Psychosocial Group Intervention at a Low-Resource Setting Environment for Women Who are Diagnosed and Treated for Breast Cancer: A Systematic Review[1]

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Abstract

Africa faces significant challenges in terms of material and personnel resources for oncology interventions. This is particularly evident in South Africa, where resources are divided into high- and low-resource settings. High-resource settings cater to those with financial means to access private oncology facilities. However, many breast cancer patients receive care in South Africa's low-resource settings, such as public hospital oncology clinics. Unfortunately, these settings have limited service providers and fail to offer comprehensive interventions, resulting in poor outcomes. However, recent research has highlighted the significance of socially supportive relationships in promoting healing and overall individual well-being, and spirituality has been identified as a source of positive outcomes in cancer patients. This systematic review paper explores the feasibility of implementing support group cancer care and interventions that incorporate social support networks available in community settings, and spiritual practices facilitated by traditional healers, and religious/spiritual leaders. These interventions can be provided within low-resource settings to women diagnosed with breast cancer. Inclusive participation of spouses, children, and extended family in the support group cancer care can facilitate healing for the entire system. Focusing on the strengths and resources within communities and

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incorporating these complementary services, can enhance the well-being and quality of life for Black African women diagnosed with breast cancer, despite low-resource settings. This approach acknowledges the potential of community-based support networks and encourages collaboration between various stakeholders, including community health educators, nurses, lay counselors, and community volunteers, to address the complex needs of these patients.

Keywords: Breast cancer, low socioeconomic status, social support system, the Collective Unconscious, Low-resource setting intervention

1 Introduction

Cancer is a leading cause of death worldwide, affecting both adults and children (Seitz, Besier & Goldbeck 2009). The disease has a profound impact on the mental health of patients, leading many to seek coping mechanisms. Group therapy has been recommended as part of the treatment plan for cancer patients to help them manage the psychological strain (Classen *et al.* 2008) . A pivotal study by Spiegel *et al.* (Spiegel *et al.* 1981) on group therapy for breast cancer patients laid the foundation for psychosocial cancer care practices, demonstrating the benefits of improving psychological health and extending survival. Research indicates that the prognosis for breast cancer patients is influenced by their participation in psychosocial interventions(Classen *et al.* 2008); Spiegel *et al.* 1981; Cipolletta *et al.* 2018; Serlin *et al.* 2000). The goal of supportive-expressive group therapy is to help patients embrace life more fully, despite their life-threatening illness [Spiegel *et al.* 1981).

Spiegel *et al.*'s (1981) model incorporated Yalom's (1995) principles of group process. Yalom emphasized the importance of cohesion in achieving psychological well-being and healing. Cohesion refers to the relationships between the group members, including the leader. Cohesion creates an atmosphere of unconditional acceptance, dissipates feelings of shame and isolation, and assures individuals that they are not alone in their struggles (Yalom 2005). Sharing existential concerns and discussions of death and dying promote cohesion within group therapy, enabling individuals to confront their fears (Butow *et al.* 2007). Emotional disclosure facilitates interconnectedness among members, allowing the group to evolve as an integrated and whole system (Cambell, Coldicott & Kinsella 2019). Contemporary studies have expanded on Spiegel *et al.*'s model (Spiegel *et al.* 1981) by adopting a systemic viewpoint that encourages new ways of relating among group members. This approach allows individuals to assert their own contributions in self-care, create futures for themselves, and make new commitments to their families and communities.

Jung's (1977) theory of the collective unconscious provides a framework that addresses the interconnectedness among human beings as part of a larger context. Jung (1977:66) describes the collective unconscious as follows: 'The collective unconscious is detached from anything personal and is common to all men [sic] since its contents can be found everywhere, which is naturally not the case with personal content'. Jung's theory incorporates cosmic processes and spirituality into everyday life, embracing the diversity, culture, spirituality, and way of life of affected women and their communities (Jacobi 1973). It operates within fluid and permeable boundaries between the sick, the healer, and the community members, including elders (Kremer 2000; and Nwoye 20002). Indigenous healing practices emphasize communal and inclusive approaches with the full participation of others.

To date, only a few studies in psycho-oncology have adopted a collective unconscious and systemic approach, by incorporating family mem-bers, spouses, children, and community members in interventions aimed at improving the quality of life for women diagnosed and treated for breast cancer. The systemic approach recognizes the significance of collective creativity in altering and renegotiating identities for the larger whole (Campbell 2000). Such an approach can be beneficial in alleviating cancer outcomes and improving survivorship, as it values the presence of multiple realities (Koster, Baccar& Lemelin 2012.

In their study, Rettger *et al.* (2015) incorporated Psycho-Spiritual Integration Therapy (PSIT) practice in the group process and found that women were able to develop inner processing that increased personal control to actualize life purpose. Similarly, Patel *et al.* (Patel 2013) adopted PSIT practice in their group process and discovered that women expanded their sense of self and developed new meanings for their lives. From a collective unconscious perspective, spirituality deepens connections to life and enhances relationships with oneself, others in the community, the environment, and something greater than oneself (Drouin 2002). Furthermore, the collective unconscious aligns with indigenous worldviews, emphasizing spirituality as a way of being. Including spirituality in group processes introduces a new way of facilitating immersion (Marques, Freeman & Carter 2022). For example, healing rituals conducted by indige-nous healers can have implications for the group process, aligning with an understanding of the meaning of illness and the messages communicated by ancestors. Such rituals deepen spiritual experiences within relationships and promote cohesion in unique ways, contributing to individual and community well-being (Nwoye 2015).

For Jung, the collective unconscious refers to the objective part of the psyche containing shared patterns of behavior among all human beings (Edinger 2002). In a similar vein, Ullman (1996:6) applied the notion of the ‘social unconscious’. According to Ullman (1996), the social unconscious pertains to the socialization process, where individuals may be unaware of the impact of external social factors on their lives. Fromm (Fromm 1980) introduced the concept of the social unconscious to describe information revealed in dreams about the existence and constraints of social, cultural, and communicational arrangements of which individuals remain unaware (p. 14). Furthermore, Hopper (2001) explains that the social unconscious can manifest when people unconsciously recreate situations that have occurred in the past, presenting the new situation as equivalent to the previous one. Hopper (2001) argues that, within a family system, groups can re-enact various aspects of social trauma from another time and place. Untreated unresolved trauma within the family system necessitates therapeutic intervention, as it can impede growth and development (Hopper (2001).

Jung’s theory of the collective unconscious posits that dreams reveal psychological processes with historical, collective, mythological, and ancestral significance (Jung 1977). Jung’s model encompasses both the individual and the community. His archetypes align with indigenous worldviews, seeking to restore wholeness (Edwards 2011). Similarly, aboriginal peoples’ concepts of health and healing emphasize interconnectedness, balance, and holism, which encompass the family, environment, and community contexts (Ellerby *et al.* 2000). A systemic approach is a framework to structure cancer support and interventions.

The ecosystem orientation considers the family as a natural, rule-governed system, wherein changes in one part of the system impact the entire system (Selvini-Palazzolli *et al.* 1978). The systemic orientation can lead to first-order and second-order change (Watzlawick, Weakland & Fish 1667).

First-order change involves modifying the activities of specific system components to enable adaptation in response to external changes (Watzlawick, Weakland & Fish 1674). For instance, within an organization, managers might decide to reduce production rates due to a decline in sales resulting in increased stock levels (Campbell 2000). On the other hand, second-order change involves altering the organization of the system by introducing new rules that govern relationships (Watzlawick, Weakland & Fish 1667). Second-order change focuses on the language used to develop critical consciousness. Change occurs through meaning-making processes that are integral to the dialogue, leading to the evolution of new rules governing each subsystem and its relationship to the entire system. Within this perspective, change unfolds during dialogue, where members share their stories and express their perspectives (Weick & Quin 1999). The systems theory framework emphasizes the importance of relationships and connections among different parts of the system (Watzlawick, Weakland & & Fish 1994).

In the literature, there is limited research that investigates the impact of breast cancer experiences on spouses, partners, and families of the patients (Cipolletta *et al.* 2019; Gabriel 2017; Lechner *et al.* 2012; Nair *et al.* 2018; Odigie *et al.* 2010: and Ristevski *et al.* 2020). Those who are affected by breast cancer experience (such as the spouses and family members) may be granted an opportunity to understand the meaning of their experiences and adapt to their new version of reality (Mertens 2010). From a transformational viewpoint, the participation of spouses in the healing process may promote wholeness (Cowling 2000). Breast cancer illness may expand spouses' consciousness, enabling them to appreciate gender differences, demonstrate empathy, and show compassion and respect for others (Asante 2011). Through breast cancer illness, spouses may engage in emancipatory learning to gain awareness and meaning of what their significant others communicate concerning their emotions (Mezirow 1990). Spouses may acquire a new meaning structure, and may potentially grow and develop new insights that can renew purpose in their marital life.

2 Objectives

This paper aims to conduct a systematic literature review to identify interventions specifically delivered in low-resource settings for women diagnosed with breast cancer. To date, only a limited number of studies in psycho-oncology have embraced a collective unconscious and systemic approach, by involving family and community members in interventions aimed at improving the quality of life for women diagnosed and treated for breast cancer. The systemic approach is a framework that recognizes the importance of collective creativity in altering, renegotiating, and developing new identities for the affected person's broader whole (Campbell, Coldicott & Kinsella 2019). This review will also encompass non-Western cultures, including African American women, Latinos, Chinese American women in the United States, aboriginal women in Canada, indigenous native women in Australia, and those in Indonesia. The review will also explore how current psychosocial interventions can meet the needs of indigenous native and Black African women diagnosed with breast cancer in developing nations, specifically within the African continent.

3 Methodology

A comprehensive computerized literature search was conducted using MEDLINE via EBSCOHost, CINAHL, PsychInfo, Google search, PubMed, and indigenous collection databases. The search terms included: breast cancer intervention, Black women, psychosocial intervention for indigenous people (women), women from non-Western cultures, and African American, Chinese American, and Latino women diagnosed with breast cancer. Furthermore, psychosocial interventions for non-western cultures such as Indonesia, Malaysia, and African countries were included in the search. The search was not restricted by publication date. The criteria for manuscript eligibility included both unpublished doctoral dissertations and published peer-reviewed articles. Qualitative and mixed-method research studies were selected, as they provided valuable insights into participants' personal experiences (Cresswell 1994). The search also involved the application of indigenous-based methods, such as circles, to give voice to vulnerable populations (Schlitz, Vieten & Miller 2010). Additionally, the reference lists of retrieved publications and reviews were manually searched to ensure comprehensive coverage.

3.1 Inclusion Criteria Used to Select Reviewed Studies

The search aimed to identify studies that met specific criteria related to breast cancer interventions for indigenous Black African, native, and aboriginal women. Out of the 32 studies reviewed, eight focused on needs assessment, while 24 examined emerging interventions in the developmental stages. In line with Jung's theory of the collective unconscious, which incorporates cosmic processes and spirituality, relevant studies that incorporated spirituality in their practice (Rettger *et al.* 2015; Patel 2013; Lechner *et al.* 2012; Banham *et al.* 2019; Chou, Lee-Lin 2016; Chun *et al.* 2009; Murray *et al.* 2021; Nzuza 2016; Struthers & Eschiti 2004; and Targ & Levine 2002) were included in the review. Studies that aligned with the collective unconscious and systemic approach framework were also selected.

Regarding cancer support care interventions and practices, only studies that aligned with a systemic framework emphasizing relationships and connections among various parts of the client system were included (Cipolletta *et al.* 2018; Gabriel 2017; Lechner 2012; Nair *et al.* 2018; Ristevski 2020; Chou, Lee-Lin & Kuang 2016; Chung *et al.* 2009; Nzuza 2016; Benson *et al.* 2020; Brooks 2009; and Ziabakhsh 2015). The review also included studies focusing on change implications of meaning-making processes (Ahmadi & Hussin 2016; and Masziliano 2018) and dialogue through which members share their stories and learning experiences (Serlin *et al.* 2000; Murray *et al.* 2021; Mokuau, Braun & Daniggelis 2012; Goelitz 2007; and Hazou *et al.* 2010).

To ensure the inclusion of studies applicable to indigenous participants, the checklist of eight dimensions developed by Huria *et al.* (2019) was employed. The CONSIDER reporting process criteria (Huria 2019) guided the assessment, with a focus on participation, methodologies, relationships, and capacity. Indigenous identity was a criterion for participation, and research reports were expected to include details of indigenous leadership, participant recruitment, participant confidentiality, and the consenting process. Indigenous community members were involved in data analysis, and research relationships were characterized by meaningful engagement and ethical processes. The expertise and capacity of indigenous participants and stakeholders were matched with their involvement in the research process.

In total, 21 studies were reviewed, and selected based on collaborative research efforts aimed at building community capacity (Wright *et al.* 2016). Collaborative research involved the inclusion of indigenous community members and elders, while qualitative methodologies were favored to give voice to indigenous people. Oral data collection methods such as traditional interviews, focus groups, circles, and storytelling were utilized to capture proximal immediacy and valued sources of knowledge in indigenous cultures. Methods like photo-voice, circles, and storytelling allowed participants to share their experiences and perspectives. Circles, viewed holistically in indigenous cultures, served as a means of passing down stories, promoting healing, and facilitating intergenerational learning. Songs were recognized as a form of contemplative knowledge, enabling spiritual awakening and providing deep cultural insights into the earth and nature.

4 Thematic Analysis

The themes were extracted using thematic content analysis (Braun & Clarke 2006). Themes were developed from the codes (and collated data) across all data items in the entire dataset. Using Jung's collective unconscious theory as a framework that incorporated spirituality in cancer support care the following themes were identified: 1) inclusion of spirituality; 2) community-based interventions can establish a social support network; 3) wider and blended participation can include families, caregivers, friends, and prayer team members. In addition, the systemic approach framework included the themes: 1) capacity to build cohesion among participants; 2) the meaning-making process is co-created by all participants; and 3) incorporated direct learning through experience.

4.1 Inclusion of Spirituality May Enhance Well-Being

Several studies by Rettger *et al.* (2015), Patel (2013), Lechner *et al.* (2012), Banham (2019), Chou, Lee-Lin and Kuang (2016), Chung et al. (2009), Marry *et al.* (2021), Nzuza (2016), Struthers and Eschiti (2004), Targ and Levinin (2002). Nracciodieta (2013) and Mohammadi, khan and Vanaki (2018) explored the incorporation of spirituality, traditional medicine, healing practices, and prayer as coping strategies for cancer. For example, Mohammadi *et al.* (2018) studied strategies for coping among Iranian women who were treated for breast cancer and found that women had increased their spiritual practice, became intentional and demonstrated self-compassion. On the other hand, African-American women relied on church-based support and prayers from their priest or pastor ((lechner *et al.* 2012; and Chung *et al.* 2009). Participation in religious interventions such as drinking holy water and receiving prayers from the priest or pastor brought comfort and alleviated anxiety during their cancer journey (Brooks 2009). Nzuza (2016) mentioned that, for Black African women, participation in divination and the animal slaughtering ritual, as well as consumption of herbal medicine, were sources of emotional support (Benson *et al.* 2020).

In their studies, Bracciodieta (2013) Patel *et al.* (2013), and Rettger *et al.* (2015) incorporated the Psycho-Spiritual Integrative Therapy (PSIT) intervention developed by Wall and Peters (2007), an integrated mind-body-spirit intervention to aid the participants in their own psychological and spiritual growth and transformation. PSIT intervention guided women to develop their own spiritual consciousness in their everyday lives (Patel 2013) . PSIT supported breast cancer patients to seek meaning and purpose, as well as deepened spirituality (Rettger *et al.* 2015). Women learned to go inward within themselves, to relax their bodies fully, and were pleased to learn how to breathe more deeply, as they gained awareness of how they were feeling (Bracciodieta 2013).

In support of the above study, Targ and Levine (2002) examined outcomes for 181 women with breast cancer who participated in a randomized study within a primary care setting. Participants in the complementary and alternative medicine (CAM) group were taught the use of meditation, affirmation, imagery, and ritual. The CAM group showed a statistically significant increase in measures of spiritual integration and was associated with decreased avoidance. The researchers found that CAM had the beneficial effect of bringing people together within a structure that allows them to speak and be heard. However, the study was weak, in that there was no control group.

Among indigenous native peoples, the inclusion of cultural healing and spirituality such as wrapping an animal cloak around the cancer patient during their medical check-ups and treatment was practiced Banham *et al.* 2019; and Murray *et al.* 2021). However, among aboriginal peoples, traditional health models and practices like the sun dance and sweat lodges were criminalized (Brooks 2009), although Frideres (2009) argued that many aboriginal patients could heal themselves by practicing these traditional methods. Aboriginal peoples viewed traditional healing and ceremonies as safe, positive, equal, natural, and free of racism (Brooks 2009).

In a case study by Struthers and Eschiti (2004), indigenous women described their lived experiences with traditional healing practices. Some participants sought healing as a way to connect with their indigenous culture after receiving a cancer diagnosis. In some cases, participants reported being aware that something was wrong through interpretations of their dreams; recurring dreams provided information about their health status and prepared them for the diagnosis. The findings indicated that indigenous women believed that participation in traditional healing practices prepared them to endure the challenges of biomedical treatments such as chemotherapy or surgery. Before starting Western treatment, women engaged in healing ceremonies and rituals, including sweat lodges, shake tents, singing songs, praying, participating in the sun dance, and taking part in *yuwipi*, a nighttime curing ceremony conducted by a medicine man in a darkened room. After traditional healing, they proceeded with the Western treatment regime, and all participants had positive outcomes. The women expressed gratitude for their culture as a source of strength, power, identity, and spiritual support.

Mehl-Madrona and Mainguy (2014) emphasized the statistically significant improvement in the overall quality of life of participants who engaged in talking circles. Attending four or more sessions out of eight led to positive changes. Talking circles, deeply rooted in the traditional practices of indigenous people, served as a useful tool for Native Americans. Ziabakhsh (Zianakkhsh 2015) highlighted that the talking circle group process facilitated rapport building, trust, acceptance, and a sense of belonging. It enabled deep emotional disclosure, vulnerability, and the sharing of personal experiences within the group. Additionally, Marques *et al.* (Marques, Freeman & Carter 2022) demonstrated that rituals such as prayer and communication with plants promoted healing. The interconnectedness of all existence, including living and non-living entities, facilitated deeper spiritual experiences and promoted individual and community well-being (Nwoye 2015).

4.2 Community-Based Interventions Can Establish a Social Support Network

Cobb (1976) defined social support as information that fosters feelings of care, love, esteem, and value among individuals. Yao *et al.* (2015) discovered that social support groups offer ‘relatedness’ support to their members during times of need. Group members form close emotional bonds by sharing collective experiences within their community and providing each other with social support resources Carú & Cova (2015) . Nzuza (2016) emphasized the role of social support from families among South African participants, with most women expressing satisfaction with the support received from their loved ones.

Various types of social support have been identified by researchers as promoting human well-being (Rosenbaum & Smallwood 2013). Emotional, companionship and informational support can be provided by participants in support groups, with emotional support being particularly important (Rosenbaum *et al.* 2021). Emotional support involves caring, acceptance, and sympathetic listening to individuals facing problems. Given the fear and confusion associated with cancer, it is essential to explore the emotional responses of indigenous peoples upon hearing about cancer in their community. African American women, as highlighted by Whitehead and Hearn (2015), have reported a lack of social support. Therefore, interventions incorporating social support strategies have been implemented to increase screening and treatment adherence among Black women. These interventions often involve community elders and the support of informal individuals or cultural brokers in the community (Lechner *et al.* 2012).

Informational support plays a role in enhancing the understanding of cancer. Storytelling approaches and culturally sensitive discussion groups have been employed to address issues related to access to services and other concerns. These interventions aim to improve women’s knowledge and skills while establishing a network of support for cancer patients. Studies conducted in the US with minority groups, including African American women, indigenous native or aboriginal women, and Chinese American women diagnosed with breast cancer, have explored these support approaches (Lechner *et al.* 2012; Chou, Lee-Lin & Kuang 2016; Chung *et al.* 2009; and Mokuau, Braun & Daniggelis 2012). Tailored group support interventions, such as the one developed by Chou *et al.* (Chou, Lee-Lin & Kuang 2016) for Chinese-American breast cancer survivors, seek to ensure relevance within specific cultural contexts. The interventions may be hosted by community organizations that create a safe and culturally appropriate environment. In addition, Dominic *et al.* (2018) piloted a Malaysian psychosocial intervention that addressed specific cultural challenges and aimed to shift cancer patients' locus of control from external to internal. The primary goals included developing an internal locus of control, improving quality of life, and reducing depression and anxiety (Ho, Spiegel & Chan 2016).

4.3 Wider and Blended Participation Can Include Families, Caregivers, Friends, and Prayer Team Members

Studies focusing on breast cancer care and support groups have highlighted the importance of including family members, particularly spouses, children, and extended family members who often serve as caregivers. Such inclusion can facilitate the healing of unresolved trauma and promote personal growth (Hopper 2001). Family members can be given opportunities to reflect on their own experiences of death, dying, fears, and anxiety, thereby contributing to their own psychological well-being. Through participation in the support group intervention, group experience can enrich interactions, enable joining with another and a sense of feeling connected, and develop a new value of we-ness (Cipolletta *et al.* 2018). Involvement of spouses, partners, and families may develop flexible self boundaries, and develop a sense of self-endangered with relatedness (Jordan 1984). Furthermore, breast cancer treatment experiences may also initiate the spouse's and family unit's individuation process to unfold, through exploration of the unconscious personal and collective processes. The family may jointly individuate and develop a renewed commitment to the psychological development of the collective.

In the context of breast cancer, studies that have incorporated family members closely connected to women diagnosed with the disease have yielded valuable insights. For instance, in Nzuza's (2016) study, women who received social support from families were reported to have developed self-acceptance and regained self-belief. Similarly, in Bracciodieta's (2013) study, one woman was grateful when her husband accompanied her to attend a support group process. She felt supported by her spouse and children, who made her feel loved and wanted throughout her cancer experience (Bracciodieta 2013). During that process, the spouse was granted the opportunity to reflect on his own experiences of death and dying, fears, and anxiety, and produced new knowledge that could lead to his own psychological well-being. Through cancer experience, the spouse's sense of self may grow by developing their ability to learn new tasks in the caring role in the house to assist the sickly woman; this may include the children and bring unity between parents and children to work together as an integrated whole.

Furthermore, Ristevski *et al.* (2020) reported the use of a yarning circle approach, which created a safe and supportive environment for participants to share experiences and personal stories. This approach resulted in the development of a culturally appropriate cancer survivorship model of care for Aboriginal people in Victoria, Australia. Similarly, Supramaniam *et al.* (2014) argued that the use of traditional medicine during palliative care, which reconnects individuals to their land, ancestral roots, and spirituality, can enhance overall well-being. Brooks (2009) captured the stories of women diagnosed with cancer and their family members through oral communication, storytelling, songs, and rituals.

In indigenous communities, decision-making processes regarding cancer treatment involve collaboration among family members and community elders. Benson *et al.* (2020) and Lambert *et al.* (2020) found that Black African women prefer spiritual and social support from colleagues at work, congregation members, and extended family members, as these provide reliable sources of strength during their cancer journey.

Informal family interactions in home and community settings can play an indispensable role in alleviating the outcomes of cancer. Qualitative studies conducted by Benson *et al.* (2020) and Lambert *et al.* (2020) examined the psychosocial needs of indigenous Black African women diagnosed with breast cancer. Studies conducted by Benson *et al.* (2020), Gabriel (2017), and Lince-Deroche *et al.* (2017) revealed that the cancer experience is a collective journey involving family and friends, providing an opportunity for spiritual growth among Black African women diagnosed and treated for breast cancer.

In a group intervention, Harris *et al.* (2016) utilized a blended delivery method (combining face-to-face, group, and individual approaches) to enhance group cohesion by involving spouses, children, family members, and community members in breast cancer care practices. For example, Harris *et al.* (Harris *et al.* 2016) piloted a six-week blended delivery program for Indonesian women with a breast cancer diagnosis. The intervention included face-to-face group activities in the second week, followed by peer mentors contacting participants individually through phone calls or face-to-face visits, often engaging with family members. Information-sharing was facilitated through the distribution of a leaflet. The subsequent weeks included individual sessions conducted via telephone or private visits at home. The final session in the sixth week involved a face-to-face gathering for post-intervention measurements and a final feedback session.

4.3.1 The Systemic Approach is a Framework to Structure Cancer Support Groups and Build Capacity through Cohesion among Participants

As described above, many researchers emphasized the importance of promoting support networks (Chung et al 2009). In the study conducted by Haozous *et al.* (Haozous et al. 2010), indigenous community members and elders collaborated in the implementation of a program, fostering understanding through relationships, dialogue, and interactions. Community health leaders could establish “walking buddy” schemes, pairing individuals living with breast cancer with local residents. This approach fostered a shared responsibility in creating, planning, and implementing the program, eliminating power dynamics and ensuring its success. Speer *et al.* (2001) attested that highly socially cohesive neighborhoods empower participants and embrace equality and democratic values, leading to positive health outcomes. Furthermore, researchers focused on developing the capacity of individuals by improving women’s knowledge and skills to establish cancer support networks (Mokuau, Braun & Daniggelis 2012). Speer *et al.* (2001) also suggested the establishment of personal networks among neighbors, such as food and tool-sharing cooperatives, which can increase membership retention within organizations and communities.

Echeverría *et al.* (2008) discovered that emotional social support networks are highly prevalent in socially cohesive neighborhoods and can contribute to positive health outcomes. Social cohesion develops through community-level social support, where members receive support and feel connected to each other Kawachi and Berkman, 2000, in Reynolds (2017). Various sources of support, such as family, religion, and friends, can promote mental health (Brooks 2009). The implementation of social support groups allows women to share mutual experiences, develop reciprocity, and increase interaction among residents(Reynolds 2017).

Lechner *et al.*'s (Lechner et al. 2012) Project CARE initiative, a community-based participatory program delivered in community settings, aimed to promote social support networks, participant engagement, and a culturally welcoming environment. The intervention involved community brokers and elders to build capacity within the community (Lechner *et al.* 2012). Project CARE incorporated participants' ethnocultural experiences, and the culture and ethnic identity of African American/Black women. It focused on adapted cognitive-behavioral strategies and included measurements of coping strategies. Women reported a greater reduction in negative affect following the uncertainty management intervention, and the program assisted women with survivorship concerns through coping and self-management based on theory.

Moreover, Haozous *et al.* (2010) developed an intervention in the USA specifically targeting indigenous native communities and females with breast cancer. The intervention involved capacity building, with local community members and content experts jointly developing the video content and presentations (Haozous *et al.* 2010). Blended participation, including members of the local community and women diagnosed with breast cancer, aimed to break barriers, improve access to social resources, and foster connections among participants. This approach aligns with Miller *et al.*'s (2022) perspective of introducing social community engagement initiatives to increase social cohesion in neighborhoods and improve chronic illness treatment outcomes. Miller *et al.* (2022) suggested encouraging people living with breast cancer to walk with family and friends in the park or participate in community park cleanups as a means to socialize and enhance their physical and mental health. This practice resonates with Reynold's (Reynolds 2017) suggestions regarding community participation as a technique to embrace those who are isolated due to chronic illness.

Through affiliations, individuals and community members can develop connections and share values toward a common goal (Kautner 2005). For example, Chung *et al.* (Chung *et al.* 2009) developed an adapted Taking CHARGE intervention for African-American women, particularly beneficial for those experiencing isolation, stigma, or divorce/separation. The intervention addressed depression, anxiety, and isolation resulting from stigma, using adapted cognitive-behavioral stress management strategies to cope with cancer-related stressors. Facilitators applied positive reframing techniques concerning depression and anxiety to assist women in accepting their illnesses.

4.3.2 The Meaning-Making Process is Co-Created by All Participants

Struthers and Eschiti (2004) conducted a case study that explored the lived experiences of indigenous native cancer patients who incorporated traditional healing practices during their cancer journey. The study reported instances where participants described recurring dreams, one of which involved a participant later diagnosed with breast cancer. Ahmadi and Hussin (Ahmadi & Hussin 2016) investigated the role of dreaming among indigenous cancer patients and found a positive relationship between dream images and patients' behavior upon waking. Dreams influenced participants to seek timely medical intervention for cancer diagnosis and throughout their cancer journey.

During the seventies, Montague Ullman (1996) pioneered a group dream work process. Ullman believed that sharing dreams in a group setting is a powerful process because, despite unique circumstances, there are universal issues such as work, family, significant others, personal growth, aging, and death. According to Ullman, everyone dreams, which reveals the interconnectedness of humankind. Participation in the indigenous dreaming approach can help reconnect and restore wholeness for those affected. Ullman (1996) claimed that dreams can serve as a catalyst for social change by revealing societal issues and fostering connections among diverse participants, breaking down racial and gender separations. Dreams have the potential to reconnect individuals to a larger whole, as life experiences in society can sometimes fragment their sense of self and connection to others (Ullman 1996).

4.3.3 Incorporated Direct Learning through Experience

Indigenous knowledge has played a significant role in the development of relevant interventions that emphasize learning through experiential practice (Sillitoe 2000). An example of such an intervention is Murray *et al.*'s (2021) engagement project, where Aboriginal and Torres Strait Islander cancer patients were provided with possum skin cloaks to wrap themselves in during treatment at the Peter MacCallum Cancer Centre. These cloaks, made from ethically sourced possum skin pelts from New Zealand, aimed to demonstrate the value of incorporating cultural healing elements into the medical process for indigenous cancer patients.

The African worldview also supports embodied practice, which enables individuals to experience a connection with vital energy and effect change. Nagata (2004) introduced the concept of body mindfulness practice, which involves cultivating attunement to experiences as they unfold, understanding the influence of one's own behavior on relationships with others, and managing energy through conscious breathing.

Serlin *et al.* (2000) incorporated dance and movement into support groups for Latino or minority women with breast cancer diagnoses, many of whom were still undergoing treatments and had experienced mutilation. The dance and movement interventions allowed these women to express themselves physically, resulting in radiant energy. The study showed improved physiological and immunological changes, as a result of combining physical activity and imagery. Through questions and discussions about their bodies, the women's narratives transformed, reflecting a spirituality based on the body and emotion.

Bosnak's Embodied Imagination (EI) dreamwork method has been beneficial in helping cancer patients explore the wisdom of dreams within their bodies for healing. Bosnak (1996) emphasized the connection between physical symptoms and psychic problems, recognizing dreams as a means of processing information. Dream work can assist cancer patients in managing their illness and addressing major issues related to cancer and its treatment. Studies have shown that dreams can regulate coping mechanisms and reduce stress (Giarmo as cited in Goelitz 2007).

The embodied imagination method employed in dream work involves several fundamental processes (Bosnak 1996). First, it takes place in a hypnagogic state, which is a hybrid state of consciousness between dreaming and sleep. Participants re-experience the dream environment and engage with dream images. Second, before encountering the dream, a brief check-in and a meditative exercise are conducted to heighten body awareness. Third, participants share dreams in a group setting, focusing on the bodily sensations and emotions evoked by the dream. Fourth, associations and personal contexts related to dream images are explored. Fifth, participants pinpoint the specific locations within their bodies where they experience sensations and emotions related to dream images. Throughout the session, a somatically anchored network of experiences is established to gain insight into archetypal dream imagery and facilitate positive changes in dysfunctional patterns that hinder mind-body wellness.

Wright *et al.* (Wright *et al.* 2015) conducted a study on meaning-centered dream work among terminally ill cancer hospice patients and found that dreams played a significant role in changing their perspectives, reconnecting them with sources of meaning, and transcending despair and loss of autonomy. Goelitz (2007) integrated body-centered interventions for cancer patients, considering their physical needs and addressing the chronic pain and fear associated with cancer. The embodied imagination approach provided space and time for somatic experiences, allowing the body to become a vehicle for self-cultivation and creative transformation.

In the dream work process, the goal is to explore the wisdom of dreams within the body, heighten body awareness through meditative exercises, encourage the re-experience of dreams, focus on feelings and body sensations, and engage dream images to expand the imagination. By gaining new perspectives and insights, dysfunctional patterns can be changed, facilitating mind-body wellness.

5 Conclusions and Recommendations

Out of the 32 studies reviewed, eight focused on needs assessment, while 24 focused on emerging interventions at the developmental stages. The paper aimed to systematically review and identify feasible interventions for women diagnosed with breast cancer in low-resource settings. The framework employed for these interventions incorporates spirituality, family members, spouses, children, and community members, using both collective unconscious and systemic approaches to improve the quality of life for women undergoing breast cancer diagnosis and treatment. The systemic approach recognizes practices that enhance participants' capacity and reshape their meaning-making processes, allowing for the renegotiation and development of new identities within the larger whole (Campbell, Coldicott & Kinsella 2019).

Four main findings were reported from the systematic review. First, 50% of the relevant studies and practices emphasized relationships and connections (Gabriel 2017; Lechner *et al.* 2012; Ristevski 2020; Chou, Lee-Lin & Kuang 2016 Chung *et al.* 2009; Nzuza 2016; Benson *et al.* 2020; Brooks 2009; Harris *et al.* 2016; Lambert 2020; Lince-Deroche *et al.* 2017; Marmarosh, Holtz & Schottenbauer 2005; Mokua 2012; Whitehea & Hearn 2015; Ziabakhsh 2015). *First*, researchers have found strength in socially supportive relationships as a source of positive well-being promotion (Rosenbaum *et. al.* 2021). It is important to empower participants to share their needs, stories, and captured images, prioritizing community knowledge (Brooks 2009). Developing social support resources that meet the psychosocial needs of non-western women can enhance their cancer outcomes and prognosis. For instance, these can include individual sessions through telephone or private visits at home, engagement of peer mentors to build open relationships and harmony, and coordination of information sessions to minimize misunderstandings and communication gaps. Transforming school gardens or empty classrooms into socially supportive resources after school hours can improve community members' access to services (Rosenbaum *et. al.* 2021).

Second, approximately 33% of the reviewed studies and practices incorporated spirituality (Rettger *et al.* 2015; Patel 2013; Lechner *et al.* 2012; Banham *et al.* 2019; Chou, Lee-Lin & Kuang 2016; Chung *et al.* 2009; Murray *et al.* 2021; Nzuza 2017; Strucuters 7 Escheti 2004; and Targ & Levine 2002; and Bracciodieta 2013). Outside church services, church buildings in low-income urban areas can be utilized and incorporate spiritual interventions (worship, prayer, etc.). Participation of traditional healers and herbalists in primary healthcare interventions can expand the benefits, offering significant outcomes and additional social support resources in community non-medical settings.

Third, 10% of the studies noted that informal family interactions in home and community settings can play an indispensable role in alleviating the outcomes of cancer. Studies incorporating family (Gabriel 2017; Ristevski *et al.* 2020;Nzuza 2016; Benson *et al.* 2020; Lambert *et al.* 2020; Lince-Deroche 2017; Bracciodieta 2013) and studies that have formally included family members Cipolletta *et al.* 2018; Harris 2015) have revealed that the cancer experience is a collective journey involving family and friends, providing an opportunity for spiritual growth among non-western women diagnosed and treated for breast cancer. Joint activities such as video-making, knitting or sewing, and nutrition education (learning how to grow a vegetable garden) can be coordinated.

Fourth, 7% of the studies and practices focused on altering meaning-making processes (Ahmadi & Hussin 2016; and Masziliano 2018) and facilitating new knowledge and learning experiences through dialogue (Serlin 2000; Murray *et al.* 2021; Mokuau Braun & Daniggelis 2012; Goelitz 2007;

Haozous *et al.* 2010). In the past, indigenous native women hesitated to actively participate in support groups due to fear of provocation and cold interactions with professionals (Brooks 2009). Activities such as dance-movement classes and fitness, poetry lessons, storytelling or writing classes, photography classes, and “play-form” associations such as dream-sharing and drawing can be offered, and the participation of spouses, families, caregivers, and friends of women can be encouraged to promote sustainability.

Community-based interventions are valuable in low-resource settings. It is therefore beneficial to develop social support resources that can meet the psychosocial needs of non-western women in order to enhance their prognosis and cancer outcome. The review highlights the importance of practices that develop capacity through cohesion among participants, co-creation of meaning-making processes, and a commitment to new ways of being, leading to whole-system change. For non-western (indigenous native and African) women, successful psychosocial interventions should incurporate spirituality, kin networks, and oral storytelling, and take place in culturally welcoming environments that foster trust (Brooks 2009).

6 Limitations and Implications

There are limited empirical studies focused on indigenous native and Black African women’s psychosocial needs during the treatment phase for breast cancer. Replication studies are needed to further explore the effectiveness of culturally sensitive intervention approaches that incorporate the contextual aspects of socioeconomic status, colonial legacy, and marginalization of those affected by breast cancer. The implication of establishing social support resources in communities is the potential development of multidisciplinary teams consisting of primary healthcare practitioners, traditional healers, and herbalists who can offer a holistic service that could turn around the plight of late diagnosis for indigenous native and Black African women.

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Conflicts of Interest

There is no conflict of interest present in this article.

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