive response of Frustration, with the fewest number of codes is in the South. On the other hand, the evenly-plain categories of Fear, Fix, Frustration, and Fatalism permits a more fluid lateral movement between the concepts and therefore more quickly changed, corresponds with the participant's data. Finally, along the edges are the connecting processes that enclose the pyramid and captures the space that defines Substantive Living (SL).

As seen in Figure 19, 281 of the SL 318 codes directly connects to the five categories of Faith, Fix, Fear, Frustration, and Fatalism, previously discussed. Only a small percentage of the codes (37) had an exclusive relationship to the overarching

Substantive Living category, as opposed to the greater majority of the others to their respective five classifications. One example of SL in isolation is with Glenn's father. In paragraph 256, he said:

> No, he was diagnosed when he got sick, right before he died. Everything, he had diabetes right before he died, everything—when he first got sick, he got burned with some hot water. Then everything started.

Here, Glenn's dad lived a careful life not to incur injuries while he continued eating the savory foods that he enjoyed. Rather than stop eating the foods that he desired he trusted the myth that the diabetes only affected those who carelessly were injured. Glenn learned this myth from his grandmother, which caused him to obsessively monitor the healing of any injuries to his body.

SL and faith. Nearly 98% of the Substantive Living codes linked to one of the five main categories, connected to Faith. Therefore, the participants faith, or what they believed about DM, for all practical purposes, is Substantive Living. Although the terms are practically synonymous, Substantive Living differs slightly because it reflects the participant's actions based upon their belief. It usually meant that the participants continued eating the types of foods they enjoyed. For example, in paragraph 20, Nick said:

> So I would go there drinking 'cause I was just always thirsty. Didn't know I was doing but I was getting the Slurpee's. I'd go get the orange slurp. It was always my favorite flavor.

Before Nick emerged with self-efficacy, he had to break his habit of taking advantage of the fringe benefits from his job. The sweet drinks became habit-forming like drugs,

perhaps due to the lack of planned moderation. In either case, SL related to Faith explains

the participants' desires to continue eating as though DM did not exist. It explains Livia

and Nick's dad refusal to modify their diet because of a desire to continue eating the

foods they enjoyed. Finally, it tells Livia's husband who enjoyed her cooking and others

who desired things to stay as they were before a diagnosis of DM.

      SL and fix. In paragraph 313, Nick give the only code directly connecting SL to

Fix. He stated:

> I get, you don't get tired of eating those meals? No, I don't, 'cause I want to live.
>
> You can go from oatmeal; Cheerios to both got oats, still got the same effect. I
>
> decided I wanted to live. So here it is now, I wake up this morning I take my
>
> blood sugar, 82. I still take the Glucophage 'cause she told me to. My next time,
>
> they said, already told me… It's coming up; she's going to say if you keep doing
>
> what you're doing you'll get off of this.

Through self-directed learning, Nick adjusted his desire for foods that he loved to foods

that were healthy and sustainable. While others wondered if he got tired of the same

meals, he merely demonstrated how to vary the meals to continue to enjoy them. After

observing Nick in different settings, even at the church feasts, he always chose healthy

and filling foods in modest portions.

      SL and fear. Nick also gave the only case that connected Substantive Living and

Fear. In paragraph 22, he said:

> I would drink one and a couple hours later I was so thirsty again, go back and
>
> drink another one. I was like I can't stay awake. Sometimes I have to go park
>
> somewhere I know no one's at just to try to take a nap. Try to wake up and pretty

much the same thing again. Then in church, I started noticing when I really, man

this is wrong, something wrong. I would see people's silhouette, but I couldn't

see their mouth moving or their eyes, it affected my vision.

Nick relates the consequences of him ignoring his diagnosis of DM for the sake of SL to

continue the foods he loved. That is; until uncontrolled diabetes produce fear and fear

produce action, as seen in Figure 15.

SL and frustration. In paragraph 157, Livia gave the only example connecting

Frustration to SL. She said:

I really want to come off it, and I know, I believe that weight got a lot—I'm

hoping that if I get off the weight, then maybe I can get rid of the medicine. I'm

just really hoping.

Livia's frustration is obvious, but the connection to Substantive Living is more

subtle. Livia is wrestling with the means of losing weight because she can no longer

exercise as she did to lose 65 pounds. Nick has the same problems with his knees and still

manages to keep his DM under control. Further, the difference is Nick modified his diet

and Livia has not. Meaning, her desire for Substantive Living, which usually means

eating familiar meals, according to data, has not changed significantly enough.

SL and fatalism. Three incidents gave codes connecting SL and Fatalism. In

paragraph 48, Nick stated, "She tried to teach me, but you know being young like I was,

it was really going in one ear, out the other." In this example, Nick explained that his

youth interfered with his better judgment of listening to his doctor and modifying his diet

to manage his diabetes. Therefore, Substantive Living, or the desire to continue with

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eating rituals that brought acquired pleasure took precedence over seemingly distant problems.

Summary of Findings

This study began by creating an open atmosphere and establishing rapport with the participants. After immersion in the collected data, it revealed five primary categories, Faith, Fix, Fear, Frustration, and Fatalism. Through inductive and deductive processes of coding and memo writing, evolve the diagrams and tables used to develop a theory grounded in the collected data. The resulting theory grounded in data explained how faith, knowledge, and the social constructs of the COGIC members with DM, work together in managing the disease. The saturation of the categories came from tens to hundreds of codes whose decreasing numbers helped rank their significance. The processes connecting the concepts resulted from the social constructs or self-directed learning of the participants.

The multiple examples from the five participants were examined through theoretical sampling, validated the findings. In addition, through abstraction of the data emerged the core category, Substantive Living, which necessarily revealed an overarching purpose of the five categories established by the participants' data. The surprising visual effects of figures 16 and 17 models, significantly help to conceptualize the theoretical findings. In so doing, they established Faith as the participants' primary category and its close relationship to Substantive Living as their purpose in living with DM. Figure 19 gives the invaluable statistics of the categories and their connecting processes. Although the codes for each outnumbered their processes or actions that connected them, their statistics prove indispensable to understanding the five concepts.

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A significantly greater number of codes for Faith helped the abstraction to elevate it above the others, which symbolize the difficulty for other categories to affect it, but the ease by which it affected the others. Furthermore, the North and South polarity of the proactive action of the Fix concept versus the reactive act of Fatalism, the less in number, corresponds to the greater efforts to live and not die with diabetes. The surprising more considerable number of codes corresponding to the processes of the Fix category over the Faith processes signifies the means and difficulty of achieving self-efficacy.

The East and West axis, with a similar number of codes, corresponds to the categorical emotions of Frustration, and Fear. Overall, the participants exhibited the emotion of Fear slightly more, but comparatively similar to the Frustration. When taking an action, Fear usually resulted in the participants fighting to Fix their problems to live, and much less in fleeing to a Fatalistic death. On the other hand, Frustrated participants were three times more likely to resort to Fatalism than when they Feared. Surprisingly, they equally resorted to Fix or Fatalism, respectively. Comparatively, they rarely affected Faith, again proof of the difficulty in effecting change uphill.

Also remarkable, statistical analysis revealed that by combining the participants relatively lower in number of processes or actions into quadrants they countered their respective quadrant categories (Figure 18). The contradicting activities seem to balance the participants' status and reveal the complexities of their diabetes management. Interestingly, according to the statistics in Figure 19, the accumulation of codes in each category far exceeded those departing, but Fatalism had no exit. The accumulation means that to some extent the participants necessarily harbored aspects of each of the five

categories at any given time since they exceeded the number exiting. Finally, the fact that

the Fatalism category does not have an exit seems significant.

V.   KEY FINDINGS, IMPLICATIONS, AND RECOMMENDATIONS

This study purposed to develop a theory grounded in the data of the way adult African-American COGIC members with DM construct understanding that reconciled their faith with their knowledge of diabetes. The development of a theory required a threefold examination of the subculture to answer four research questions. That is, it required: 1) an understanding of the determination of the COGIC members' faith concerning diabetes, 2) their knowledge of DM, and 3) the relationship of both to their social constructs.

Key Findings

Several important findings emerged relevant to the COGIC members with DM, as well as the larger African-American community with diabetes. In addition, the findings in this study are beneficial for the diabetic community at large. The study also revealed important findings that contradicted several views held.

Faith

Defining faith in connection to COGIC participants with DM from their perspective proved more of a conundrum than first believed possible. Although they openly expressed a belief in God based on their Afro-Theistic cultural practice, as predicted by Eltis (2008), the participants did not connect their belief in God with diabetes. Instead, they kept faith in God separated from their beliefs about diabetes. Therefore, the participants kept an open mind to the realities of oppositions. For example, they acknowledged the hegemonic activities of doctors and pastors concerning matters of

diabetes. Their compartmentalized faith gave the participants independence when responding to social injustices.

Therefore, the religious practices of these individuals do not make them predictable in the choices they make during crisis. Their ability to compartmentalize their belief means they could be the pacifists despised by Asante (1988), or support critical race theorists like Giles (2010). For the COGIC member with diabetes in this study, beliefs concerning social issues about the disease did not vary based upon economic status, as predicted by Hurston (1981). The ability to compartmentalize their faith explains the diversity in the church during the civil rights movement in the 1960s. Some, like my dad, became pacifists, others supported the church leaders' decision to support Martin Luther King (see COGIC History), and others empathized and held Malcom X's funeral in their church. Furthermore, COGIC members' faith allowed them to switch positions during other crises. For example, my dad, a church elder, became an activist in order to marry a biracial couple at an unacceptable time in the South, in the 1960s.

A composite definition of the participants' compartmentalized faith proved crucial to this to study. Despite the compartmentalizing of their faith, the five participants' definitions overlapped and coalesced into only three parts. They believe that COGIC members with diabetes should respond with knowledge based upon their beliefs about the disease while relying on God for circumstances beyond their control. The participants did not necessarily accept the clinician's diagnosis of their condition, but gathered information from various sources to determine the degree of severity then acted according to that belief.

Knowledge

The participants obtained knowledge from diverse sources, but relied heavily upon the understanding of DM learned from ancestral and family members' experiences. These served as mentors, and in a secondary sense, so did doctors, pastors, celebrities, and knowledgeable individuals, with whom the participants' made comparisons to their condition. Regardless the source of the knowledge, it did not always result in action. In fact, it took the ingredient of fear to move the participants to one of three decisions. Through different degrees, they either worked to fix (most frequent) their problems with DM based upon their comparisons, continued fatalistic eating habits, or pursued self-directed learning (least frequent) opportunities.

During times of self-directed learning, the participants only used literature to confirm or dispute a diagnosis, or enhance their knowledge about a product others used to mitigate the effects of diabetes. Interestingly, the belief (faith) of these individuals concerning their status with DM had more than 12 times the influence on fear than the low response to fear for self-directed learning. Therefore, knowledge gained through the experiences of mentors heavily influenced their beliefs or faith, and caused greater fear of diabetes than the literature's impact on their faith. None of the participants attempted to learn about diabetes prior to their diagnosis. In fact, the younger the participant during the time of the doctors warning, the less likely they would respond by learning or attempting to prevent the disease.

Conversely, the longer periods of warning produced the most avid efforts to manage DM, provided they believed (faith) the diagnosis. For example, both Carlos and Nick became self-directed learners and obtained a high degree of self-efficacy. However,

only Carlos' faith (belief) that he had the same disease as his ancestors caused enough fear to fix the problem. Nick on the other hand, did not attempt to fix this problem even though he suffered from multiple complications from diabetes. It took several bouts with the disease to convince him that he had the disease of his ancestors. Once convinced, his fear propelled him into superseding Carlos in managing the disease.

Nick especially, fulfilled Bandura's (1977, p. 191) "four principal sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states," for self-efficacy. The difference between Carlos and Nick, and the others lies in Mezirow's (1997) statement that, "Frames of reference are the structures of assumptions through which we understand our experiences" (p. 5). Overall, the other three, diagnosed later in life as having diabetes, minimally manage the disease. Again, the best explanation for the differences is Mezirow's theorized transformational learning processes of frames of references. However, these frames of references were unpredictable, but depended on the individuals' faith or belief's concerning the severity of their condition by making comparisons to ancestors, in particular. Therefore, in confirmation of Baumgartner's (2011) meta-analysis concerning the application of knowledge, regardless of age, the participants' acted according to their belief about DM based on knowledge obtained through the vicarious experiences of them with close social ties.

Social Constructs

The social constructs of the COGIC participants with DM proved to be the most used factor in managing diabetes based on the recorded data. The participants revealed three groups that affected their decision-making processes concerning DM. The social

constructs consisted of primary and secondary mentors, with ancestors and family members being principal, which agrees with Weiler's (2007) finding, and doctors, pastors, and others being secondary. The difference being that the participants learned from the primary mentors over the course of their life prior to having diabetes. However, of the two in the main group, the participants mostly acted according to what they vicariously learned from ancestors, such as parents and grandparents. Finally, a tertiary group of some doctors and pastors (leaders) had an undesirable impact on them managing DM.

As the term social constructs suggests a psychosocial (Dewey, 1982) interaction for meaning making; it gives the definition of constructivism from great societal influences of the COGIC members. While teasing out the data of the participants, as a constructivist, and knowing the influential social interactions of the COGIC church from its beginning, gave confidence that the theory would have support from the data. However, the degree of meaning making through these COGIC social constructs is a complete surprise. In fact, the data revealed that the participants acted based on their individualized faith concerning their diabetes status. Nonetheless, their understanding of the degree of severity (meaning making) came through comparisons made with mentors who had the disease. Moreover, none of the participants took action to prevent the disease regardless the number of warnings, which correlates with their mentors. Furthermore, it is evident that the participants had preconceived notions of how diabetes would appear based on what they saw in their mentors. As a result, the degree of belief varied when the physicians said they had diabetes.

For example, despite years of warning, followed by severe physical ailments from uncontrolled diabetes, Nick still did not believe he had diabetes for two reasons. First, he had spent years being convinced that he was invincible, which correlated with none of his mentors having diabetes at a young age. Secondly, he dismissed the doctor's diagnosis after making comparisons to mentors, down to minute details, until finding the slightest of differences. Both Livia and Glenn currently live in doubt about their diagnosis, for similar and different reasons. Similarly, neither has symptoms, but both were diagnosed based on having and elevated hemoglobin A1c.

They differ in their knowledge of the disease, and both the greater knowledge and lesser knowledge makes them skeptical. Furthermore, they continue to make comparisons to their ancestors. Livia's dad dismissed his doctor's diagnosis because of his age, and Glenn relied on his grandmother's meager bits of information about diabetes. However, both to varying degrees take precautionary actions by following their doctor's advice. Arianna ignores her doctor's advice for the most part, because she does not have symptoms of her ancestors, and her glucose readings are within normal ranges, the few times that she took it. On the other hand, the diagnoses of diabetes struck fear in Carlos, because of his stored memory of ancestors with diabetes, which caused him to take immediate actions to control the disease. Nevertheless, a theory grounded in the participants' data of how faith, knowledge, and social constructs work together emerged.

Theory

Five key categories emerged out of the participants' data concerning DM along with knowledge-based processes or actions taken that connected them. Prevailing were the participant's knowledge-based beliefs, called Faith concerning their status with

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diabetes. Behind Faith came the participant's attempts to eradicate their condition in the knowledge-based action called Fix. The third and fourth categories were closely related to numbers of codes but distant from the first two. These were the knowledge-based emotions of Fear followed by Frustration. At a further distance in numbers is the final category, Fatalism, which is the second action, but in polar opposition to Fix. The concepts emerged from the knowledge gained through the interactions with social constructs and produced the overarching concept called Substantive Living that identified the participant's purpose in all they did concerning DM.

Through the differences in the number of codes and connecting processes of each category emerged an astonishing three-dimensional model in the shape of a pyramid. The abstracted matrix revealed that the participants Faith is the primary influence of the other four categories and is strikingly similar to prevalence and importance to Cordova's (2011) Spirituality in her study. However, the prevailing processes or actions from Fix to Faith in solving problems with DM revealed the difficulty of achieving self-efficacy. The small number of Fatalistic responses correlate to the desire of participants to live. However, the connection of all concepts to Substantive Living reveals a supreme desire to enjoy or celebrate while continuing to live with familiar cultural events, private or social that usually involved ethnic foods, despite having diabetes.

Research Questions

1. What does diabetes education look like for the Afro-Theistic COGIC diabetes mellitus sufferers?

The primary source of the participants' knowledge about DM came through ancestral social constructs of parents and grandparents followed by other family

members. The participants' vicarious experiences defined their beliefs or faith concerning their diabetes status once diagnosed. Furthermore, this belief dictated the actions taken by the participants to manage or eradicate diabetes.

2. How can Afro-Theistic faith and diabetes education coexist to help DM sufferers?

Answering this question required defining faith in terms of diabetes since the participants compartmentalize faith based upon the point of application. Meaning, the definition of faith when applied to unseen spiritual matters is different from the participants' definition when applied to physical issues. A composite definition is the participants' belief that COGIC members with DM should "respond with knowledge based on their convictions about the disease while relying on God for circumstances beyond their control." To quote Carlos, "faith is one thing but man, don't be stupid." Therefore, the participants found the idea of divine healing by faith to be obtuse and repugnant.

3. What are diabetic COGIC members' Afro-Theistic social constructs' beliefs about diabetes mellitus?

The social constructs of the COGIC members with DM consist of promoters and distractors of healthy living with the disease. The promoters of healthy living appeared in the form of mentors. Ancestors and family members served as primary sources for knowledge about DM, and doctors, pastors, church members, and other knowledgeable people were secondary sources. However, only primary sources serve to educate the participants concerning diabetes prior to the onset of the condition. In other words, the participants primarily defined diabetes in terms of vicarious experiences with ancestors who had the disease. They learn through constructivism, which meant the meaning

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making equated to individualistically constructed impressions rather than overt teaching. As a result, the participants' belief that they did or did not have diabetes came from reflections upon ancestral experiences with the disease over a doctor's diagnosis. The distractors to healthy living came from hegemonic overtones of physicians, omission of teachings against obesity from pastors and the dominance of unhealthy foods during social gatherings.

4. How does the Afro-Theistic social constructs' interpretation of diabetes mellitus overtly or covertly influence COGIC members' resolve to disregard intervention?

The answer to this question is more subtle, but appears to result from respect for constructivism. That is, each COGIC member with DM constructs kowledge and makes decisions based on their idea of "Substantive Living." Therefore, members of their Afro-Theistic social constructs respect the sufferer's decisions as being resolute and refrain from interference. In fact, observers seem to view these decisions as being noble, which becomes part of their folklore. For example, in admiration, Livia said, "My dad got out of the hospital; he said God had gave him all the years that he promised. He was going to eat what he wanted, and he did just that." Even when condemning these decisions it is with reverence. For example, Nick said of his dad in paragraph 181, "But when I walked out, I was like you know I saw my dad die from complications of diabetes." Later in paragraph 309, Nick said, "And the whole while my dad would say you're digging your grave one fork at a time."

Recommendations

The overall aim of the recommendations is threefold: 1) rescue African-American youth from current trends of diabetes in the African-American community, 2) assist

current African-Americans with diabetes to manage their disease, and 3) change the attitude of the two leading communities, medical and church, concerning an African-Americans with diabetes.

The study shows that the participants in the subculture of African-Americans with DM rely on experiences of ancestors to determine their status despite the diagnosis of their doctor. Therefore, the recommendation suggested by one participant is advisable. Carlos suggested training the youth in the COGIC church because they will influence the future. This following paragraph 142 to 149 is that conversation.

> Carlos: But to answer your first question, I don't think—probably not as far as most of the time in our church. In the Church of God and Christ, you got big mega churches, but for the most part, you got the real small churches. Education levels are different and so, most of the time, we kind of key on moral issues and probably it's going to continue to be like that until we make room for some of the younger generation.

> Researcher: So what do you think that the younger generation will bring to the table? Or what do you think can change if we push in that avenue; push. What should be changed?

> Carlos: You've got to allow the younger generation to [have space] because they've got fresh ideas. They've got more information at their disposal than the older generation.

Researcher: Such as what? Where are they getting this information?

Carlos: They getting it from the social media, they getting it from the websites and the leadership of the church. For the most part, as you know, they've been around, they hold onto their position, I mean forever, until they die.

Researcher: Right.

Carlos: So, we're talking generations of no change, same concepts. Same everything, but you got to make room for the younger generation, and I believe when we do that, and we kind of doing that here at this church. I know in the different auxiliaries, we don't just teach the lessons. We make room, sometime we'll have a night or whatever is promoted. Publicized in the community that maybe help professionals [are] going to be here, and they [are] going to be talking about that and I believe churches need to start doing that.

Researcher: Ah-ha.

What should the youth learn? The findings of this study suggest that the place to start training young people in the African-American churches is their role in diabetes management. That is, to understand the significance of them having the primary influence on the next generation. Therefore, the need exits for a proper understanding of diabetes and its effects on African-Americans. Just as important is training in churches; the study suggests that support groups in African-American churches be formed using African-Americans who are successfully managing their diabetes, as facilitators.

In addition, leaders in the medical and church community should reconsider their position in helping African-Americans control their diabetes based on the findings from

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this study. Doctors should know that African-Americans view them as prophets of doom.
Therefore, along with making predictions, doctor should immediately encourage
appointments for regimented diet and exercise training, with follow-ups, when African-
Americans are in the pre-diabetic stage. The idea being that the patient learns to prevent
the onset of diabetes or learns to manage it prior to the onset, if it is not preventable. This
mindset should also have precedence in the American Diabetes Association for African-
Americans to decrease the number of cases in this population. Based on this study, the
medical community should actively support African-American support groups with
African-American who are successfully managing their diabetes.

Pastors and leaders in the COGIC church and African-American churches in
general should understand their role in helping African-Americans manage diabetes.
Based on this study, members mimic them. Therefore, if the leaders do not address issues
with obesity, a contributing factor to diabetes, the possibility exists that the congregations
will follow their example and disregard weight management.

Permeated Learning

Although this study did not focus on transformational learning, there are clear
implications for change. However, the knowledge of the participants seemed to be
haphazard with several relapses and vacillations on the Theory in 3-D (Figure 20), but the
word permeated better captures the phenomenon. One definition of permeated is, "if an
attitude or feeling permeates something, you can feel or see its influence clearly in every
part of that thing" (Bullon et al., 2007). Permeated learning, when considering the nouns,
attitude and feeling in conjunction with permeation, captures the type of learning
experienced by Nick and Carlos. It appears that the participants changed over time as

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knowledge slowly permeated their mind, and very being or soul. A formal definition of Permeated Learning is, "internalized knowledge that affect changes in ontology and processes, where ontology is the individuals' faith, and their processes are their actions, interactions, and emotions." Therefore, "Permeated Learning" seems to be the best explanation of the self-efficacy expressed by Nick and Carlos. Keeping in mind that the entire process began with ancestral knowledge that evoked fear when compared to their circumstances with type 2 diabetes mellitus (DM). The circumstances that evoked fear is a disorienting dilemma necessary for transformation (Mezirrow, 1991). Nevertheless, the actual changes were complicated and sometimes circular or repetitive, often due to the subtle nature of DM. Change required time, trial and error, failure, relapses, and reflection, with a slow movement towards a new reality of healthy living as it permeated Nick and Carlo's mind, body, and soul.

Most important in this Permeated Learning, based on the findings of this study, doctors, and COGIC leaders play a significant role for African-Americans in the COGIC church to avoid or manage diabetes. However, those with diabetes becomes the mentors that the next generation emulates. All of these are mentor at times and hegemonic on other occasions. For example, when doctors condescendingly predict failure to African-Americans in the COGIC church it is hegemonic. When obese pastors are not open about the relationship of obesity to diabetes, they leave space for the congregation to follow, which is hegemony through omission of helpful information. When those with diabetes in the African-Americans COGIC church do not help the youth in avoiding the same by teaching and being open, it is hegemonic by influence. Therefore, to facilitate Permeated Learning from uncontrolled diabetes to management of the disease, pastors should

encourage monthly meetings concerning parishioners' health, with DM as part of every

session. Doctors of patients with type 2 diabetes mellitus (DM) should encourage them

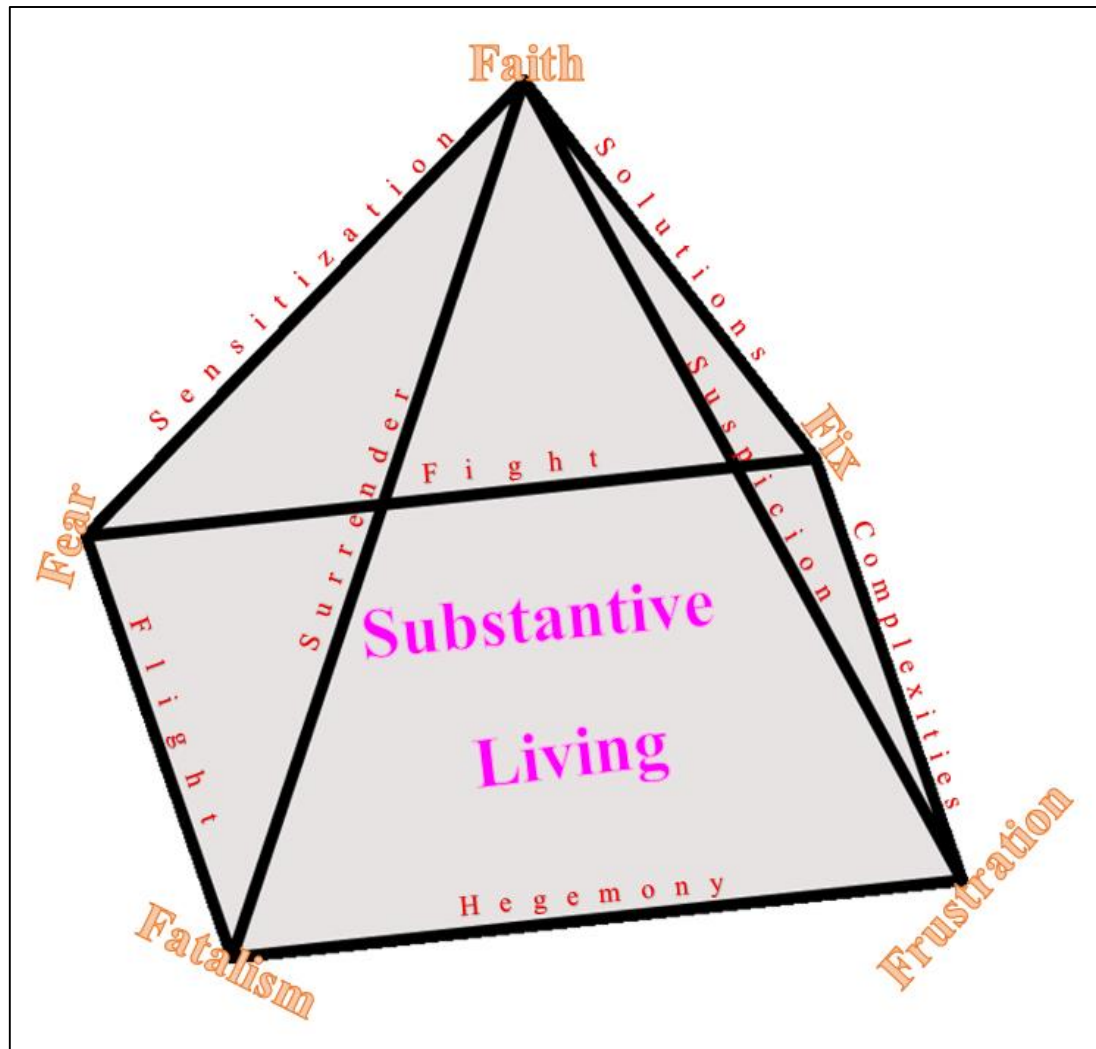by actively seeking a list of local churches that provide the support group for African-

Figure 21. Permeated Learning.

Americans with DM. Personally, the study brought about a change in attitude about

exercise, by doing "old folk," calisthenics daily, only taking about 15 minutes. The new

approach and calisthenics are works in progress towards Permeated Learning.

Accessibility

Finally, plans for accessibility to this study is primarily through two venues,

publications, and presentation. The next section discusses both in relationship to

professionals, but making the information accessible to African-Americans similar to

those in this study is another matter. For African-American subcultures, trusted pastors

must distribute the information. Locally, the American Diabetes Association (ADA) has

given an invitation to work with other pastors on a committee to promote diabetes

management in their congregations. In so doing, comes the anticipation of using these

findings in discussions and consequently present them to each congregation of the

pastors. In the broader sense, there is anticipation of the same conversations with pastors

and presentations with their congregations, starting with those in this study and

expanding to other associates. Furthermore, once established, anticipated is

announcements on African-American gospel stations for upcoming presentations and at

their local churches.

<div align="center">

Future Research

</div>

Permeated Learning Model Expansion

This study leaves room for expansion to other African-American subcultures

followed by cross-subcultural comparative analysis. Each category that emerged is

worthy of a study, and the connecting processes, especially the self-efficacy process of

"solutions" connecting Fix to Faith. These studies should include more participants since

this study has chartered the unknown in laying the foundation. Furthermore, other studies

are necessary to add, subtract, refute, or enhance claims made to the Permeated Learning

model grounded in the participants' data. For example, revisiting the original idea for this research study, Participatory Action Research (PAR).

PAR

Participatory Action Research (PAR) is a methodology where the participants co-construct knowledge with the researcher while implementing change (McIntyre, 2008). Applied, this means that collaborators take actions along with the researcher. Initially, based on research such as Two Feathers (2005), it made sense to do a Participatory Action Research (PAR) study. That is; PAR provided a direct means of change for African-Americans suffering from type 2 diabetes mellitus (DM). The idea floundered because the researcher had more questions concerning approaching such a study without cultural knowledge in relationship to DM. Although the researcher is an African-American with DM, and qualified to conduct research, the lack of knowledge of about the underlying problem brought more questions on how to start a PAR study. The researcher acknowledges that his quantitative background increased the felt need to have a point of reference for developing a theory related to African-American DM sufferers, since the literature had none. With the completion of this study grounded in the participants' data that produce the Permeated Learning model for African-Americans, a PAR research is most desirable in effecting Permeated Learning. A committee member introduced one way of conducting the PAR study by following the guidelines developed by Wilson (2014), called Most Significant Change (MSC).

In essence, MSC is a three-step process that has a learning focus that monitors and evaluate change through PAR. First Step: Introducing the stakeholders to MSC. This step is the ideal time to introduce African-Americans to the Permeated Learning (Figure

21) model developed in this study. Having the Permeated Learning model helps to know what is currently happening in one African-American subculture then use it with the PAR methodology to co-create knowledge (McIntyre, 2008). That is since the model expresses one subculture of African-Americans processes (action, interactions, and emotions) it is available to establish current methods of monitoring the group. Second Step: Assess the changes for monitoring. Third Step: the final step is to determine the frequency of monitoring. Of course, there are more details, but the previous three steps is the essence of the goals in the MSC process that works synchronously with the Permeated Learning (Figure 21). "Now what?" Answers to this question lie in the gaps in the literature.

Filling the Gaps in Literature

The literature review found gaps in four areas that need revisiting since the study is complete. The gaps in type 2 diabetes mellitus (DM) studies exclusively related to African-Americans are theory of how social constructs influenced diabetes sufferers, spirituality, and knowledge of how faith and knowledge evolve through social constructs. Out of the four, this study focused on the "exclusivity" of the social constructs, and the evolution of faith and knowledge through them. First, the study carved at the dearth of research explicitly related to African-Americans with DM, with a focus on one subculture. As for as the researcher knows, this is the first qualitative study completed using grounded theory exclusively with a subculture of African-American participants. Next, the study discovered that ancestors in the social constructs of a subculture had the greatest influence on what participants believed about their status with DM. Therefore, the biggest predictor of the actions, interactions, and emotions of the chosen African-American subculture, is their faith or belief concerning their status with diabetes. Afro-

Theism that resulted in the Permeated Learning (Figure 21) model represents the interaction between faith, knowledge and social constructs. Finally, although faith resembles Cordova's (2011) Spirituality, which is an important topic deserving an investigation for African-Americans, it was not the goal of this study. This study lays the foundation for others to build upon it. It only considers one subculture of African-Americans due to the cultures usual division along religion social lines. As a result, the selection of the Church of God in Christ (COGIC) denomination with more than 5 million members (Houdmann, 2012) in America became the choice. Choosing them resulted because of the potential impact of the number of church members and a familiarity with the denomination.

Nevertheless, in spite addressing the dearth of literature in three of the four areas the study is limited. The limitation is in the number of participants used to develop a theory of how Afro-Theistic faith, knowledge of DM, and Afro-Theistic social constructs worked together for this African-American subculture. This study followed the latest processes of the grounded theory methodology developed by Corbin and Strauss (2007) who considered theoretical saturation in developing a theory more important than the numbers of participants. As such, the study required thick and rich descriptions that saturated emerging categories from a few accomplices informative enough to comprehend the all-important question of "what is going on here?" Howbeit, the study leave room for expansion upon the three gaps addressed in this study by using more participants, in the COGIC denomination, but also other subcultures in the African-American community. In addition, spirituality in African-Americans with DM deserves a

fool study alone. Even so, the Permeated Learning (Figure 21) model in conjunction with spirituality of African-Americans with DM segue in filling the gaps in the literature.

Reflections and the Permeated Learning Model

Discoveries in developing the Permeated Learning (Figure 21) model grounded in the data of the participants helped in reflections and celebration of ancestral heritage. It also caused reflections upon the effects of desegregation on the health of African-Americans. Also the application of the Permeated Learning to type 2 diabetes mellitus (DM) and other situations from the perspective of a pastor and scientist.

Legacy of Health (1888-1965)

The importance of ancestors in the participants understanding of type 2 diabetes mellitus (DM) provoked the recall of suppressed memories related to health. The suppression resulted from embarrassment from rearing in a home more primitive than peers were and from desegregation. However, the study revealed the need for ancestors to model healthy living to the youth who will in turn become the ancestors emulated. Therefore, in reflection, is knowledge back to 1888 through Papa (dad). That primitive upbringing reflected him; in that, we burned the wood that we cut on our property in similar ways to his upbringing. The water we drank, until they ran dry, came from wells that he dug. We ate the foods that he (we) raised, picked, fed, or hunted. Our access to more than 600 acres of forest, thickets, swamps, red dirt and sandy white soil meant hard work, but healthy living and fun on Saturdays. Papa raised hogs, bees, and acres of black eye peas, purple hull peas, sweet potatoes, squash, okra, corn, cantaloupes, and "black diamond" red meat watermelons. We planted up to 40 acres annually with a mule or two, and an assortment of plows. However, in the mix came stories from 1888. Papa

mentioned Indians seen from time to time in the backwoods, and some of them he called "Black Indians." This researcher never knew who they were, but did not question it for two reasons. First, the fear of a swatting for asking the question, but even more, most of the things in the rural world was an enigma. Papa was 70 years old when he fathered this researcher and had three other children afterward. He was short, bow-legged, with a black face, yellow torso, and brown legs. His Uncle, Uncle Mitchell, a World War I veteran, and his daughter Cuten (cousin) Farris, looked like Indians. Both had beautiful yellow skin, an India nose and black wavy hair. Papa showed the researcher the wagon trails that his daddy would take once a year for supplies in Nacogdoches Texas, approximately a 120-mile round-trip.

With a sixth-grade education, Papa was simple and lived in a dualistic world of his own. Things were either-or, black or white, yes or no, on or off. For example, somehow (he did not say how) he was enlisted in the military for World War I, he told of the many prejudices that he faced on his train trip from East Texas to New York. He said he got off the train and, "heard all of that commotion of hooting and hollering," found out that the war was over and came back to his farm. In 1985 at the age of 97, following his death, with efforts to procure a flag for his service in the military, a sister-in-law (Yvonne) found that he never bothered with the discharge processes from the army. For him, no war, no service. So what does this have to do with DM? The fact is he left a legacy from his generation of hard work that reduced obesity and diabetes. However, he also left a legacy of physical exercise (see Figure 22) in spite having a labor intense life, apparently inherited from his father. Knowledge from this study revealed the need for ancestors to pass along healthy means of managing DM to the youth. In an epitome came

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the realization that Papa, with his sixth-grade education, had done more than the researcher did with his children. Figure 22 is a group photo of Papa, and based on the words of an older brother, Wilmer (now deceased), was Grandpa Henry, along with some Negro League baseball team. Older siblings also mentioned that the Negro League that produced Jackie Robinson wanted Papa to join it, but he refused to leave his farm. Another event removed any doubt. At the age of 12 years old, which means Papa was 82, an older nephew (Henry, aka Butch), and the older brother, now deceased, challenged Papa to race the researcher for about 40 to 50 yards. To this day, this nephew talks about Papa beating the researcher in that race. The researcher probably let him win, but the point is, "how many 82-year-olds can run respectably enough to look as though they can win?" Fittingly, Butch Henry plays intermural baseball in Denver Colorado, and he has gone to many championship tournaments over the years. A cousin we called "Bimbo," though his name was Roger, loved baseball and seemed to take up where Papa left off. Bimbo was the son of Papa's Uncle Columbus, the brother of Uncle Mitchell though neither looked like the other. Roger's nephew, Stanly Redwine is the head track coach at Kansas University, former Olympic head coach, and in the Kansas Athletics Hall of Fame. However, desegregation caused many youths the age of the researcher to suppress knowledge of the culture of their ancestors out of felt shame of seemingly African-Americans slave mentality of conducting business. In retrospect, the need existed to transition from the old to the new. That is, during the desegregation African-Americans needed a wise elder (male and female) to put things into perspective by explaining what was, and why, and what needed to be going forward. Instead, desegregation

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unceremoniously disenfranchised African-Americans of their heritage, including topics

related to living healthy.

Figure 22. Ancestors Legacy of Health, "Hard Hustles," Circa 1910.
Photo: Curtesy of Earnest and Yvonne Redwine

The Second Diaspora, Health (1966-Present)

There is a striking resemblance between the African Diaspora and desegregation for many African-Americans, especially in relationship to health. Although desegregation was appropriate, but the poor execution if not purposely orchestrated, was shameful. Desegregation began the researchers first year of public school while in the first grade at the age of seven. By the age of nine, in the third grade, came the culture shock of the White school. There were only two years to observe African-Americans in a segregated school environment, with African-American administrators, teachers, bus drivers, and other entrepreneurs. Many things were bad and provided a good reason for integration, but African-Americans did not deserve the observed unfair treatment in the process of desegregation. There are good memories of Christmas plays, the introduction to "secular music," like Jimmy Mac. Finally, baseball was the highlighted sports activity that began with after school practices, on the baseball field to the left and rear of the school. Observation of the practices brings back memories of a baseball zooming from player to player in lightning speed with quick reflexes and dexterity, and frightening to a seven year old. The baseball field was simple, but functional, with the anticipations of something special about to happen. One day, it must have been a game day, Bimbo had on one of the school's beautiful black and gold baseball uniform, instead of the drab white practice one. However, abruptly in 1963, officials gave African-American parents one of two choices. Starting the next school year they could send all of their children to the White public school, or send half the first year and the others the next year. Our parents decided to do, as did most of the community, like Jacob in the Bible, did with his family to the imminent threat from his brother Esau. Jacob sent the older children ahead

of, the younger ones (more loved). The big difference was Esau had more mercy than the White schools of desegregation. All of the African-Americans sent to the White schools the first year flunked except to ones mixed and had light skin. Considering the following previously written statement:

The social constructs of African-Americans began with slavery that initially imported only young virulent men, who were not fully indoctrinated in the African culture (Frazier, 1963). Furthermore, no more than five could congregate without a White man in the presence, which continued until introduced to the white man's religion (Frazier, 1963). These young men never fully gained the experiences of tribal customs, which made it easy to forget most of them.

The reality is desegregation unceremoniously dismissed an entire generation of African-Americans culture, especially detrimental to health. Although African-Americans maintained and still maintain that heritage of Afro-Theism through the African-American churches, most of the younger ones apparently lost the will to pursue baseball like ancestors. Desegregation should have transitioned with a celebration of African-Americans doing an amazing job of educating its youth despite lack of support from those with resources in the White community. Instead, authorities told African-Americans directly or indirectly that all of their school systems were worthless. As a result, most youths did not dare go to Historically Black Colleges and Universities once they graduated from high school. However, this study revealed the importance of ancestry and produced a Permeated Learning (Figure 21) model for evaluating an understanding of DM. The development of this model grounded in the data of the

participants also awakened the need to revisit African-Americans former means of combating DM that the nature of desegregation caused the culture to suppress.

Pastor and Scientist Combination

The Permeated Learning (Figure 21) model show that faith concerning diabetes mellitus is the primary link between the processes in relationship to type 2 diabetes mellitus (DM). Being a pastor, accentuates the importance of faith, as it helps individuals cope with DM. However, as a scientist comes the realization of the implications of inefficient or ineffective insulin, high glucose, and hemoglobin A1c values in relationship to DM. As an African-American with diabetes comes an appreciation of the Permeated Learning (Figure 21) that seamlessly helps the researcher as both a pastor and scientist. This study uses faith like older pastors who related it to the belief concerning any assumptions. Pastors in the Pentecostal church are notorious for using faith in conjunction with sitting in a chair. They say, "you must have faith to believe that the chair will not collapse when taking a seat." Here, faith is the compartmentalization expressed by the participants who demonstrated their belief about their condition based on their ancestor's with DM condition. The Permeated Learning (Figure 21) gives a frame of reference to evaluate personal beliefs about DM, and even better, it provides a visual map to transforming or changing, which are currently used. As a scientist it is irresistible to tests the model in circumstances other than with diabetes. For example, when feeling extremely stressed, a mental image of the model appears and the self-assessment ensue to determine the damage to faith. Assessing others based on the Permeated Learning (Figure 21) model is also common. For example, six-year-old Jayla (aka Punkin), one of two granddaughters, was traumatized by a doctor at the age of two.

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Base upon the Permeated Learning (Figure 21), with the fear (emotion) of doctors there is one of the three directions of movement. Either fix (positive action), fatalism (negative action), or faith (precautionary action). Based on the Permeated Learning (Figure 21), she will react by making a comparison to ancestors or family (see Figure 15), primarily her mother. Fixing the problem is not an option since she cannot erase the event; Fatalism, which means avoiding the doctors, is just as bad. The best choice is to speak and model confidence when discussing or associating with clinicians, that will "sensitize" her with knowledge and actions that builds her faith in the doctors. Without her knowing the reason, Punkin's mother, the youngest of three daughters, is encouraged to model confidence through verbal communication with her daughter.

How to foster change personally? As a pastor, with the realization that the African-American community has suffered second cultural losses of identity through desegregation it is imperative that the idea of camaraderie through physical activities such as age-categorized softball be reintroduced. Therefore, as an African-American pastor this study is a reminder of the importance of celebrating a heritage that support physical activity in managing diabetes while using the Permeated Learning (Figure 21) to monitor changes. The intent is to present the idea to the pastors who are working with the ADA as facilitators in support groups at local churches. As a scientist, the best opportunity to exhibit the use of the Permeated Learning (Figure 21) for African-Americans is through presentations as discussed under "Future Research." Currently, understandings as an adult educator, scientist, and pastor (neither required) is applied in conjunction with the Permeated Learning (Figure 21) as a means to develop self-efficacy towards DM. Recalling that the self-efficacy branch is the "solutions" interaction joining

"Fix and Faith," I exercise (old folks type) daily, take glucose reading, and take the prescribed medication. Finally, with an evitable failures I am able to assess the cause based on the model. Whether it is complications leading to frustration, surrendering leading to fatalism or any other interactions leading to one of the major categories. In either case, it is clear from the Permeated Learning (Figure 21) model that "Substantive Living," is the motive and should be embellished as a motivator toward self-efficacy in healthy living with DM.

APPENDIX SECTION

APPENDIX A

RECRUITMENT (FLYER AND IRB)

Type 2 Diabetes Mellitus: Faith, Knowledge, and Social Study

If you are part of this study, you will be helping African-Americans with faith practices who suffer with diabetes mellitus now or in the future.

1. Are you an African-American that is at least 18 years old?

2. Have you been told you have type 2 diabetes mellitus for at least one year?

3. Have you been a COGIC member for at least one year?

4. Were you a COGIC member prior to becoming a diabetic patient?

If you answered YES to these questions, you may be eligible to participate in an important research project.

The purpose of this study is to investigate how COGIC members with type 2 diabetes develop their understanding and knowledge about their condition. The intention is to explore how African-Americans with strong faith practices who are concerned about their condition discover, learn, and adapt to type 2 diabetes mellitus.

Participants <u>will</u> <u>receive</u> an incentive <u>payment</u> for their time to answer some questions.

Participants will be interviewed about their type 2 diabetes mellitus experience for 1-2 hours.

A potential follow-up interview may be required.

Adults over the age of 18 with a diagnosis of type 2 diabetes mellitus at least one year prior to the interview and currently a COGIC member for the same period are eligible.

This study is being conducted at Texas State University, 601 University Drive, San Marcos, TX 78666 USA

Please call Gerald D. Redwine at (512) 661-6682 or email at gr20@txstate.edu for more information.

This study has been approved by the Texas State University Institutional Review Board (IRB Application 2014P1443)

CONSENT FORM

Consent Form

<u>PURPOSE</u>

The purpose of this research study is to find out how Church of God in Christ (COGIC) members with diabetes learn about diabetes and adjust to living with it. My name is Gerald D. Redwine, and I am a Ph.D. student in the Education Department (Adult Professional & Community Education) at Texas State University, located in San Marcos Texas. I am also an Assistant Professor in the Clinical Laboratory Science Program at Texas State University. You are being asked to be in this study because you have been told you have diabetes, you are a member of the COGIC church, and an adult above the age of 18. I hope to have 6-10 people in this study. If you have any questions, please ask me. You can contact me at (512-245-6682, gr20@txstate.edu) or my advisor,

Dr. Steven R. Furney (512-245-2939, sf02@txstate.edu).

<u>CONSENT</u>

You are asked to read this consent form and ask any questions you wish. Participation in this research project is <u>completely</u> <u>voluntary</u>. You are deciding if you want to be a part of this project. You should be over the age of 18 and a member of the Church of God in Christ for at least <u>one</u> <u>year</u>. You will be asked to participate in an interview that will be audio recorded. This interview will take approximately 60 to 90 minutes of your time. Please make arrangement for the interview to last 90 minutes. A follow-up call may also be required to clarify statements, or you may be asked additional

questions. While the investigator believes the research is very important, especially for African-Americans with diabetes, participation is totally up to you. You will not be penalized in any way for not participating in this study. You may choose not to participate in this study at any time. If you decide you want to do this now and later decide you do not want to do this, it is okay. Just tell the investigator that you decided not to participate, and all materials (recording, notes and so on) will be destroyed. Deciding not participate <u>will</u> <u>not</u> <u>reflect</u> <u>negatively</u> on you by the investigator or anyone associated with this project.

<u>BENEFITS</u>

I am anticipating that your participation in this project will be meaningful, and rewarding to you and fellow sufferers of diabetes, like me, and other African-Americans. The research seeks to develop a model that will bring understanding of African-American church members suffering from diabetes. The results of the understanding are for the purpose of inviting much needed support to decrease the spread of the disease and help those with the disease better manage it. The interview will take no more than two hours of your time, plus approximately 30 minutes if a follow-up is needed. The investigator is anticipating receiving a grant from the American Society of Clinical Laboratory Science (ASCLS). You will receive $75.00 for completing the first interview and $25.00 more for any follow-up, if needed, should you decide to participate. You will receive the money upon completion of the interview, with or without me receiving the grant. The money is in appreciation for your willingness to participate in this study.

RISKS

There is no known risk of physical harm beyond any preexisting limitations in your ability to speak. While I do not anticipate any emotional or psychological damage, the possibility exists that painful memories may be stressful. Remember, you are in control of the interview, in that you inform the investigator of what you believe is best. For example, you may want to take a break, postpone the interview, or terminate the interview. You should do what you think is best for you.

CONFIDENTIALITY

I am the only one that will know your name and will not share it with anyone. Your confidentiality will be maintained with a pseudonym. All data collected, including the recording will refer to you with a pseudonym. The recording of you will be erased one year after completing my analysis. In addition, only I will have access to all documents (physical and electronic). Physical data will be locked in a file and electronic data will be password protected on my computer. This study will be published as part of my dissertation, but your name and all information will be made untraceable to you. Your name will have a pseudonym and information will be obscured with untraceable references. I will also seek to publish my finding in professional journals (medical, educational, conference talks, forums, and so on) or in books as part of my commitment to solicit support for the African-American community suffering from diabetes. However, your name will maintain confidentiality with a pseudonym along with any other references, to prevent the information being traced back to you.

Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB chair, Dr. Jon Lasser (512-245-3413 - lasser@txstate.edu) and to Becky Northcut, Director, Research Integrity & Compliance (512-245-2314 - bnorthcut@txstate.edu).

Your Consent at a Glance

I have read the preceding consent form, or it has been read to me, and I fully understand the meaning of the words of this document or they were explained to me to my satisfaction and I voluntarily consent to participate in the research study titled:

DM in an African-American Subculture: Grounded Theory of Faith, Knowledge, and Social Constructs. I understand that I may withdraw my consent at any time.

I give my permission and understand that the data are used for educational research and certain quotes may be used and published for viewing by the public, but my name will not appear in the document, as explained above. I understand that I will receive a stipend for participating in this study, as detailed in the above consent form. I have received a copy of this consent form if requested.

_____

Printed Name   Date

_____

Signature   Date

_____

Signature of Investigator obtaining consent   Date

INTERVIEW GUIDE

Interview

Read Prior to Interview

This interview consists of open ended questions, meaning you are encouraged to talk freely, including facts, thoughts, impressions and so on. The questions are sequenced to reduce my influence on your answers. In other words, please do not give me what you think I want to hear or what you think will make you look favorable to me. I also have secondary questions in case you did not touch on an area I would like you to address.

I want you to know that I am an ordained elder in the COGIC with diabetes who does not have the answers to these questions. I am also a researcher and without knowing the true feelings of those with diabetes like you and I, we will never get the support for African-Americans that is needed. We have almost the greatest number of sufferers; not the greatest number, but percentage. I have seen many, I even know a COGIC Bishop with amputations because of diabetes, so please do not think this is a judgment session. Without you and others like us speaking out and giving our opinions, good or bad, then others will do it for us.

Please relax, this is not a test, but one of my greatest lessons from this research is finding out that talking to someone you can trust is like therapy. Remember, the information will be disguised so it will not be traced back to you. Also, remember, you are in control of the interview, in that you inform me of what you believe is best. For example, you may want to take a break, postpone the interview, or terminate the

interview. You should do what you think is best for you. Do you have any questions or concerns before we start? Let us take a final look at the consent form.

The Interview

1. **Tell me about diabetes.** [Afro-Theistic faith, knowledge, and Afro-Theistic social construct]

   - What kinds of diabetes do you know about?

2. **How did you learned about the diabetes (sugar)?** [knowledge, Afro-Theistic social construct]

3. **What has life been like since you have had diabetes?** [Afro-Theistic faith, knowledge, and Afro-Theistic social construct]

   - Would you share some examples?

4. **Recall a time when your diabetes was bad or you were convinced that what was happening to you was not good.** [knowledge]

   - Do you have some examples?

5. **Tell me about your experiences with diabetes last week.** [knowledge]

6. **Tell me, what thoughts do you have when you think about church members teachings about faith and having diabetes?** [Afro-Theistic faith, knowledge, and Afro-Theistic social construct]

   - How do you believe preachers, church members, and other acquaintances feel about you having diabetes?

   - Fasting and praying…

   - Democracy…

7. **What kinds of church and personal activities help when you experience the most difficult times with diabetes?** [Afro-Theistic faith, knowledge, and Afro-Theistic social construct]

- What other kinds of support for diabetes do you know about to manage diabetes? [knowledge] [Research question 3]

- How do you feel about that support? [Research question 3]

INTERVIEW MATRIX

<table>
<tr><td colspan="3" align="center">Interview Question Matrix</td></tr>
<tr><th>Research Question</th><th>Data Collection Sources</th><th>Subject Category</th></tr>
<tr>
<td>1. What does diabetes education look like for the Afro-Theistic COGIC diabetes mellitus sufferers?</td>
<td>Interview Guide Questions 1, 2, 3, 4, 5, 6, 7</td>
<td>Afro-Theistic Faith, Knowledge, and Afro-Theistic Social Construct</td>
</tr>
<tr>
<td>2. How can Afro-Theistic faith and diabetes education coexist to help DM sufferers?</td>
<td>Interview Guide Questions 1, 4, 5, 6</td>
<td>Afro-Theistic Faith and knowledge</td>
</tr>
<tr>
<td>3. What are diabetic COGIC members' Afro-Theistic social constructs' beliefs about diabetes mellitus?</td>
<td>Interview Guide Questions 1, 2, 3, 4, 5, 6, 7</td>
<td>Afro-Theistic Faith and Afro-Theistic Social Construct</td>
</tr>
<tr>
<td>• What are the Afro-Theistic social constructs?</td>
<td>Interview Guide Questions 1, 2, 6, 7</td>
<td>Afro-Theistic Faith and Knowledge</td>
</tr>
<tr>
<td>4. How does the Afro-Theistic social constructs' interpretation of diabetes mellitus, overtly or covertly influence COGIC member's resolve to disregard intervention?</td>
<td>Interview Guide Questions 1, 2, 3, 4, 5, 6, 7</td>
<td>Afro-Theistic Faith, Knowledge, and Afro-Theistic Social Construct</td>
</tr>
</table>

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