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Adaptation of a Psycho-Oncology Intervention for Black Breast Cancer Survivors: Project CARE

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Abstract

Black women are traditionally underserved in all aspects of cancer care. This disparity is particularly evident in the area of psychosocial interventions where there are few programs designed to specifically meet the needs of Black breast cancer survivors. Cognitive-behavioral stress management intervention (CBSM) has been shown to facilitate adjustment to cancer. Recently, this intervention model has been adapted for Black women who have recently completed treatment for breast cancer. We outline the components of the CBSM intervention, the steps we took to adapt the intervention to meet the needs of Black women (Project CARE) and discuss the preliminary findings regarding acceptability and retention of participants in this novel study.

Keywords

health psychology; content; multiculturalism; race/ethnicity; dimensions of diversity

Black women are traditionally underserved in all aspects of cancer care (National Cancer Institute Center to Reduce Cancer Health Disparities, 2007). Despite lower incidence of disease, Black women have a higher mortality rate than other racial and ethnic groups (Carey et al., 2006; Lannin, Mathews, Mitchell, & Swanson, 2002; Reynolds et al., 1994, 2000). In addition, Black women with breast cancer are more likely to be diagnosed with later stage disease, imparting a poorer prognosis and greater need of social support (Coates et al., 1992; Eley et al., 1994; Lannin et al., 1998). Later stage disease also requires more invasive treatments to eradicate the cancer, resulting in diminished quality of life and more physical discomfort (Aziz & Rowland, 2002). Whether Black Americans experience poorer cancer-related quality of life is a controversial topic in a growing body of literature; the mixed findings are most likely the result of differences in sample composition with regard to

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income, neighborhood characteristics, sociodemographic factors, stage of disease, and other medical and treatment variables (Ashing-Giwa, Ganz & Peterson, 1999; Ashing-Giwa & Lim, 2001; Giedzinska, Meyerowitz, Ganz, & Rowland, 2004; Hao et al., 2011; Janz et al., 2009; Matthews, Tejada, Johnson, Berbaum, & Manfredi, 2012; Paskett et al., 2008). In a notable study with a very large representative sample of survivors that used data from the Women's Health Initiative,Paskett et al. (2008) reported significant disparities for health-related quality of life between African American breast cancer survivors and White survivors in the areas of physical functioning, role limitations due to emotional health, and general health but not in other patient-reported outcomes such as emotional wellbeing, sleep disturbance, and depression. However, there is a robust influence of socioeconomic status on quality of life, such that women of lower socioeconomic status perceive poorer quality of life (Ashing-Giwa & Ganz, 1997; Beder, 1995; Ell & Nishimoto, 1989), and regrettably, this factor affects the majority of Black breast cancer survivors in the United States.

In this article, we describe the development and preliminary testing of an evidence-based psychosocial intervention for Black breast cancer survivors, Project CARE (Cope, Adapt, Renew, Empower). The intervention was derived from an empirically validated behavioral medicine program based on cognitive-behavioral theory (i.e., cognitive-behavioral stress management [CBSM]; Antoni, 2003) and was then adapted to be sensitive to cultural and social norms for Black women. We outline the components of the overall CBSM intervention and the psychosocial needs of Black breast cancer survivors and comment on the cultural adaptation of the intervention. Finally, we present some preliminary findings regarding acceptability and retention of participants in this novel study. The development of this program is presented here to highlight the important role that counseling psychologists can play in assisting women who have undergone treatment for breast cancer and to highlight important factors to consider when adapting evidence-based interventions to Black clients with breast cancer.

Psychosocial Interventions for Women with Breast Cancer

The 10-week Cognitive-behavioral stress management (CBSM) intervention approaches stress management from a multifocal view: cognitive-behavioral skills and relaxation skills training in a group environment setting. The manual of the initial psychosocial intervention study for women with breast cancer is available elsewhere (Antoni, 2003); a summary is presented here for convenience. Each CBSM session is divided into two parts: a relaxation skills component and a CBSM component. Relaxation techniques include progressive muscle relaxation, visual imagery, deep breathing, and meditation techniques. The didactic and experiential components of CBSM have been specifically designed to teach strategies to reduce arousal and anxiety, change negative stressor appraisals (e.g., cognitive restructuring), provide coping skills training (e.g., enhancing adaptive coping skills, accurate matching of problem-focused or emotion-focused strategies on the basis of the controllability of the stressor, acceptance of uncontrollable stressors), interpersonal skills training (e.g., communication skills, anger management and assertiveness training), and enhance social networks (e.g., identifying tangible and emotional sources of support, spousal or partner communication and support) (Antoni, Lechner, et al., 2006). The facilitator encourages emotional expression and provides the opportunity to experience social support,

replaces feelings of doubt with a sense of confidence, and discourages avoidance while encouraging reframing and acceptance as coping responses.

The CBSM intervention was developed within Miami's multicultural population and thus needed to be responsive to the needs of women of many cultural and economic backgrounds. The CBSM intervention has been validated in individuals with various medical conditions, including cancer (Antoni et al., 1991, 2001, 2008; Antoni, Lechner, et al., 2006; Antoni, Wimberly, et al., 2006; Lopez et al., 2011; Lutgendorf et al., 1997; Penedo et al., 2004). These studies show that stress management interventions have been highly effective in enhancing adaptation to illness. However, one of the primary limitations of this work in our breast cancer populations was that the samples consisted of mostly middle-class, non-Hispanic White women with breast cancer, thus limiting generalizability to other women with breast cancer. Our preliminary, unpublished evidence showed that CBSM intervention was equally as effective in the small percentage of the sample from minority backgrounds as it was in White women. Thus, the next logical step was to test whether the intervention imparted benefits to a sample of community-dwelling minority women.

Despite compelling evidence that psychosocial interventions are efficacious in attenuating difficulties in aspects of quality of life in cancer survivors (for meta-analyses, see Meyer & Mark, 1995; Osborn, Demoncada, & Feuerstein, 2006; Rehse & Pukrop, 2003; Tatrow & Montgomery, 2006), there is little racial and ethnic diversity in most samples of psychosocial intervention trials to date. Reviews of intervention research with cancer patients reveal that psychosocial interventions reduce emotional distress, improve quality of life, enhance coping, foster social support, and encourage stress management (Andersen, 1992; Antoni, Lechner, et al., 2006; Classen et al., 2001; Luebbert, Dahme, & Hasenbring, 2001; Trijsburg, van Knippenberg, & Rijpma, 1992). In one of the few intervention studies designed to evaluate an intervention for Black women,Taylor et al. (2003) found that a psychoeducational group-based intervention was efficacious for low-income Black women with nonmetastatic breast cancer. The research group highlighted the need for culturally appropriate interventions that address the specific concerns of minority women with breast cancer.

Our targeted intervention helps women enhance social support, coping, and relaxation strategies during an important milestone: the end of cancer treatment. This phase is a particularly troubling time for many women, who may think "Now what?" and may feel abandoned by the formal health care system when they are no longer receiving active curative treatment (Holland & Reznik, 2005). In fact, the end of breast cancer treatment has been cited as a time of great stress and distress, characterized by ongoing side effects from treatment, anxiety about recurrence, feeling misunderstood by social support networks ("Treatment is over, why aren't you happy?"), uncertainty about how to develop strategies for healthy living posttreatment in the face of conflicting information, and feeling that one has been profoundly changed by the challenging life experience (Hewitt, Greenfield, & Stovall, 2005).

Needs of Black Breast Cancer Survivors

To inform our adaptation of the intervention, we started with an extensive literature review. We found that low-income Black women may have some unique concerns, in addition to the issues that plague breast cancer survivors in general (Ashing-Giwa, Padilla, Tejero, & Kim, 2004; Taylor et al., 2003). Ashing-Giwa et al. (2004) suggested that race and ethnicity can play an important role in a woman's personal experience of breast cancer. This literature provided several clues about content areas that should be covered in interventions for Black breast cancer survivors. Black women have specific concerns about feeling attractive after breast surgery, the possibility of forming keloid scars, the lack of prosthetic devices that match skin tone, how to live with a chronic illness, and the erosion of social support (Ashing-Giwa et al., 2004; Spencer et al., 1999; Wilmoth & Sanders, 2001). In fact, social support during the breast cancer experience may be of great importance. In a 2003 study of Black and White women with breast cancer, lower perceived emotional support at diagnosis predicted higher risk for death over a 10-year follow-up period (Soler-Vila, Kasl, & Jones, 2003). Such findings suggest that Black women with breast cancer could benefit greatly from supportive interventions that teach them skills to maintain and enhance their social support networks. By addressing the aforementioned concerns in a group context, women can also support one another, validate their experiences and their concerns, and reduce feelings of isolation.

Tailoring of CBSM Intervention for Minority Women

All of this information led us to focus on two categories of adaptation to the treatment manual: the content of the material and the process of the intervention.

Tailoring the Content of CBSM Modules

Changes were made to specific didactic portions to increase salience to minority women. The in-session examples, language, scenarios, and role-plays were adapted to fit Black preferences without sacrificing the main tenets of the issue being discussed. Three specific examples of adaptation are presented here for reference; however, nearly every page of the more than 200-page treatment manual was edited to make the content culturally relevant to the Black subgroups in the study.

Coping skills—Black women report using religious and spiritual coping strategies more so than their White counterparts (Culver, Arena, Antoni, & Carver, 2012), as well as coping by suppressing emotions, wishful thinking, and positive reappraisal (Reynolds et al., 2000). Because there may be women in the group who use these strategies to the exclusion of all other coping strategies, it is useful to emphasize the importance of having a wide coping repertoire. Religious coping and the beliefs associated with this coping strategy coincide with some of the messages of the CBSM intervention, such as respecting the use of religious behaviors (e.g., praying) as a legitimate coping strategy and matching specific coping strategies to the controllability of stressors. In this CBSM intervention, we use the serenity prayer as an example of matching coping strategies to the uncontrollable and controllable aspects of a given situation.

Social support (informational, tangible, and emotional)—Because churches are a common source of support for Black women (McRae, Carey, & Anderson-Scott, 1998), the role of a higher power is highlighted as a resource in a manner that was not used in previous versions of the intervention because it was not culturally relevant. In addition, Black women may be more likely than Caucasians to turn to family members and/or spouses for medical information and decision making (Sanchez-Hucles, 2000), so the intervention works with women to find ways to elicit support without alienating others. Minority women tend to be given less detail about their disease and medical options and may therefore have a greater need for informational support (Moore, 2001). Project CARE not only provides information but coaches women on ways to enhance the doctor-patient relationship and how to optimally communicate with medical staff members. Black women may keep their cancer diagnoses to themselves and their immediate families, limiting opportunities for social support (Wilmoth & Sanders, 2001). We explicitly recognize this fact in the sessions, providing the opportunity to process this cultural phenomenon. The intervention groups then provide opportunities for support from other cancer survivors who are familiar with similar cultural taboos. The interventionist guides participants on methods to elicit and use optimal social support from family and friends. Our previous nonintervention work showed that women with breast cancer often experience an erosion of social support after treatment, during a time when they need it most (Alferi, Carver, Antoni, Weiss, & Durán, 2001), again highlighting the need for encouragement in reaching out for social support. Also, Black women report a desire to talk about intimate relationships and report issues related to sexual attractiveness after a breast cancer diagnosis (Taylor et al., 2003) but also note the scarcity of open discussions of sexuality, even among close female friends (Wilmoth & Sanders, 2001). CBSM intervention aids in encouraging quality of life specifically as it relates to sexuality for women with breast cancer (Wimberly, Carver, Laurenceau, Harris, & Antoni, 2005).

Relaxation and imagery exercises—Relaxation skills exercises may be foreign to low-income Black women. We deemphasize techniques for which group members may not have prior exposure, knowledge, or experience and accentuate more familiar techniques that do not require extensive practice. To this end, the intervention focuses on deep breathing techniques and guided imagery techniques, which were well received in previous studies. Because progressive muscle relaxation is an unfamiliar skill to most women and is a complex, learned skill requiring practice, we reduced its complexity by introducing fewer muscle groups. Meditation is presented as a beneficial health behavior devoid of religious associations (Speca, Carlson, Goodey, & Angen, 2000) for those women who might see meditation as a conflict with their religious beliefs.

Tailoring the Process of CBSM Modules—The group-based exercises in our intervention are designed to facilitate feelings of trust, safety, and empowerment. Developing trust is important in any group but may be particularly relevant for Black Americans, who have a history of marginalization or exclusion by institutions, as well as mistreatment by researchers, the U.S. Public Health Service Syphilis Study in Tuskegee being one of the most notorious examples, though there are others (Corbie-Smith, 1999; Gamble, 1997). Because the groups are held in community (rather than academic) locations,

and because members of churches and other community organizations have recommended the program, women report that they feel more comfortable addressing concerns in the group setting. Within the Black community, a stigma still surrounds breast cancer diagnosis and treatment, and confidentiality remains a major concern to Black women (Sisters Network Inc., 2007). Group interventionists encourage participants to explore concerns and spend more time on this topic than in past studies. Other important factors that guided our tailoring of the intervention are listed in Table 1.

Methods

Recruitment

Recruitment took place through a variety of different venues, including community-based breast cancer programs, local churches of several denominations, community centers, health fairs, hospitals, private physicians within the community, public service announcements in local media that cater to the Black community in the South Florida area, and cultural activities. The project was also promoted through culturally appropriate communication channels, such as local radio programs and print media.

Women were eligible to participate in Project CARE if they met the following criteria: age 21 years or older, English speaking, self-identify as Black (African American, African, Caribbean Black, Black Hispanic), have been diagnosed with breast cancer (any stage of disease, any type of breast cancer), have received at least one type of traditional medical treatment for breast cancer (i.e., surgery, chemotherapy, radiation therapy) and completed treatment within 6 months of enrollment, have no previous history of cancer, have a self-reported life expectancy of 12 months or longer, have endorsed moderate stress or distress (a score of 4 or greater on a scale of 0 to 10), have had no inpatient psychiatric treatment for severe mental illness (e.g., psychosis) within the past year, have no active suicidality, and have no substance dependence within the past year.

Participants were between 27 and 77 years old (M = 49.45 years, SD = 8.82 years). Approximately half of the participants were employed full-time or part-time (49%), while 9% were retired, 18% were on disability, and 24% were unemployed. The average education level was about 13 years (range = 9 to 18 years), and the average income was about $31,000 (range = $0 to $130,000). One hundred percent of participants reported affiliation with Christian denominations, although there was variance in attendance at religious services and study groups (from not at all to several times a week). Table 2 presents the sample characteristics classified by intervention condition.

Control Condition: Enhanced Breast Cancer Education

In this article, we report the adaptation of the CBSM intervention to meet the needs of Black women with breast cancer. As a randomized controlled trial, the control condition was also made salient for the needs of survivors by using a time-matched psychoeducation condition. This condition used a classroom setting and structured PowerPoint slides to present information on breast cancer incidence, control, and treatment, as well as healthy lifestyle information. Because of the study team's ethical obligation to provide a relevant and

culturally sensitive group for women randomized to control, the psychoeducation condition was specifically designed to be a pleasant and enriching experience. The development of the enhanced education program is discussed in detail elsewhere (Lechner, Dumercy, Ennis-Whitehead, Phillips, & Vargas, 2008).

Procedure

All study procedures were approved and monitored by the Institutional Review Board at the University of Miami. Participants were self-referred and did not require medical provider referral to enroll. Screening for eligibility and in-person assessments were conducted by a Black female assessor who was supervised by a licensed clinical psychologist. Assessments took place in the participant's home or a location of her choice (e.g., a private room in a community center). Given that we expected a wide range of literacy and educational levels within the sample, all of the scales were given in interview format, with printed prompts for each of the response sets that were formatted in a manner to increase understanding. Assessors were trained in how to reword items that were unclear without influencing the participant's responses. After completing the interviews, participants were paid for their participation.

Participants (overall $n = 55$ at baseline) were randomized into the 10-week group CBSM intervention ($n = 33$) or a time-matched group psychoeducational program ($n = 22$). The Consolidated Standards of Reporting Trials (CONSORT) flowchart is depicted in Figure 1. Participants completed a battery of assessments at three time points: at study entry and prior to beginning the CBSM or psychoeducation groups (Time 1), at the conclusion of the CBSM or psychoeducational groups (Time 2), and 6 months after the conclusion of the groups (Time 3, not analyzed for the current article). Of interest here, a series of items were administered at the end of the second assessment battery (i.e., after the completion of the CBSM or psychoeducational group) to measure the acceptability of the CBSM and psychoeducational programs, the group leaders, the assessments and surveys, and the Project CARE staff. While the other psychosocial questionnaires were administered via structured interview and entered electronically by project assessors, the acceptability items were completed directly by the participant on a laptop computer. Participants were informed that these responses would not be reviewed by the interviewer and would be kept confidential to reduce the possibility of social desirability influences.

Measures

Retention percentages at Times 2 and 3 were calculated as the number of women who completed each of these assessments divided by the number of women who were randomized and completed the baseline assessment (Time 1).

A 14-item scale assessed the acceptability of the CBSM and psychoeducational programs, the group leader, the assessments and surveys, and the Project CARE staff. Participants were asked to rate their levels of agreement with various statements on a 4-point scale ranging from *completely agree* to *completely disagree*. See Table 3 for item content. Participants in both the experimental and control conditions completed this questionnaire. The acceptability questions are administered at the second assessment time point (the first postintervention

time point). Because many of acceptability items are related to general study participation, such as scheduling appointments, these questions are administered to everyone who completes the Time 2 assessment, not just those who attended the intervention groups. Women who did not attend the study sessions were not forced to decline the items that related to the group, and thus, these women who did not attend study intervention sessions provided data regarding study acceptability. See Figure 1 for the CONSORT flowchart of participants in the study.

Intervention Adaptation and Design

Project CARE was designed to test the effects of a relatively brief, culturally informed, psychosocial intervention with a strong evidence base. The project recruits, assesses, and delivers the intervention in the community settings where women obtain most health-related information and health care. Consistent with one of the basic tenets of counseling psychology, the intervention is strength based and focuses on skill building to facilitate personal and interpersonal adaptation over the life span (Corey, 2008). Drawing on the need for wider cultural acceptability and support of this project, as well as principles of community-based participatory research, an aim of Project CARE is to have a seamless collaboration with community organizations that are dedicated to the underserved with a strong community presence.

The literature on adapting an evidence-based intervention to meet the needs of specific cultural groups recommends that researchers focus on aspects of cultural sensitivity (e.g., interdependence among group members, spirituality, the experience of discrimination), ecological validity (which includes language, persons, metaphors, content, concepts, goals, methods, and context to reduce the discrepancy between the psychotherapist's assumptions and the actual ethnocultural experience of participants; Bernal, Jiménez-Chafey & Domenech Rodríguez, 2009) as well as the unique mechanisms that may influence uptake in a specific group of people (Castro, Barrera, & Holleran Steiker, 2010; Hays, 2009). In this study, we not only adapted the intervention manual but also employed Black psychologists and research associates so that there was a match between participants, group facilitators, and assessors, in addition to mandatory cultural sensitivity training for the entire research team (Griner & Smith, 2006).

The Project CARE CBSM intervention was guided by a conceptual model of culture derived from several theoretical frameworks (e.g., Cross, 1991; Krieger, 2001; Marín & Marín, 1991; Meyerowitz, Richardson, Hudson, & Leedham, 1998; Phinney, 1996; Williams, 1997). These theories conceptualize ethnicity as multidimensional, composed of cultural values and norms, ethnic identity, and social implications of minority status. We relied heavily upon three recommended constructs to make the Project CARE intervention culturally relevant as we adapted the treatment program: culture, ethnic identity, and minority status. Black culture is not a unitary construct and needed to account for a variety of African American cultural values, as well as Black Hispanic and Caribbean Black cultures as well. We focused on several common threads that run through these cultural groups (including respect for others and a flexible orientation to meeting start time) to make the intervention salient to these Black subgroups. Second, although each subgroup maintains

its own unique identity, we focused on the commonalities of the experience of being a Black woman living in the United States and the experience of subtle and overt discrimination to strengthen bonds between group members while appreciating and acknowledging such differences among members. Finally, to address issues related to the social implications of minority status, interventionists addressed the confounds of Black race/ethnicity and income. Although being Black does not necessarily imply that one is low income, sadly, this is the case in much of our local area. Statistics show that 28.6% of Black women in Miami-Dade County live below the poverty level, and there is an overall median household income of about $33,000 per year for Black women (U.S. Census Bureau, 2002). South Florida's large population of Black women may face several challenges in addition to issues related to breast cancer, including poverty, discrimination, inadequate housing, a high proportion of single-parent families, addiction, low educational attainment, and residence in noisy and overcrowded neighborhoods (U.S. Department of Health and Human Services, 2012).

Briefly, the steps taken to adapt the CBSM intervention included a needs assessment, a focus group of members of the target community, a focus group with stakeholders, an iterative process of manual adaptation, pilot testing with a small group of participants, and now a large-scale controlled clinical trial (Barrera & Castro, 2006; Wingood & DiClemente, 2008). In this article, we focus on the preliminary results of the acceptability of the intervention as determined by the pilot group and the first seven intervention waves of the larger clinical trial. The first focus group was composed of Black breast cancer survivors who ranged from 6 months to 5 years after diagnosis. We specifically queried about the cultural sensitivity of specific components of the adapted CBSM intervention and elicited culturally sensitive examples for use in the treatment manual. We asked about their psychosocial needs during specific phases of breast cancer treatment and issues related to survivorship. The focus group provided valuable in-group insights into cultural norms, gender roles, and power differentials that could affect women's opinion of the intervention. The group revealed information regarding norms of social support networks, highlighted the influence of religious organizations as a common source of support, and outlined the ways in which women turn to extended family members and/or spouses for medical information and decision making. We queried about gaps in knowledge about breast cancer, medical options, and doctor-patient relationships. Participants felt that our program of stress management would be warmly received by their peers and would be meaningful and able to meet the needs of Black breast cancer survivors, and several participants were excited to help us spread the word about the study.

We also conducted a focus group of community stakeholders in addition to our team from the university. This group provided information on recruitment strategies, community organizations and locations, logistics of home visit assessments and intervention locations, and their perceptions of community acceptance of the program. Next, we hired a Black female community consultant who was a licensed psychologist to survey for culturally relevant themes within the intervention. She scrutinized the manual and edited the content of several sections to add relevant examples, role-plays, and descriptions. She detailed the ways in which the flow of the sessions needed to be revised to reflect those values relevant to women of African American and Black Caribbean backgrounds, especially in relation to starting the groups on time and communication patterns.

Retention Strategies

Retention of ethnic/racial minorities in cancer studies is of great concern to psycho-oncology researchers (Sears et al., 2003). Focus group data revealed that it is critical to develop a strong collaborative relationship between participants and members of the research team, and this relationship begins at the moment of first contact between the recruiter and potential participant (Anderson, 2004; Brown, Fouad, Basen-Engquist, & Tortolero-Luna, 2000). Women welcome an atmosphere in which they know that they are making a contribution and that their efforts have the potential to improve other people's experiences (Needham, 2004). By expressing appreciation verbally and in writing, the research team fosters participants' desire to remain in the study. Participants also feel valued when they receive newsletters and flyers with useful and pertinent information. Project CARE sends regular updates and information on resources, local events, and breast cancer information. Participants have especially appreciated holiday cards, token gifts such as pens or notepads with study information and contact numbers, and certificates of completion (Needham, 2004).

Interventionist Training

All interventionists participated in a structured training program that was delivered by the first and second authors. This training provides education on the basic concepts in breast cancer biology, epidemiology, treatment, and psychosocial aspects of cancer. The training was also used to increase the multicultural competencies of the therapist. Specifically, we emphasized an awareness of cultural code switching and its use in therapeutic process, the impact of stereotypes held by each group, and the importance of acculturation and Black identity on the individual and group process. Even though interventionists for Project CARE are required to be Black themselves, the expected diversity within our sample necessitated multicultural competence of the interventionists per recommendations of the American Psychological Association (2012b) and the U.S. Department of Health and Human Services (2005). Counseling psychologists are well versed in attending to multicultural issues and social justice factors in community-based settings, which makes counseling psychologists particularly well suited to delivering this type of intervention (Corey, 2008).

Results

The findings presented here reflect preliminary testing of the intervention on the basis of the first 7 waves of the larger clinical trial, which will include a total of 12 waves of assessment and intervention delivery when it is complete.

Acceptability

Table 3 presents acceptability data from (a) all participants (irrespective of assigned group condition), (b) participants in the psychoeducation condition, (c) participants in the CBSM condition, and (d) those who attended at least one group session. Note that the acceptability questionnaire was given to all participants at Time 2, irrespective of attendance (see the "Methods" section). As expected, women are highly satisfied with the program, and participants in both conditions rated the program favorably. Average attendance rates at

group sessions, which may be considered an indicator of investment in the program, was 7 out of 10 sessions.

Retention

Project CARE has enjoyed an exceptionally high retention rate (see Figure 1). Participant tracking revealed a 96% retention rate between baseline and the immediate postintervention assessment and a 95% retention rate between baseline and 6-month follow-up. Given the competing demands and hardships facing the sample, attendance rates and retention rates speak to the extremely high satisfaction of participants.

Discussion

Project CARE is the first intervention study of its kind to test a CBSM intervention that was designed specifically for Black breast cancer survivors. In this article, we provide the rationale for the adaptation of an empirically validated psychosocial intervention and the methodology used to create the adapted intervention manual, and we highlight some of the many issues that need to be considered in developing a culturally sensitive targeted treatment for Black breast cancer survivors. Adjustment to breast cancer is affected by many factors, and we capitalized on the potential role of culturally sanctioned behavioral and social responses that might influence a woman's adaptation to this stressful life event to adapt the intervention.

This type of intervention is especially relevant for counseling psychologists who work with cancer survivors in a variety of settings and venues. Counseling psychologists are attuned to assisting clients with adapting to life circumstances via focusing on strengths and building on the clients' unique assets (American Psychological Association, 2012a). As readers are well aware, counseling psychology focuses not only on treatment for emotional and physical disorders but also on normal psychological development over the lifespan in diverse groups (Sue & Sue, 2007). The CBSM intervention is consistent with this approach and encourages women to use stress management skills to both manage cancer-related and life stress and enhance social support, increase benefit finding, and improve psychosocial well-being.

Through this formative work, we have learned that the transition from conducting clinical research in academic settings into implementing an evidence-based intervention in community settings is extremely challenging and requires a great deal of flexibility on the part of the research team and community organizations. Future directions for this research program include developing an Internet-based, live videoconference protocol to further disseminate the intervention to groups of isolated Black women who might not have the opportunity to meet with others in a group in their geographical locations.

In sum, CBSM intervention combines psychoeducation with client-centered counseling techniques to enhance each participant's ability to cope with cancer and its aftermath. Preliminary acceptability findings from Project CARE suggest that it is one example of efficacious treatment modalities for women who have survived cancer, and future work should focus on developing interventions that can enhance psychosocial adaptation over the life courses of those who have been diagnosed with cancer.

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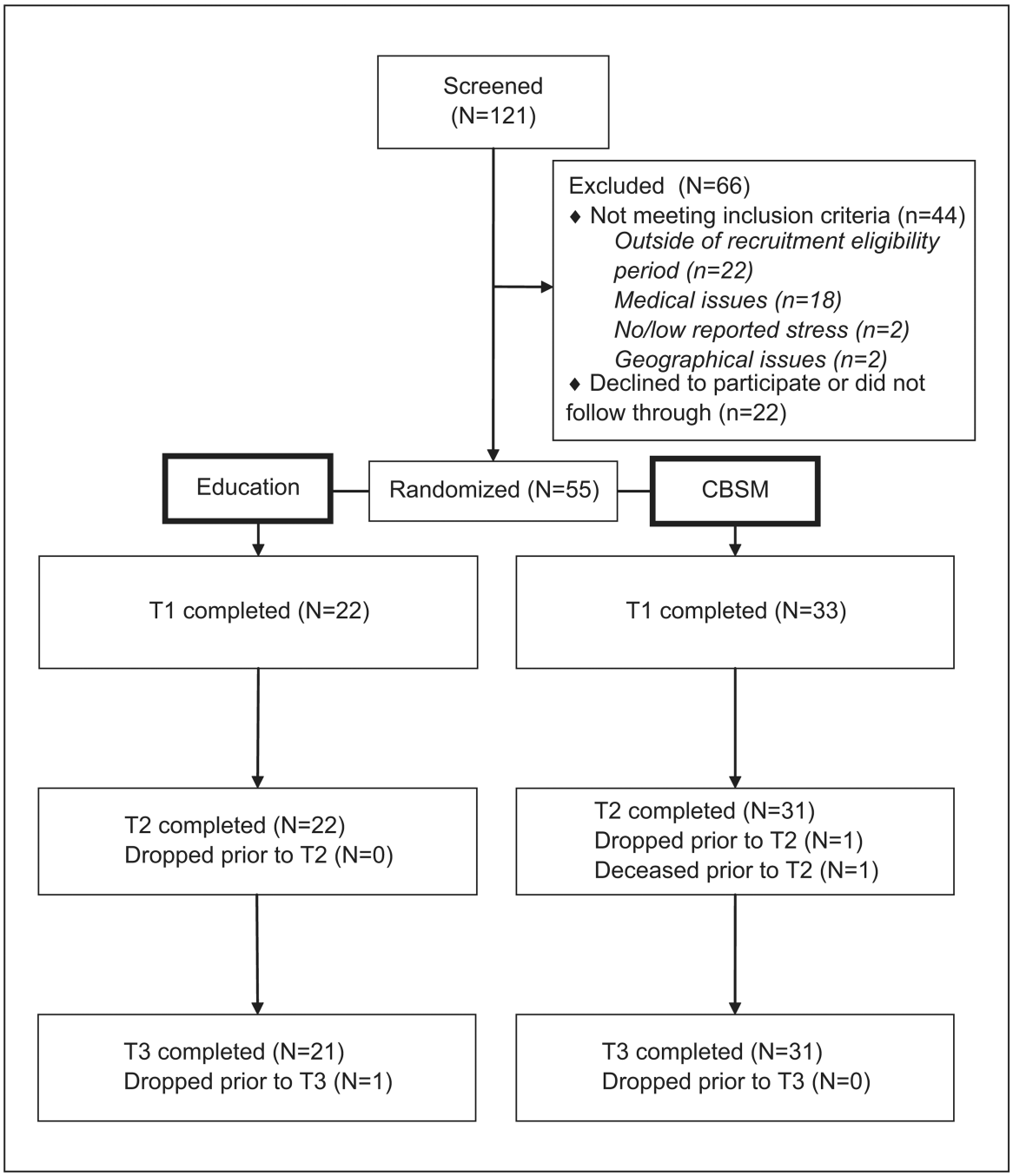

Figure 1. Flow of Project CARE Participants From Screening Through Follow Up
Note: CARE = Cope, Adapt, Renew, Empower; CBSM = cognitive-behavioral stress management; T = time.

Table 1

Examples of Cultural Factors That Were Considered When Adapting the Cognitive-Behavioral Stress Management Intervention for Black Breast Cancer Survivors

Cultural Factor	Culture-Specific Definition	Intervention Adaptation
Interpersonal orientation	The group or collective is emphasized over the individual.	The concept of sisterhood is woven throughout the intervention as a means of creating lasting bonds and empowering women to make healthy choices for themselves.
Spirituality and religiosity	There exists a force greater than oneself, and faith in God is an important aspect of daily life.	There are explicit discussions about the role of spirituality and religion in the intervention, and women are encouraged to view religiosity and spirituality as naturally derived strengths to bolster them during challenging times.
Harmony	All aspects of one's life are connected and must be balanced.	Guided by the notion that all individuals are embedded in, and affected by, larger social and cultural spheres of influence, stress is presented as a facet of life that must be balanced. Too much stress creates tension, whereas too little stress may result in a situation in which a person feels unmotivated. Stress can affect individuals internally and externally, which has an impact on larger social units.
Time as a social phenomenon	Time is not an entity in itself but is created as a consequence of interpersonal interaction.	Groups do not begin on time.
Negativity to positivity	Value is placed on being able to turn bad situation into something good.	Women are encouraged to find balance between viewing situations as inherently "good" or "bad" but that all events are an opportunity for growth and empowerment.

Source: Adapted from Belgrave, Brome, and Hampton (2000).

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Table 2

Demographics of Project CARE Participants

Variable	EE Condition	CBSM Condition	*F*	χ^2	*df*	*p*
Age (years), *M* (*SD*)	50.32 (10.06)	48.88 (7.80)	0.35		1, 53	>.50
Years of education, *M* (*SD*)	13.14 (1.70)	13.33 (2.36)	0.48		1, 52	>.70
Income (thousands of dollars annually), *M* (*SD*)	28.23 (25.20)	32.79 (28.02)	0.38		1, 53	>.50
Months since breast cancer diagnosis, *M* (*SD*)	13.41 (5.51)	14.39 (6.74)	0.32		1,53	>.50
Work status				0.63	3	>.80
Unemployed	6 (27%)	7 (21%)				
Employed	11 (50%)	16 (48%)				
On disability/leave	3 (14%)	7 (21%)				
Retired	2 (9%)	3 (9%)				
Marital status				1.13	4	>.90
Single, never married	5 (23%)	6 (18%)				
Married/partnered	7 (32%)	10 (30%)				
Separated	4 (18%)	4 (12%)				
Divorced	5 (23%)	10 (30%)				
Widowed	1 (4%)	3 (9%)				
Have children	20 (91%)	28 (85%)		0.44	1	>.50
Breast cancer stage				5.35	4	>.20
0	3 (14%)	2 (6%)				
I	8 (36%)	5 (15%)				
II	7 (32%)	16 (48%)				
III	4 (18%)	9 (27%)				
IV	0 (0%)	1 (3%)				
Underwent surgery	21 (96%)	31 (94%)		0.06	1	>.80
Received chemotherapy	15 (71%)	29 (88%)		2.30	1	>.10
Received radiation	16 (73%)	23 (70%)		0.06	1	>.80
Received hormonal therapy	12 (57%)	19 (58%)		0.00	1	>.90
Received targeted therapies	3 (15%)	9 (31%)		1.65	1	.20

Note: CARE = Cope, Adapt, Renew, Empower; CBSM = cognitive-behavioral stress management; EE = enhanced breast cancer education.

Table 3

Frequencies and Percentages for Intervention Acceptability Questions Administered After the Conclusion of the 10-Week Program

Item	Rating	All Participants (*n* = 52)	EE Condition (*n* = 21)[a]	CBSM Condition (*n* = 31)	Attended at Least 1 of the 10 Sessions (*n* = 48)
This program was a good use of my time	Completely agree	45 (86%)	17 (81%)	28 (90%)	43 (90%)
	Agree	5 (10%)	3 (14%)	2 (6%)	4 (8%)
	Disagree	1 (2%)	0 (0%)	1 (3%)	1 (2%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
This program was helpful	Completely agree	44 (85%)	17 (81%)	27 (87%)	42 (88%)
	Agree	7 (13%)	3 (14%)	4 (13%)	6 (12%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
This program will be helpful in my daily life	Completely agree	41(80%)	15 (71%)	26 (87%)	39 (83%)
	Agree	9 (18%)	5 (24%)	4 (13%)	8 (17%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
	Declined to answer	1		1	1
This program has helped me deal with my breast cancer	Completely agree	42 (81%)	15 (71%)	27 (87%)	40 (83%)
	Agree	7 (13%)	4 (19%)	3 (10%)	7 (15%)
	Disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
	Completely disagree	2 (4%)	1 (5%)	1 (3%)	1 (2%)
I felt comfortable with my group leader	Completely agree	44 (86%)	17 (81%)	27 (90%)	42 (89%)
	Agree	6 (12%)	3 (14%)	3 (10%)	5 (11%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
	Declined to answer	1		1	1
The group leader made everyone feel welcome and understood	Completely agree	47 (92%)	19 (90%)	28 (93%)	45 (96%)
	Agree	3 (6%)	1 (5%)	2 (7%)	2 (4%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
	Declined to answer	1		1	1

Item	Rating	All Participants (*n* = 52)	EE Condition (*n* = 21)[a]	CBSM Condition (*n* = 31)	Attended at Least 1 of the 10 Sessions (*n* = 48)
It was easy to participate in the weekly groups	Completely agree	42 (81%)	17 (81%)	25 (81%)	40 (83%)
	Agree	7 (13%)	3 (14%)	4 (13%)	7 (15%)
	Disagree	2 (4%)	0 (0%)	2 (6%)	1 (2%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
The staff made it easy to schedule my appointments	Completely agree	45 (86%)	18 (86%)	27 (87%)	44 (92%)
	Agree	5 (10%)	1 (5%)	4 (13%)	4 (8%)
	Disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
It was easy to do the surveys and questionnaires	Completely agree	39 (75%)	14 (67%)	25 (81%)	37 (77%)
	Agree	12 (23%)	6 (29%)	6 (19%)	11 (23%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
The Participant Workbook was easy to read and understand	Completely agree	41 (79%)	16 (76%)	25 (81%)	40 (83%)
	Agree	9 (17%)	4 (19%)	5 (16%)	7 (15%)
	Disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	0 (0%)	1 (3%)	1 (2%)
The program staff was friendly and helpful	Completely agree	48 (92%)	19 (90%)	29 (94%)	45 (94%)
	Agree	3 (6%)	1 (5%)	2 (6%)	3 (6%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
Overall, this was a good program	Completely agree	47 (92%)	18 (86%)	29 (97%)	45 (96%)
	Agree	3 (6%)	2 (10%)	1 (3%)	2 (4%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	1 (2%)	1 (5%)	0 (0%)	0 (0%)
	Declined to answer	1		1	1
This program was applicable to my life experience	Completely agree	44 (85%)	15 (71%)	29 (94%)	42 (88%)
	Agree	6 (12%)	5 (24%)	1 (3%)	5 (10%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	2 (4%)	1 (5%)	1 (3%)	1 (2%)
I would recommend this program to other women who have had breast cancer	Completely agree	47 (90%)	18 (86%)	29 (94%)	45 (94%)

Item	Rating	All Participants (*n* = 52)	EE Condition (*n* = 21)[a]	CBSM Condition (*n* = 31)	Attended at Least 1 of the 10 Sessions (*n* = 48)
	Agree	3 (6%)	2 (10%)	1 (3%)	2 (4%)
	Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Completely disagree	2 (4%)	1 (5%)	1 (3%)	1 (2%)

Note: CBSM = cognitive-behavioral stress management; EE = enhanced breast cancer education.

[a]One participant had missing data for this questionnaire.