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Development of Decision Support Intervention for Black Women with Breast Cancer

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Abstract

Adjuvant therapy improves breast cancer survival but is underutilized by Black women. Few interventions have addressed this problem. This preliminary report describes the process we used to develop a decision support intervention for Black women eligible for adjuvant therapy. Aims were to use qualitative methods to describe factors that influence Black women's adjuvant therapy decisions, use these formative data to develop messages for a treatment decision-support intervention, and pilot test the acceptability and utility of the intervention with community members and newly diagnosed women. Thirty-four in-depth interviews were conducted with breast cancer patients in active treatment, survivors and cancer providers to gather qualitative data. Participant ages ranged from 38 to 69 years. A cultural framework was used to analyze the data and to inform intervention messages. Most women relied on their providers for treatment recommendations. Several women reported problems communicating with providers and felt unprepared to ask questions and discuss adjuvant treatment options. Other factors related to treatment experiences were: spiritual coping, collectivism, and sharing breast cancer experiences with other Black survivors. Using these formative data, we developed an intervention that is survivor-based and includes an in-person session which incorporates sharing personal stories, communication skills training and decision support. Intervention materials were reviewed by community members, researchers/clinicians and patients newly diagnosed with breast cancer. Patients reported satisfaction with the intervention and felt better prepared to talk with providers. The intervention will be tested in a randomized trial to enhance decision support and increase use of indicated adjuvant treatment.

Keywords

African-American; breast cancer; treatment decisions; communication; oncology

Background

Black women experience higher breast cancer mortality rates than White women, despite lower age-adjusted incidence rates and steady improvements in the use of screening [1,2,3]. Recent data suggest this disparity is widening [4,5]. Adjuvant systemic therapies, such as chemotherapy and endocrine therapy are beneficial for survival of both node-positive and node-negative disease [6]. However, disparities persist in referral and uptake of adjuvant treatment for Black women [7,8,9]. For example, compared to Whites, Black women have fewer oncology consults, receive less aggressive chemotherapy regimens, are more likely to discontinue chemotherapy, and are less likely to have endocrine therapy prescribed for ER/PR-positive tumors [10,11,12,9,13]. When Black women do receive systemic treatment, their survival outcomes are similar to Whites [14,15]. Thus, survival disparities may be partly explained by the lower use of adjuvant therapies [9].

Prescription of adjuvant therapy generally occurs within the context of the patient-provider relationship, therefore, communication between these parties may influence its use [16,17,18,19]. Previous studies have found that Black patients report fewer participatory medical encounters, ask fewer questions, receive less medical information in consultations for cancer treatment, and have more problems communicating with physicians than Whites [20,21,22,23,24]. In one study, Blacks' lower receipt of information from physicians than Whites was explained by Blacks' lower engagement in active communication behaviors (e.g., asking questions, voicing concerns, etc.) that typically elicit information from physicians [20]. Other research has documented that women who ask more questions report better patient-provider communication, are more informed and tend to follow treatment recommendations than women who ask fewer questions [13,25]. Thus, less participatory patient-provider encounters could result in inadequate knowledge about and use of adjuvant therapy among Black women [22,23,22,23].

In non-Black populations, communication skill practice and peer role model interventions have been effective in improving communication skills and promoting patient's involvement in care [26,27]. Krupat et al. found that Black women were more likely to have full staging of their tumors ordered if they were more assertive with their physicians [28]. These studies and others suggest that improving patient communication skills may positively influence provider communication [28,29,19,30]. Building upon important cultural values may also strengthen interventions with Black women [31,32]. Unfortunately, there is a paucity of skill interventions for Black women considering adjuvant therapy.

The purpose of this formative study was to build upon existing knowledge about treatment decisions and use a cultural health behavior model to develop a culturally appropriate intervention for newly diagnosed Black women. In this paper we: (1) describe key *perceptions, enablers, and nurturers* that are important to women when making adjuvant therapy decisions and (2) describe how we used these data to develop an intervention strategy to promote better patient-provider communication. This formative study is part of a larger feasibility study which is examining the impact of the intervention on intermediate outcomes of communication and decision satisfaction. Our long-term goal is to improve adherence to adjuvant therapy among Black women by improving their interaction with providers.

Methods

Overview

The Institutional Review Board approved this study which was conducted in the Washington, DC metro area. First, qualitative data were collected and analyzed. Next, these

formative findings were translated into specific intervention activities and messages using domains of a cultural behavioral model. Lastly, community members, researchers/clinicians and newly diagnosed patients reviewed the intervention materials and provided feedback for revisions and the resulting intervention workbook was pilot tested.

Theoretical Framework—The PEN-3 Health Behavior Cultural Model provided the primary framework for formative data collection, analysis and the development of intervention messages. We selected this framework because it has been successfully used to analyze qualitative data and inform the development of other culturally appropriate interventions [33,34,35,36]. PEN-3 has three interrelated domains: 1) cultural identity, 2) relationships and expectations, and 3) cultural empowerment as applied to cancer chemotherapy communication [36,37,38]. The cultural identity domain determines the intervention focus (i.e. person, extended family, and/or neighborhood). The relationships and expectations domain is used to determine the *perceptions*, *enablers*, and *nurturers* that impact health behaviors such as uptake of adjuvant therapy. *Perceptions* include the knowledge, attitudes, values, and beliefs that either facilitate or hinder a woman's motivation to use adjuvant therapy. *Enablers* are community and/or structural factors (e.g., resources, accessibility, etc.) that facilitate behavior. *Nurturers* are reinforcing factors, such as those from one's social network. The third domain, cultural empowerment, assesses the cultural appropriateness of health beliefs from the second domain and categorizes these as "positive" (practices that improve use of adjuvant therapy), "existential" (practices that neither positively nor negatively influence health treatment), or "negative" (practices that decrease the likelihood of using adjuvant therapy) [37].

Formative Data to Inform Intervention Development

Data Collection—Qualitative data were collected using in-depth interviews with women in active treatment, survivor advocates who mentored other women, and cancer providers. Patients in active treatment were participants in a randomized psycho-educational group intervention for women with early stage breast cancer that was previously detailed [39,40]. Semi-structured in-depth baseline interviews of the women occurred prior to randomization and followed an oral narrative format and guided women through a discussion of their breast cancer discovery and treatment experiences and their interactions with providers. For the current study, we reviewed transcripts for women who were residents of the District of Columbia (n=14). Semi-structured interviews were also conducted with *survivor advocates* (n=10; ≥ 2 years post diagnosis) recruited from a breast cancer organization [41]. Survivors described their breast cancer treatment experiences and the challenges of their mentees. Finally, ten *cancer providers* (5-Black; 3-White; 2-Asian) were interviewed to describe their self-reported interactions with Black patients.

Analysis—All three interviews were recorded and transcribed verbatim. During the first coding phase, two investigators independently read all transcripts and extracted key statement categories to identify initial coding categories [42]. A unit of text was regarded as a statement that expressed one complete idea. Categories were added (e.g., concerns about side effects, family reactions) to reflect as many nuances in the data as possible. Each reviewer made a list of codes after which they were combined to ensure one exhaustive list. A coding guide was developed which provided a description of each code and exemplar units of text. The investigators coded one transcript from each respondent group (e.g., patients, survivors, providers) to ensure that there was mutual understanding of how to follow the coding guide.

For the second coding phase, investigators independently coded remaining transcripts using the agreed upon set of codes. Data for each respondent group were analyzed separately;

however, consistent themes were compared among the groups. After coding was completed independently, the investigators met to discuss codes; disagreements were resolved by consensus. The PEN-3 domains of *perceptions*, *enablers*, and *nurturer* domains were used to group the coded data according to the model framework [37,38]. The final step in the analysis involved labeling thematic statements in the perception, enabler, and nurturer categories as positive, existential, or negative factors [37,38,43].

Methods to Use Formative Data to Inform Intervention Strategies

Formative results were shared with the research team (which included breast cancer survivors) who aided in data interpretation and confirmed final groupings. During this meeting, participants discussed how findings regarding key perceptions, enablers, and nurturers could be integrated into intervention messages, graphics, strategies, materials, and content. Together we draft a list of potential barriers (e.g., concerns about treatment side effects) and facilitators along with methods to address them.

Methods to Obtain Community and Patient Intervention Feedback

After materials and messages were developed, community members, experts, and newly diagnosed patients reviewed them. Two focus groups were held: one with Black breast cancer survivors and advocates (n=8) and another with cancer researchers/clinicians (n=12). Cancer researchers/clinicians were Black (n=4) and female (n=9) and were medical oncologists (n=4) nurses (n=2), or surgeons (n=3). Before each group, participants were mailed a copy of the facilitator and patient guide along with evaluation forms. Participants briefly assessed each section using a five -point Likert scale (1- Poor to 5-Outstanding). We trained three survivors to use intervention materials using role-plays and didactic techniques; an expert storyteller modeled narrative strategies. Lastly, eight newly diagnosed women were recruited from surgery and oncology practices to pilot the intervention and offer feedback.

Results

Using the PEN-3 framework formative data regarding factors that influence women's adjuvant therapy decisions are presented first. An overview of the intervention is presented next. Lastly, we provide results from the community and patient assessment of the intervention. Table 1 displays characteristics of women that participated in the study by phase of development.

Results of Formative Data Collection

Cultural Identity—All respondent groups discussed the importance of ensuring that all Black women receive information on breast cancer and related treatments. Many patients were surprised to learn of their diagnosis, although several had first-degree relatives who were diagnosed with breast cancer. One patient shared, “*I knew my mother, my aunt, [and] one sister had [cancer]. But I never thought me.*” All respondent groups agreed that many Black women would benefit from improved communication with providers. Patients and survivor advocates felt that provider-focused interventions were important, however, they stressed the importance that Black women be empowered with information to be their own advocates. One woman described, “*Go in informed. Go out better informed.*” Hearing the personal stories from the survivor coaches was also stated as inspirational.

Relationships and Expectations and Cultural Empowerment—In Table 2, the key themes across each PEN-3 domain are summarized and organized according to cultural empowerment categories of *perceptions*, *nurturers* and *enablers*. *Positive perceptions* were hope, determination, faith in God, and acceptance of breast cancer. *Negative perceptions*

included fear of adjuvant treatment side effects (nausea and hair loss), beliefs that systemic adjuvant therapies were experimental, concerns about being unable to care for family members, and feelings of mistreatment by the medical community. Many women held negative perceptions about breast cancer therapy based primarily on observations of others receiving treatment. One woman explained why she decided against chemotherapy, *"I know what [chemotherapy] did to my husband. It took all of his hair out."* Myths included the belief that chemotherapy and/or hormonal therapies were experimental, and that an injury led to breast cancer. In some instances, these myths influenced women to decide against chemotherapy or hormone therapy.

Existential perceptions that did not directly influence treatment decisions included fatalism, fear for the future, and preference for mastectomy to avoid chemotherapy and additional treatment. Several women held fatalistic beliefs about breast cancer prior to but not after their diagnosis. All respondent groups commented that Black women held strong spiritual beliefs that aided their ability to cope with the disease and treatment, but these were not a primary decision-making resource. More often non-Black providers reported that their patients were fatalistic.

Enablers of adjuvant therapy decisions were patient-provider communication, access factors, and the availability of anti-nausea medications. Women who reported good communication were more satisfied with their treatment decisions, were more knowledgeable about their treatment, and proceeded with recommended adjuvant therapies. Women who reported adhering to physician recommendations for adjuvant therapies described providers' explanations as responsive and thorough. As one woman shared, *"I have excellent communication with [providers]. They explain things. They take time with me. They always call me back. They've been very open about the prognosis."*

Women who reported poor patient-provider communication, or who were uncomfortable asking questions, reported feeling less confident about their adjuvant treatment decisions. Other women felt that they did not receive all necessary information and attributed it to the fact that they were passive in their interactions with providers. *"You know, they always ask [if] I have anything to say, and I never have anything to say so it's mostly my fault."* This lack of participation in decision-making and limited questioning affected treatment decisions as several women rejected chemotherapy because they perceived few benefits relative to the risks. Others opted to receive mastectomies to avoid additional treatment and reduce the chance of recurrence. As one survivor summarized, *"The problem is that you just don't get the right information at the right time."* A few women felt that some doctors talked down to them or assumed that they did not understand the medical terms because of their race or economic status.

Nurturers that were important to women in facilitating adjuvant treatment decisions included close relationships with nurturing, caring, and empathetic providers. Nurses helped patients understand physician instructions and manage treatment-related side effects. Women also stressed the importance of having providers address the emotional aspects of breast cancer. One patient stated, *"What would have made it better [is] if any of [the physicians] had talked about what you would feel. They always talk about the statistics, the numbers, the medicines, the side effects."*

Several *nurturers* embodied cultural norms of collectivism. For example, familial relationships and relationships with breast cancer survivors were important to most women. In some instances, family members provided information and support, and facilitated interactions with providers. One woman reported an increase in her provider's attentiveness due to familial presence. She noted, *"I had two of my daughters with me, and they asked a*

lot of questions. But since I've been going by myself, I [have] really felt neglected." Exchanging personal stories with other breast cancer survivors, either one-on-one or through support groups, was also important. As one patient described, *"I talked to people who had gone through [breast cancer]. I asked for their opinions."* Survivor advocates emphasized the utility of survivor mentors assisting their counterparts based on personal experiences. One woman declared, *"Everyone should be issued a partner."* Providers cited nurses and navigators as important contributors to patient nurturing.

Occasionally, negative family member feedback influenced patient decisions to delay treatment or to withhold specifics about their condition from family members. A few who were concerned about perceptions from community members chose not to share their diagnosis.

Results: Use of Formative Data to Inform Intervention Strategies

Qualitative findings informed the development of a peer-based intervention to improve women's communication with their providers and support them while making decisions about adjuvant therapy. Qualitative findings related to the PEN-3 model domains informed the intervention delivery and messages (see Table 3). For example, given consensus regarding the need for patients to be better informed about breast cancer adjuvant treatments and to improve their communication with providers, we focused the intervention on patients rather than on providers and/or family members. We also included suggestions of how to discuss treatment options with family members because some women reported receiving negative reactions to their adjuvant treatment choice from their relatives. Patients in active treatment and survivors commented on the benefits of survivors sharing their stories and that they liked the story-telling activity. Therefore, we decided to use survivors to deliver the intervention and to include survivor testimony in the intervention.

Because the importance of having a strong patient-provider relationship was consistently voiced we developed strategies to support and enhance that relationship. The intervention communication-decision support framework, TALK BackSM! uses a narrative communication approach that builds on the rich oral tradition of storytelling that is rooted in African American culture [37,44,45,46,47]. Cultural values of collectivism encourage women's active communication with their providers [48]. Major steps in the T.A.L.K. BACKSM! Model include: **telling** your story (presenting detailed information to healthcare providers and the sharing of stories between the survivor coach and newly diagnosed woman), **asking** questions (practice writing and asking questions with the survivor coach in preparation for their medical appointments), **listening** actively (practicing skills to ensure understanding of recommendations and responses to questions), and **knowing** treatment options (providing a simple framework to facilitate understanding of the pros and cons associated with adjuvant therapy and discussing with the physician available options). Messages were framed to focus on providing information with facts about adjuvant treatments with an emphasis on managing chemotherapy side-effects.

A facilitator's guide was developed which deconstructs each step in the TALK Back!SM intervention to coach women through the communication and decision-making processes using role modeling techniques. Patients can follow along with the survivor coach using a patient-focused guide. The patient guide includes space for women to write their story with specific prompts regarding values, beliefs, preferences, and testimonials from breast cancer survivors. Also included are pictures of Black women interacting with physicians and receiving chemotherapy. The guide has a glossary of cancer-related medical terms, examples of frequently asked questions, and a personalized worksheet to aide in their treatment discussion with their physicians. Because spirituality was a consistent theme in formative data, inspirational quotes and Bible verses were included.

Results: Intervention Feedback from Community Members and Patients

The facilitator guide and intervention workbook were presented to community members, experts, and advocates who provided written feedback and participated in focus groups. Participants stated that the intervention would be useful for Black women. Overall ratings of the materials (from highest to lowest) were either “Outstanding, Excellent, or Very Good.” The overall ratings for the patient guide’s readability, content, and format were “outstanding” (66.7%) and “excellent” (33.3%); the graphics were equally rated “outstanding” and “excellent” (50% each). Survivors appreciated the personal stories, inspirational quotes and pictures. Suggestions were made to provide pictures of “real” people versus stock photos. Thus, pictures of “real” survivors were added. Debate occurred regarding the use of too much technical information in the patient guidebook. Survivors and advocates (in contrast to researchers/clinicians) felt that more information was better. Thus, we retained the background information but re-organized the guidebook, placing key intervention components first and more detailed breast cancer/treatment-related information at the end.

Using the facilitator’s guide, one trained survivor coach piloted the intervention with newly diagnosed patients; each session took approximately 1.5 hours. All patients expressed high satisfaction with their survivor coach. Moreover, survivor coaches, by sharing their personal story and listening to women share their experience, provided factual information about treatments, and identified key questions and concerns. One patient noted, *“I appreciated speaking with her. She made me feel quite at ease in the face of a difficult situation. She gave me hope.”* Patients suggested adding narratives to the guidebook and that women should receive the materials immediately following their diagnosis. They also suggested that patients should be matched with coaches that had similar treatments. Revisions to materials were made based on feedback from community members and newly diagnosed patients.

Discussion

To our knowledge this is the first description of adjuvant treatment decisions and communication experiences of urban Black women with breast cancer. Additionally, this is the first paper to describe a skills intervention approach that may meet their needs. Most efforts to reduce racial disparities in breast cancer outcomes have focused on improving screening. Ensuring that Black women receive indicated adjuvant treatment may be a cost effective approach to improving their breast cancer outcomes [49]. Our preliminary results suggest that the use of a peer-based adjuvant decision support intervention may be acceptable and useful to Black women with breast cancer. Our formative data suggest that patient-provider communication influenced women’s adjuvant therapy decisions and that improved communication might lead to adherence to adjuvant therapy.

In our study, women who reported better communication were able to explain their diagnosis, provide a rationale for treatment options, and were more likely to receive adjuvant therapies compared with women who were less informed about their diagnosis [20]. These findings support studies on breast cancer screening that highlight the importance of physician recommendations after a patient receives medical test results [5,50,51]. Breast cancer patients who ask more questions have been found to be more knowledgeable than those who ask fewer questions [51,52]. While some women in our study blamed themselves for their lack of participation in discussions with physicians, they should not be blamed. Women’s lack of participation may be due to feeling intimidated by their lack of understanding of technical terms and medical jargon [35]. Consultation planning and skill development approaches as offered in this pilot may help patients organize and prepare for important treatment decisions.

We found that several cultural values (e.g., spirituality, collectivism) were important in women's cancer therapy experiences [12]. Faith in God helped women cope with their diagnosis, believe they could endure treatment, and ultimately survive the disease. In concert with Gibson [53], inner strength and hope were prevalent among study participants. We observed that women who described fatalistic beliefs prior to their diagnosis were less likely to report being fatalistic after their diagnosis. Thus, contrary to some reports, cultural beliefs such as fatalism did not negatively impact women's treatment decisions [54,55]. This may be due to sample differences in geographic region and other demographic factors [55,56,33]. Fatalistic beliefs were not prominent factors that prevented women from adhering to their physician's recommendations. Yet, in qualitative interviews, compared to Black providers, non-Black providers were more likely to report perceptions of fatalism in some of their Black patients. Powe and colleagues [57] noted that physicians perceived Black patients as more fatalistic than their actual fatalism scores reflected. Thus, it may be useful to recognize the potential impact that provider perceptions can have on patient-physician relationships interactions [10].

Survivors suggested that newly diagnosed women should be matched with peer survivors. This supports studies that suggest that survivors are important *nurturers* for Black women and provide education and support [32,33]. Storytelling by survivors and survivor advocates was an important activity, especially for newly diagnosed women. Storytelling is an important tradition within African and African-American cultures for maintaining a lively and widespread verbal art tradition [58]. The communication exchange between the coach their stories mirrored the faith-based activity of giving a "witness" testimony which has been used to promote cancer screening [32,33,59]. The coaches and patients shared a common reliance on God which created what Banks-Wallace describes as "touchstones": things that remind people of a shared heritage [58].

The use of narrative methods has expanded beyond the effective use of cancer survivors to deliver cancer screening messages to also include empirical evaluation of specific factors that may influence the effectiveness of survivors' stories [46,47]. Krueter and colleagues found that the best predictor of whether women became engaged in a survivor's story was whether they viewed her as similar to themselves and liked her [46,47]. Future assessment of the "story exchange" may aide in helping to further target our intervention messages.

Overall, our results provide insight into the decision-making experiences of some Black breast cancer patients and provides valuable information to guide intervention development. However, there are some limitations to our approach that should be acknowledged. First, our approach is based on data from a small convenience sample of highly educated women. This sample may not be representative of all Black breast cancer patients and the intervention should be tested in more educationally diverse samples. Another limitation is that we relied on patient and provider self reports about communication because it was not feasible to videotape, audiotape, or observe encounters. However, our in-depth qualitative approach provides rich data and enabled valuable feedback in order to revise the materials before conducting a larger study.

The National Cancer Institute asserts that telling one's health "story" is an important form of active patient communication [29]. Building upon the existing cultural processes of story telling, our intervention incorporates strategies for activating patients by asserting oneself and asking questions. It facilitates informed decision-making, describes options for the alleviation of treatment side effects, instills active listening skills, and inspires hope. These preliminary findings can be used to inform patient-provider interactions or other interventions.

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Table 1

Characteristics of Patients and Survivor Participants (N=32)

Characteristic	Total N %	Women in Active Treatment* N=14	Survivor Advocates* N=10	Newly Diagnosed Women** N=8
<u>Education</u>				
< 12 years	1 (3)	1	-	-
> 12 years	26 (81)	13	5	8
Unknown	5 (16)	-	5	-
<u>Marital/Partner Status</u>				
Unmarried/Unpartnered	16 (50)	6	4	6
Married/Partnered	9 (31)	6	1	2
Unknown	7 (22)	2	5	-
<u>Stage</u>				
0	1 (3)	1	-	-
I	8 (25)	7	-	1
II	11 (34)	6	1	4
III	3 (9)	-	1	2
IV	1 (3)	-	-	1
Unknown	8 (25)	-	8	-
<u>Type of Surgery</u>				
Mastectomy	18 (56)	8	6	4
Lumpectomy	7 (22)	-	3	4
Unknown	7 (22)	6	1	-
<u>Chemotherapy</u>				
Yes	19 (59)	6	7	6
No	12 (38)	8	2	2
Unknown	1 (3)	-	1	-
<u>Radiation</u>				
Yes	12 (38)	5	5	2
No	18 (56)	9	3	6
Unknown	1 (6)	-	1	-

* Women who completed in-depth interviews for formative data collection;

** Newly diagnosed women who provided feedback on intervention.

Table 2Summary of Treatment *Perceptions, Enablers* and *Nurturers* that Influence Adjuvant Treatment Decisions

Domain Description	Positive	Existential	Negative
Perceptions “knowledge, attitudes, values, and beliefs that may facilitate or hinder personal motivation to maintain or change health beliefs and/or practices”	Faith in God Hope, Determination Acceptance Need to be strong for family Sharing stories of survival	Cancer Myths Spiritual beliefs Fear/Fatalism Finality/Mastectomy Concerns about recurrence	Fear of treatment side effects/tolerating treatment Experience of others; cancer myths Ability to take care of family/children Belief that chemotherapy is experimental Concerns about Hormonal therapy side-effects, long-term Doctors don't have time to address questions Treatment impacts daily life and activities Silence and privacy (re: sharing the diagnosis) Mistreatment from the medical system
Enablers “community and structural factors that may affect treatment decisions”	Access issues Strong relationships with providers Social Support Spiritual beliefs Women should speak-up for themselves Good patient-provider communication Writing down questions	Decision-making preferences Prefers professional to make decisions Doesn't know as much about cancer as cancer providers	Poor Patient-provider communication Limited knowledge about treatment options Uncomfortable asking questions of providers Base decision on – future concerns (fertility, etc.) Neglected by providers
Nurturers “reinforcing factors from a person's social network that may influence a person”	Supportive Spouse & Family Survivors, Faith Community Close relationship with providers Empathetic Providers Family Faith in God	Religious Beliefs No help with emotional aspects of the disease	Family members' negative reactions and concerns Lack of empathetic providers Family members who lack knowledge Provider Bias Uninformed family and community members

Table 3

Examples of Integration of Formative Findings for the TALK BACK! Intervention Strategy

Formative Findings		Exemplar Messages/Strategies for Survivor Coach	Examples from Patient Guidebook
Perceptions <i>Sharing/hearing stories of survival</i> <i>Strong faith</i> <i>Concern about negative side effects</i>		<ul style="list-style-type: none"> Encourage reliance on faith. Address key fears about treatment Help is available for potential side effects. Survival rates are higher with appropriate treatment. 	Message 1: You Are Not Alone Presentation of facts, list of support resources and glossary of oncologic terms. Worksheet of Values, preferences, related to key decision, stories from other survivors.
Enablers <i>Patient-provider relationship</i> <i>Need/desire for better communication</i>		<ul style="list-style-type: none"> Identify values, preferences for decision-making. Help patient handle negative physician responses. 	Message 2: Sharing in Treatment Decisions Definition and diagram of informed decision-making, information to consider when weighing treatment options, sample and blank worksheets to weigh pros and cons of treatment options, and issues to discuss with physicians.
Nurturers <i>Other Survivors Family</i> <i>Faith in God</i> <i>Interaction w/providers</i>		<ul style="list-style-type: none"> Use of a Black breast cancer survivor. Review strategies to share information with family members. Role-play patient-physician interactions. 	Message 3: TALK BACKSM Focus on: Telling Story, Asking Questions, Listening Actively, and Knowing treatment options, provides sample conversations on how to use the communication-decision model, sample questions to ask physicians, blank sheets for patient's use.