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Digital Object Identifier: <https://doi.org/10.13023/ETD.2017.254>

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BLACK WOMEN'S PERSPECTIVES ON BREAST CANCER DETECTION MESSAGING

DISSERTATION

A dissertation presented in partial fulfillment of the
requirements of the degree of Doctor of Philosophy in the
College of Communication and Information
at the University of Kentucky

By
Denise M. Damron

Lexington, Kentucky

Director: Dr. Kevin Real, Professor of Communication

Lexington, Kentucky

2017

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ABSTRACT OF DISSERTATION

BLACK WOMEN'S PERSPECTIVES ON BREAST CANCER DETECTION MESSAGING

A qualitative approach was used to explore the influence of mass media campaigns on Black women's perceptions of breast cancer. The primary purpose of this study was to address the high breast cancer mortality rate among young Black women, thus informing strategies to increase awareness of risk and encourage prevention activities. Black women have higher incidence rates before age 45 and are more likely to die from breast cancer at every age. Although the breast cancer mortality variance has been linked to socioeconomic status, studies have shown that differences in cancer knowledge and beliefs persist even when educational and socioeconomic measures are statistically controlled.

Because little is known about how various ethnic group members form ideas about breast cancer in the U.S., semi-structured interviews were conducted with 27 Black women between the ages of 30 and 40 to determine their knowledge and beliefs about breast cancer, as well as their personal perceptions of susceptibility to being diagnosed with breast cancer, in order to illuminate the interplay of culture and health belief systems on participants' understanding of breast cancer messaging.

To explore the potentially complex dynamics involved in how young Black women come to construct meanings about breast cancer, a theoretical framework that coupled Cultural Models Theory with the Risk Perception Attitude framework was used to address how health campaigns influence the behaviors and breast cancer detection experiences of Black women.

Findings from the study revealed that young Black women's perceptions of breast cancer are primarily driven by personal experiences, as opposed to mass media influences. The Black women in this study had a lack of knowledge of risk and prevention factors and did not perceive themselves to be affected by breast cancer due to their young age. In spite of cultural taboos

against discussing health issues with family and friends, the women in this study tended to take responsibility for their health and were proactive in seeking and acting on health information.

KEY WORDS: Breast cancer, Black women, African American women

Denise M. Damron

June 28, 2017

Date

BLACK WOMEN'S PERSPECTIVES
ON BREAST CANCER DETECTION MESSAGING

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Acknowledgements

Many thanks to my committee chair Kevin Real, PhD for his guidance and oversight of my comprehensive examination and dissertation process. Additional thanks go to my committee members Michael Arrington, PhD, Alan DeSantis, PhD, Phillip Hutchison, PhD, and Beth Rous, PhD for continued support and encouragement. I greatly appreciated the opportunity to engage in scholarly discussion with all committee members through my coursework, comprehensive examination, and final examination.

Additional thanks go to my initial sponsors who supported me in my efforts to return to graduate school to pursue my PhD after a 30 year career in marketing and advertising: Jane Thibault, PhD, Amy D'Apris, PhD, and Professor Helen Davis. I would especially like to thank Ms. Gail Miller for her unwavering support and willingness to allow me to complete my coursework while working full-time under her leadership.

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Chapter 1

Introduction

Black Women's Perspectives on Breast Cancer Detection Messaging

Context

Literature on health disparities affecting Black women in the U.S. suggests they are linked to economic and social inequality in healthcare. Disparities occur when “beneficial medical interventions are not shared by everyone in this country” (Freeman & Chu, 2005, p. 655). While there is no agreement on a singular cause of health disparities, it is believed that there are sociocultural, behavioral, economic, environmental, biological, or societal correlations (Gibbons, 2005). Blacks experience healthcare differently than other populations in the United States (Nelson, Smedley, & Stith, 2002).

The U.S. Commission on Civil Rights described the circumstances this way:

[This experience is] mixed in corrosive sociocultural, health and biomedical system legacies of 2000 years of being portrayed as being biologically and intellectually inferior; 246 years of chattel slavery, including a slave health deficit and a slave health subsystem; 100 years of legal segregation and discrimination and a "Negro medical ghetto;" and contemporary social, political, economic isolation, oppression, exploitation, and a "dual" and unequal health system. (Nelson et al., 2002, p. 476)

As a result of such disparities, the health outcomes of Blacks are vastly different from those of Whites in the U.S., with 13% of Blacks reporting they are in fair or poor health. Adult obesity rates for Black women are greater than those for White women in nearly every state in the nation. Blacks have higher rates of diabetes, hypertension, asthma, and heart disease than other groups. In regard to cancer, Blacks experience higher incidence and mortality rates from many cancers that are amenable to early diagnosis and treatment. This group is underrepresented in cancer trials and is less likely

to survive prostate cancer, lung cancer, and breast cancer than Whites (Center for American Progress, 2015).

In this study, the designation of race is described as Black to mean all women of color and includes women of African American descent as well as women of color whose parentage is derived from Belize and the Dominican Republic. All of the women in the study were born in the United States.

In the case of breast cancer, although White women historically have had higher incidence rates than Black women, the rates converged in 2012. In fact, from 2008 to 2012, incidence rates were significantly higher in Black women compared to White women in seven states, primarily located in the South. Today, breast cancer is the most commonly diagnosed cancer and the second most common cause of cancer death among Black women (American Cancer Society, 2015a). The mortality disparity between Black and White women nationwide has continued to widen, with death rates 42% higher in Black women than in White women (DeSantis et al., 2016). Additionally, Black women have a higher incidence rate before 40 and are more likely to die of breast cancer at every age (American Cancer Society, 2015a).

Breast cancers diagnosed in Black women carry a poor prognosis when compared to those in White women due to diagnoses at a higher grade and more advanced stage, and more frequent negative hormone receptor status. Premenopausal Black women have a higher risk for triple-negative and basal-like breast cancers, which are particularly aggressive subtypes of breast cancer with a shorter survival period. Additionally, reproductive patterns such as giving birth to more than one child, younger at age of menarche, and early age at first pregnancy, may increase the risk for more aggressive subtypes of breast cancer (American Cancer Society, 2015c).

Young women under the age of 30 account for approximately 5 to 6% of all newly diagnosed cases of breast cancer in the U.S. Compared to women over 40, younger women face higher rates of recurrence and death, are diagnosed at later stages, and have tumors that are higher in grade and larger in size. Unlike diagnoses among older women with breast cancer, Black women under the age of 40 are diagnosed more frequently and with more aggressive forms of breast cancer than White women (Buchanan, Roland, Rodriguez, Miller, & Farley, 2013). Compared to 5% of White women, 10% of Black women with breast cancer are diagnosed prior to age 40 (Anders, Johnson, Litton, Phillips, & Bleyer, 2009).

The Breast and Cancer

Cancer is a disease that causes the cells in the body to change and grow out of control, eventually forming a mass called a tumor. The majority of breast cancers begin in the parts of the breast tissue comprised of glands for milk production (American Cancer Society, 2015a). Breast cancer is considered to be a group of diseases distinguished by different molecular subtypes, risk factors, clinical behaviors, and responses to treatment (American Cancer Society, 2015a). It is distinguished by up to 21 distinct histologic subtypes and at least four different molecular subtypes associated with distinct risk factors. These cancers are biologically variable in presentation, response to treatments, and outcomes (DeSantis et al., 2016). Breast cancer is most often detected either during a screening examination, before symptoms have developed, or after a lump is noticed.

In 2015, more than 231,000 new cases of invasive breast cancer and more than 60,000 cases of in situ breast cancer were diagnosed in U.S. women, resulting in over 40,000 deaths. More than 2,000 men were diagnosed and 440 men died from breast

cancer. The median age at the time of breast cancer diagnosis during the years 2008 to 2012 was 61. Between the ages of 60 and 84, breast cancer incidence rates are higher in White women than in Black women. However, Black women have a higher incidence rate before age 45 and are more likely to die from breast cancer at every age (American Cancer Society, 2015b).

Breast cancer is classified based on hormone receptors and a growth-promoting protein called HER2/neu, shortened to HER2. If the cancer cells contain estrogen or progesterone receptors, they are called hormone-receptor-positive (HR+). If neither estrogen nor progesterone is present, they are considered to be hormone-receptor-negative (HR-). Cancers with too much HER2 protein are called HER2 positive (HER2+), while cancers without excess HER2 are called HER2 negative (HER2-) (American Cancer Society, 2015h). From 2008 to 2012, the majority of breast cancers (74%) were HR+/HER2- (luminal A), while 12% were HR-/HER2- (triple negative), 10% were HR+/HER2+ (luminal B), and 4% were HR-/HER2+ (HER2-enriched), with varying distributions by race/ethnicity. Black women have the smallest proportion of HER+/HER2 status and the largest proportion of triple negative (HR-/HER2-) status compared to other races/ethnicities. Triple negative breast cancers are considered to be more aggressive and have more poor prognoses, in part because there are currently no targeted therapies for these tumors (DeSantis et al., 2016).

Some factors known to increase the risk of breast cancer are not modifiable, such as age, family history, early menarche, and late menopause. Modifiable factors include postmenopausal obesity, use of combined estrogen and progestin menopausal hormones, alcohol consumption, and breastfeeding (American Cancer Society, 2015c).

Black Women and Breast Cancer

In the U.S., breast cancer deaths slowly increased from 1974 to 1990, but decreased 34% from 1990 to 2010. The drop in breast cancer mortality has been attributed to improvements in both breast cancer treatment and early detection. However, not all segments of the population have benefited from these advances. Notably, a gap in long-term breast cancer mortality rates between Black and White women began to develop in 1980. The American Cancer Society (ACS) says this difference might “reflect earlier uptake and greater mammography usages by Whites during the 1980s, as well as differences in access and response to new treatments, including tamoxifen, used to treat hormone receptor-positive breast cancers, which are less common among Black women”(American Cancer Society, 2015d, p. 9). From 2007-2011, the rate of breast cancer among Black women was 41% higher than that among White women (American Cancer Society, 2015b).

Table 1

Breast Cancer Incidence and Mortality by Ethnic Race & Ethnicity in the U.S. 2007 - 2011

	Non-Hispanic White	Non-Hispanic Black	Asian and Pacific Islander	American Indian and Alaska Native	Hispanic/Latina
Incidence	13%	12%	8%	9%	9%
Mortality	22%	31%	11%	15%	24%

(American Cancer Society, 2015i, p. 38)

As detailed in Table 1, Black women have the lowest breast cancer survival rate of any racial or ethnic group, with cause-specific survival meaning the probability of not dying of breast cancer within 5 years of diagnosis.

The earliest recorded U.S. cancer statistics from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) date back to 1960. From 1960 to 1963, the 5-year relative survival rate for White women was 63% and for Black women was 46%. As better detection and treatment methods were introduced throughout the years, the 5-year survival rates increased. From 2005 to 2011, the 5-year relative breast cancer survival rate for Black women was 80.5%, while for White women it was 90.6% (Ries et al., 2008). Researchers have attributed this survival disparity to later stage detection and more poor stage-specific survival among Black women. Moreover, according to the ACS, "poverty, less education, and a lack of health insurance are also associated with lower breast cancer survival" (American Cancer Society, 2015c, p. 10).

Breast Cancer Detection

Prior to the advent of radiographic imaging, breast cancer was detected visually or by palpation. In James S. Olson's 2002 book, *Dying of Breast Cancer in the 1800s*, he gives a detailed account of Abigail "Nabby" Adams, the daughter of John and Abigail Adams, and her fight with breast cancer. According to Olson, in 1808, Nabby found a small "old age" dimple on her breast that was actually a malignant tumor rapidly spreading throughout her body. In 1809, she noticed that the dimple had turned into a solid lump behind her breast which continued to grow in size. After consulting with multiple physicians, she was given the news by Boston surgeon John Warren that she would need a mastectomy. In 1813, more tumors recurred until she eventually died at age 46 (Olson, 2002).

Mammography can be traced to the discovery of x-rays by Wilhelm Röntgen in 1895. The evolution of mammography began in 1913 when German surgeon Albert Salomon first used radiography of mastectomy specimens to show the spread of tumors

to axillary lymph nodes (Gold, Bassett, & Widoff, 1990). Further work by Walter Vogel in 1931 demonstrated the ability to differentiate benign breast lesions from carcinoma. In the late 1950s, Robert Egan at the University of Texas M.D. Anderson Cancer Center devised a technique using low levels of radiation and single emulsion films to create a method of screening mammography for the first time (Gold et al., 1990). Raul Leborgne in Uruguay fueled the interest in mammography in a 1953 article that discussed the importance of breast compression for improving image quality. The widespread use of mammography can be attributed to Robert L. Egan who, in 1960, used a mammographic technique that used reproducible industrial film (Gold et al., 1990). Today's modern mammography methods were developed in the late 1960s and were first recommended by the American Cancer Society in 1976 (American Cancer Society, 2015f).

Early detection and health education are two critical factors affecting breast cancer survival. Mammography, a low-dose x-ray procedure that presents a visualization of the internal structure of the breast, reduces the risk of dying from breast cancer by 15 to 20%, while early detection offers a wider range of treatment options such as less-extensive surgery and the use of chemotherapy with fewer side effects (American Cancer Society, 2015d). Since 2000, mammography use in Black women has been relatively stable and on par with the rate in White women. In 2010, 51% of Black women reported having received a mammogram within the past year, compared to 52% of White women (American Cancer Society, 2015d). Despite similar screening rates, breast cancer continues to be detected at an advanced stage more often in Black women than in White women. The difference has been attributed to longer intervals between mammograms and a lack of timely follow-up of suspicious results (American Cancer Society, 2015d).

The U.S. Preventive Services Task Force (USPSTF), an independent, volunteer panel of national experts in prevention and evidence-based medicine, issued their final recommendations on screening for breast cancer on January 16, 2016. Their recommendations consist of age-based screening methods. For women ages 40 to 49, the task force recommends “informed, individualized decision making based on a woman’s values, preferences, and health history” (USPSTF, 2016, p. 1). Women aged 50 to 74 are urged to get a mammogram every 2 years. The task force indicated that more research is needed to recommend for or against mammograms for women ages 75 and older. While the task force does not make recommendations for or against insurance coverage, most insurance companies follow the task force’s guidance when determining mammography coverage (USPSTF, 2016).

When the USPSTF published its initial, and now final, screening guidelines in May of 2015, the President of the Black Women’s Health Imperative, Linda Goler Blount, issued the following statement:

We are disheartened by the U.S. Preventive Services Task Force recommendations for breast cancer screening. As the only national organization dedicated to the health and wellness of the nation’s 20 million Black women and girls, we know these recommendations do a tremendous disservice to women everywhere, and, particularly, put the lives of Black women at risk. (Black Women’s Health Imperative, 2015a)

The American Cancer Society recommends that women age 40 to 44 “have the choice to start annual breast cancer screening with mammograms if they wish to do so” (American Cancer Society, 2015e). The organization further recommends that women ages 45 to 54 get mammograms every year, while women 55 and older can either continue yearly screening or switch to mammograms every 2 years. The ACS indicates

that screening should continue “as long as a woman is in good health and is expected to live 10 more years or longer” (American Cancer Society, 2015e).

Debbie Wasserman Schultz, who represents Florida’s 23rd Congressional District, wrote an op-ed piece for *The Washington Post* where she said that the recommendations “could lead to insurance companies dropping coverage of mammograms for women under age 50.” She went on to say the following:

Most staggering of all: On the same day these draft recommendations became public, the National Cancer Institute announced that the total number of breast cancer cases in this country will rise by 50 percent by 2030....This staggering increase will strike women from all backgrounds, races, and ethnicities. It will strike the rich and the poor, those with access to quality health care and those with little or no healthcare. It will affect women under 40 and those over 40. And it is more likely to target Black women in more aggressive forms. (Schultz, 2015)

Breast Cancer Detection Marketing

Social marketing is a term first introduced by Kotler and Zaltman in 1971 to refer to the application of marketing to the solution of social and health problems. Social marketing is not a theory in itself, but it is a framework that draws from other bodies of knowledge such as psychology, sociology, anthropology, and communication theory, to understand how to influence people’s behavior (Kotler & Zaltman, 1971). Social marketing evolved in parallel with commercial marketing. During the late 1950s and early 1960s, marketing scholars considered the potential and limitations of applying marketing to political and social arenas (Kotler & Zaltman, 1971). This expansion of the marketing concept, combined with a shift in public health policy toward disease prevention, paved the way for the development of social marketing. During the 1960s, commercial marketing techniques were applied to health education campaigns (Ling, Franklin, Linsteadt, & Gearon, 1992). Then, in 1971, Kotler and Zaltman published their seminal article in the *Journal of Marketing*: “Social marketing: An approach to planned

social change.” By the 1980s, academics were exploring how marketing should be applied to social issues through the development of social marketing theory and practice (Ling et al., 1992).

Today, social marketers, health educators, healthcare providers, and cancer prevention specialists use breast cancer communications as a key promotional tool to motivate mammography screening and timely help-seeking behaviors for breast cancer symptoms. In addition to messages that encourage mammography and prompt help-seeking, commercial marketing efforts in the U.S. promote breast cancer-related messages through corporate philanthropy and sponsorships, cause-related marketing, and similar public relations activities. While such corporate promotions, news coverage, and public relations may not promote specific behaviors (such as screening) in the same way as focused breast cancer communications, they nonetheless contribute to the prevailing cultural images of breast cancer, and they influence attitudes, beliefs, and behaviors about breast cancer (Barg & Grier, 2008).

Research has found that the images and themes used in breast cancer communications converge to form that of a young, professional White woman who tells a story of developing breast cancer and overcoming the adversity she faces. The narrow focus on young, professional White women is inconsistent with the statistical realities of breast cancer occurrence and survival rates, and consumers’ attitudes, beliefs, and behaviors have deviated from the themes prevalent in breast cancer communications (Barg & Grier, 2008).

Although traditional approaches to understanding health-related behaviors such as mammography usage have been studied, “relevant academic research examining marketing and health-related behaviors focused on ethnic minority populations is lacking,

despite the fact that minority populations are growing in number” (Barg & Grier, 2008, p. 335). Kinney, Gammons, Coxworth, Simonsen, and Arce-Laretta (2010) explored the beliefs and attitudes of Latino women about hereditary breast cancer and genetic services. Focus group participants expressed the importance of including key socioeconomic factors in the design and implementation of genetics education. Participant responses indicated that information needs to be personally relevant to be cognitively processed. The researchers concluded that “increasing availability of culturally sensitive genetic cancer risk information to Latinos may aid in lowering barriers to sharing cancer history information with family members and healthcare providers” (Kinney et al., 2010, p. 114).

While breast cancer health communication targeted to specific consumer segments does exist, prior research suggests a lack of messages targeted specifically to Black women which resonate with their own life experiences (Barg & Grier, 2008). In focus group research conducted by Talbert (2008) with Black women who have survived breast cancer, one participant said this:

I would like to see messages that are culturally sensitive...in lay terms to help Black women understand breast cancer symptoms and assist with perceived susceptibility. Many Black women associate breast cancer with an automatic death sentence. ...Communication is lacking and we need to start presenting and disseminating breast cancer awareness messages in areas where the need is greater. (Talbert, 2008, p. 355)

This sentiment is supported by the idea of segmented, or targeted, health communication messages that reflect the cultural values of ethnic groups.

Problem Statement

Inspired by the red ribbons worn to raise awareness of AIDS, the pink ribbon campaign first came into being in the fall of 1991 when the Susan G. Komen Foundation began handing out pink ribbons to the runners in a New York City race to commemorate

breast cancer survivors (Fernandez, 1998). Yet despite 25 years of pink ribbon breast cancer awareness campaigns, as well as advances in detection and treatment that have improved breast cancer survival rates, Black women still have higher mortality rates and lower survival rates than White women. Breast cancer detection campaign messaging is primarily derived from nationally recognized guidelines followed by physicians when it comes to treatment and from insurance companies when it comes to payment. For instance, the U.S. Preventive Services Task Force recommends various mammography screening scenarios based on a woman's age starting at age 40. This dynamic ignores the fact that Black women in the 30 to 39 age category "represent a high-risk group that may benefit from efforts at earlier detection" (Johnson, 2002, p. 149).

Research has demonstrated that consumers who are members of different groups construct meanings from advertisements based on their own cultural and social experiences. A cultural model for breast cancer has emerged that posits breast cancer as not having any particular relevance to Black women, who may perceive breast cancer to be something that affects White women. Instead, the model suggests that Black women perceive other health threats such as HIV and hypertension as more salient than breast cancer (Barg & Grier, 2008). These disparities are also due to health knowledge, beliefs, behaviors, and expectations derived from media messages that paint breast cancer as "a White woman's disease" (Barg & Grier, 2008, p. 339).

Currently, little is known about how various ethnic group members form ideas about breast cancer in the U.S., and whether these ideas are congruent with the implicit messages related to consumer behavior which underlie breast cancer communications. Understanding how members of different groups think about breast cancer can contribute to the creation of persuasive messages that effectively motivate people to undertake

breast cancer screening or to seek medical care (Barg & Grier, 2008). Discovering how social forces influence Black women's awareness of breast cancer is vital to making an impact on health behaviors that lead to greater prevention and early detection of breast cancer.

Purpose Statement

The primary purpose of this study was to address the high breast cancer mortality rate among young Black women, thus informing strategies to increase awareness of risk and encourage prevention activities. Social marketing "has the ability to popularize positive ideas and change attitudes; furthermore, it empowers individuals to change their behavior" (Talbert, 2008, p. 348). The 25 years of the "pink campaign," designed to raise awareness of breast cancer, have created a homogenous view of victims of breast cancer that largely excludes Black women under the age of 40 who "represent a high-risk group that may benefit from efforts at earlier detection" (Johnson, 2002, p. 149). It is important for researchers to learn more about the impact of media messages to understand if and how they contribute to breast cancer health disparities affecting Black women by potentially discouraging prevention and detection behaviors.

Using the lens of cultural and health belief models, the current study investigated how media messages shape the meanings associated with breast cancer among a group of insured Black women under the age 40. The study explored Black women's knowledge and beliefs about breast cancer in general, as well as their personal perceptions of susceptibility to being diagnosed with breast cancer, in order to illuminate the interplay of cultural and health belief systems on participants' understandings of breast cancer messaging. Strategies to detect breast cancer among Black women continue to emphasize compliance with guidelines recommended for the general population. There is

a “gaping difference in racial incidence and an ominous prognosis for young Black women” supporting “the notion of increased vulnerability in young Black women” (Johnson, 2002, p. 152). Although previous studies have identified factors associated with breast cancer disparities, there is a lack of understanding related to the relationship between breast cancer detection messaging and how cultural and behavioral issues may contribute to a lack of understanding by those at “increased vulnerability” for being diagnosed with breast cancer. The purpose of this study was to examine the linkages between mass media campaigns and the impact such messaging has on the perceptions and behaviors of a population that experiences health disparities.

Research Questions

The current study was guided by the following research questions in order to understand how breast cancer health campaigns inform insured young Black women’s experiences and perspectives on breast cancer:

RQ1: What is the nature of insured young Black women’s perceptions about breast cancer detection and its relevance to their lives?

RQ2: How do insured young Black women experience mass media communications regarding breast cancer prevention, detection, diagnosis, and treatment?

Nature of the Study

A qualitative research design was used to answer the aforementioned research questions. This study examined how culture and mass media campaigns inform Black women’s perceptions of breast cancer risk. In-depth, semistructured qualitative telephone interviews were conducted with young Black women Louisville, Kentucky.

Participant criteria included the following: female of African American descent, between the ages of 30 and 40, have private health insurance, are employed full-time, and have never been diagnosed or treated for breast cancer. Additional information collected at the time of each interview included occupation and highest level of education. In this study, the designation of race is described as Black to mean all women of color and includes women of African American descent as well as women of color whose parentage is derived from Belize and the Dominican Republic. All of the women in the study were born in the United States.

A pilot study was conducted with employees of one managed care company recruited through an established Black company networking group. Black women ages 30 to 40 were recruited through a Web announcement forwarded by email by a group member that directed interested parties to contact this researcher via email. Once contact was established, the researcher scheduled a 45-minute phone interview at a time that was convenient for the participant. In accordance with the University of Kentucky's nonmedical Institutional Review Board guidelines, each participant was asked to review an Informed Consent for Research Study form before proceeding with the actual interview.

Once five pilot interviews were completed, the interview protocol was revised to include more in-depth questions about media awareness and cultural issues. The original questionnaire of 34 questions was expanded to a total of 47 open-ended questions. Participants were recruited through a process of snowballing whereby pilot interview participants were asked to recommend individuals who met the research criteria to participate in a 1-hour telephone interview. A total of 22 respondents were scheduled for the 1-hour interview. Interviews were arranged via email. An Informed Consent form

was forwarded to each participant prior to the interview. A \$50 incentive was provided to the 22 respondents for completing the interview.

Regarding the use of phone interviews for data collection, there is an assumption that face-to-face interviews are superior to telephone interviews due to concerns of lack of visual cues that may lead to a loss of data (Novick, 2008). However, according to Novick (2008), “there is little evidence that data loss or distortion occurs, or that interpretation or quality of findings is compromised when interview data is collected by phone. In fact, telephones may allow respondents to disclose sensitive information more freely,” (p. 8). Because interviews for this study were conducted with professional Black women, telephone interviews offered the benefit of convenience for participants. Additionally, the influence of participant racial bias may have been minimized with a telephone interview by a White researcher.

Through discussion about their perceptions of breast cancer, the semistructured interviews endeavored to uncover participants’ shared meanings of breast cancer. During these phone interviews, participants were asked to describe their personal experiences, as well as their familiarity with news reports, advertising campaigns, and other mass media communications, regarding breast cancer prevention, diagnosis, and treatment. Further discussion sought to solicit participants’ opinions on ways to structure breast cancer messages within a context appropriate to their cultural and health belief systems.

Significance

Black women have the highest breast cancer rates of all ethnic/racial groups and a 41% higher rate of breast cancer deaths than White women do. More than 10% of Black women with breast cancer were diagnosed before the age of 40 compared to 5% of White patients (Johnson, 2002). Many Black women do not fit the profile of the average

American woman who gets breast cancer, as depicted in mass media campaigns. By understanding young Black women's perceptions and experiences of breast cancer detection messaging, social marketers can begin to create relevant campaigns to counteract mass media generalizations about who is susceptible to being diagnosed with breast cancer. Culturally sensitive campaigns may lead to meaningful changes in health behaviors, thus reducing morbidity and mortality rates among this population.

Chapter 2

Literature Review

Literature Review Overview

The phenomenon of greater breast cancer mortality among young Black women in the U.S. involves a host of factors. In order to fully address the scope of these factors, this literature review includes an examination of the epidemiology of the disease, historical trends in the progression of breast cancer, incidence and mortality trends among various populations, breast cancer in young women, risk factors for breast cancer, and the role of detection breast cancer screening. In addition to an exploration of the disease itself, this review delves into the meaning of disparity in health, breast cancer in Black women and the impact of disparity, and the social construction of breast cancer that may play a part in breast cancer disparity. A comprehensive review of health communication and cancer was undertaken to investigate their relationship, including the importance of health communication, depictions of women in the media, and a review of public breast cancer awareness campaigns. Gaps in the literature in relation to the topic of Black women, breast cancer, disparity, and communication were noted, followed by the establishment of a theoretical framework that served as the foundation for this research. The theoretical lens is supported by two theories: risk perception attitude (RPA) framework and cultural models theory.

Literature for this review was obtained from several sources, including PubMed—a database of the National Institutes of Health’s U.S. National Library of Medicine that comprises more than 25 million citations for biomedical literature from MEDLINE, life science journals, and online books. Additional articles were secured from the University of Kentucky Library’s online database. Several government websites, including the

Centers for Disease Control and Prevention, the National Center for Health Statistics, and the U.S. Preventive Services Task Force, were utilized in addition to the website of the American Cancer Society. Health communication theory and research text books were referenced, as well as several targeted books related to health disparity, breast cancer, and national breast cancer campaigns. For the campaign analysis section, the websites of each noted organization were accessed. Database search terms included the following topics: breast cancer statistics, breast cancer epidemiology, breast cancer historical trends, health disparity, breast cancer and health disparity, African American/Black women and breast cancer, young women and breast cancer, health behavior theories, RPA framework, culture and breast cancer, culture and health, cultural models, mammography, breast cancer detection, breast cancer and the media, and breast cancer screening and detection behaviors.

Overview of Breast Cancer

Breast cancer epidemiology. Cancer consists of a group of diseases where cells in the body change and eventually form a tumor, and it is named after the part of the body where the tumor originates. Most breast cancers begin in the milk production glands (American Cancer Society, 2015a). Ductal carcinoma in situ (DCIS), which is considered a noninvasive form of breast cancer, is the most common type of breast cancer and accounts for about 83% of in situ cases diagnosed 2008 – 2012. Lobular carcinoma in situ (LCIS), which is considered a marker for increased risk of developing invasive cancer, accounts for about 13% of in situ cancers diagnosed 2008 – 2012 (American Cancer Society, 2015a).

Most breast cancers are invasive, meaning they have broken through the walls of the glands or ducts where they originated and grown into surrounding breast tissue. Two

main staging systems for cancer indicate the spread of the cancer when first diagnosed. The tumor-node-metastasis (TNM) classification of tumors, developed in 1943 and 1953 by Professor Pierre Denoix at the Institute Gustave-Roussy, includes tumor size and how far it has spread within the breast to adjacent tissues, as well as the presence or absence of the spread to distant organs. Once the T, N, and M are determined, a stage of 0, I, II, III, or IV is assigned. Stage 0 indicates in situ, stage I early stage invasive cancer, and stage IV the most advanced cancer (American Cancer Society, 2015a).

While breast cancer is commonly referred to as a single disease, it actually consists of up to 21 distinct histological subtypes and at least four different molecular subtypes. The four main molecular subtypes include Luminal A (74%), Triple negative (12%), Luminal B (10%), and HER2-enriched (4%) (American Cancer Society, 2015a). When a tumor is small, breast cancer typically produces no symptoms and is most easily treated. When breast cancer has grown to a size that can be felt, the most common symptom is a painless lump. Pain, or lack of pain, does not indicate the presence or absence of breast cancer (American Cancer Society, 2015a).

Historical trends in breast cancer. According to the American Cancer Society (2015d), breast cancer is second only to lung cancer in the number of U.S. cancer deaths. Excluding skin cancer, breast cancer is the most common cancer in women and is one in three cancers diagnosed in U.S. women (American Cancer Society, 2015d). Breast cancer incidence rose during the 1980s and 1990s because of increased mammography screening (American Cancer Society, 2015d). Incidence rates of in situ breast cancer have stabilized since 2000 in women 50 and older, and since 2007 in younger women (American Cancer Society, 2015d). These trends likely are a reflection of greater mammography screening, which peaked in 2000 and stabilized to a lower rate after 2005.

The increase in mammography screening inflated the incidence rate due to cancers being diagnosed 1 to 3 years earlier (American Cancer Society, 2015d). Rates stabilized between 1987 and 1994, followed by a slower increase during the late 1990s. The rising breast cancer trend may be due to increased mammography screening rates, rising rates of obesity, and the use of menopausal hormones, the latter two being breast cancer risks (American Cancer Society, 2015d). Between 2002 and 2003, breast cancer rates dropped nearly 7%, likely because of the decreased use of menopausal hormones following the 2002 publication of clinical trials that found higher breast cancer risk among hormone users (American Cancer Society, 2015d).

Incidence rates for White and Black women are available starting in 1975, and for women of other ethnic groups since 1992. Between 2008 and 2012, overall incidence rates increased 0.4% per year for Black women and 1.5% for Asian/Pacific Islander women, but were stable among Whites, Hispanics, and American Indians/Alaska Natives. Breast cancer rates for Blacks and Whites converged in 2012, which reflected the incidence increasing in Black women while stabilizing in White women (American Cancer Society, 2015d).

Breast cancer rates were steady during 2008 - 2012 for women under age 50, while rates increased 0.7% for women over 50. Trends by age at diagnosis differ by race and ethnicity. In women under 50, incidence rates increased in Whites (0.4% per year) and Asian/Pacific Islanders (0.8%) from 2008 to 2012, yet were stable in other racial/ethnic groups. Among women over 50, increases were seen in Black (0.4%) and Asian/Pacific Islander (1.3%) women (American Cancer Society, 2015d).

Breast cancer incidence and mortality. Excluding cancers of the skin, breast cancer is the most common cancer in U.S. women, consisting of 29% of newly diagnosed

cancers (American Cancer Society, 2015b). Men, however, are at low risk for developing breast cancer. Breast cancer incidence and death rates increase with age. From 2008 to 2012, the overall median age at the time of diagnosis was 61. The median age is younger for Black women (58) than for White women (62) (American Cancer Society, 2015b).

Between the ages of 60 and 84, breast cancer incidence rates are higher in White women than in Black women (American Cancer Society, 2015b). Black women have a higher incidence rate before age 45 and are more likely to die from breast cancer at every age (American Cancer Society, 2015b). Incidence and death rates for breast cancer are lower among women of other racial and ethnic groups than among Black and White women, with Asian/Pacific Islander women having the lowest incidence and death rates (American Cancer Society, 2015b). Breast cancer death rates in the U.S. decreased 36% between 1989 and 2012 after increasing 0.4% per year since 1975 (American Cancer Society, 2015b). Breast cancer rates declined annually from 2003 to 2012 in Whites (1.8%), Hispanics (1.5%), Blacks (1.4%), and Asian/Pacific Islanders (1.0%). During this time, rates remained stable for American Indians/Alaska Natives (American Cancer Society, 2015b).

Breast cancer mortality declines have been attributed to improvements in treatment and in early detection. However, a divergence in long-term breast cancer mortality trends between Black and White women began in the early 1980s. This difference could be due to several factors, including “differences in stage at diagnosis, obesity and co-morbidities, and tumor characters, as well as access, adherence, and response to treatment” (American Cancer Society, 2015d, p. 8). Despite improvements in treatment for breast cancers, the racial disparity has widened such that the death rates for

Black women are an alarming 42% higher than for White women (American Cancer Society, 2015d).

Breast cancer in young women. Approximately 7% of women with breast cancer in the U.S. are diagnosed before the age of 40 (Anders et al., 2009). Breast cancer accounts for more than 40% of all cancers in women in this age group (Anders et al., 2009). It ranks as the most frequently diagnosed invasive cancer in adolescent and young women and represents approximately 25% of breast cancer cases diagnosed in the U.S. Breast cancer in younger women has more aggressive characteristics, such as higher grade tumors, more advanced disease stage, and lower hormone receptor positivity. Breast cancer in younger women varies by race/ethnicity, with young Black women having a higher incidence compared to White women of the same age (Ademuyiwa et al., 2015).

Black women under age 40 have a worse outcome than White women under age 40, resulting in a higher mortality rate. Several reasons have been posited for this differential. Black women are more likely to be diagnosed with basal-like breast cancer, which has a poorer outcome due to the lack of treatments (Ademuyiwa et al., 2015); however, outcome differences are still evident even when biology is considered. In addition to higher incidence and mortality rates and greater risk of reoccurrence in young Black women, the incidence of invasive breast cancer among this group continues to increase (Ademuyiwa et al., 2015). Because 10% of Black women versus 5% of White women with breast cancer are diagnosed before age 40, and due to poorer outcomes in Black women, it has been suggested that this younger group should be considered at high risk and thus be offered routine mammography screening (Anders et al., 2009).

Risk factors. Many of the known risk factors for breast cancer are not modifiable, such as age, family history, early menarche, and late menopause. Modifiable factors include postmenopausal obesity, use of combined estrogen and progestin menopausal hormones, alcohol consumption, and breastfeeding (American Cancer Society, 2015c). Several studies have shown that risk factors differ across racial/ethnic groups (Hall, Moorman, Millikan, & Newman, 2005; Hines et al., 2010). Hines et al. (2010) studied how established breast cancer risk factors, including reproductive history, family history, menstrual history, hormone use, alcohol consumption, physical activity, height, and body mass index, might explain some of the differences in the occurrence of breast cancer among racial/ethnic groups. White women have a higher incidence rate than Hispanic women, and the Hines et al. (2010) study found that 62 to 75% of breast cancer cases among White women were attributed to known breast cancer risk factors, compared to only 7 to 36% among Hispanic women (Hines et al., 2010). Hispanic women were more likely to exhibit characteristics associated with lower breast cancer risk, such as earlier age at first childbirth, having more children, less hormone use, and less alcohol consumption. This study showed that “these observed differences could at least partially explain the disparity in breast cancer incidence rates and may provide unique insight into the etiology of breast cancer” (Hines et al., 2010, p. 7). This indicates that models used to estimate a woman’s risk of breast cancer that were developed from studies of White populations need to be evaluated among other ethnic/racial populations (Hines et al., 2010).

Hall et al. (2005) found that racial/ethnic variations in prevalence and risk factors may contribute to the higher incidence of breast cancer among younger Black women. Black breast cancer patients are more likely to be diagnosed at a younger age and with

more aggressive cancers that respond more poorly to treatment than those in older women. Because of this, the mortality rate for younger Black women is twice that of younger White women (Hall et al., 2005). Among younger women (aged 20 – 49 years), versus older women (aged 50 – 74 years), numerous statistically significant differences in risk factors were seen by race/ethnicity. Risk factors for younger Black women included younger age at first full-term pregnancy and having more births, less likelihood of breastfeeding, less but longer use of oral contraceptives, larger body size, higher waist/hip ratio, lower levels of education, more alcohol consumption, and more smoking. Hall et al. (2005) found that most variations in risk factors occurred in women less than 50 years of age. According to the authors, these results demonstrated the following:

[They showed] the importance of assessing modification by age when discerning risk estimates, and they support the hypothesis that racial variation in risk combined with racial differences in prevalence for particular risk factors may contribute to the higher incidence of breast cancer among younger Black women. (p. 50)

Role of detection screening. Mammography, a low-dose x-ray procedure that visualizes the internal structure of the breast, is recommended by the American Cancer Society for the early detection of breast cancer, depending upon a woman's age (American Cancer Society, 2015i). Mammography reduces the risk of dying from breast cancer by about 20%. Earlier detection allows for a greater range of treatment options, including less extensive surgery and the use of chemotherapy with fewer side effects (American Cancer Society, 2015i). While mammography is not 100% effective in detecting breast cancer, the ACA describes it this way:

[Mammography is] the single most effective method for early detection since it can help identify cancer several years before physical symptoms develop. It is the position of the American Cancer Society that the balance of benefits to possible harms strongly supports the value of regular breast screening in women for whom it is recommended. (American Cancer Society, 2015i, p. 19)

In 2013, 67% of women 40 years of age and older reported having had a mammogram (National Center for Health Statistics, 2014). In women 40 years of age and older, mammography increased from 29% in 1987 to 70% in 2000, declining slightly from 2000 to 2005, and then stabilizing. In 2013, mammography screening rates for Black women were 67.1% compared to 66.8% for White women (National Center for Health Statistics, 2014). Strategies to detect breast cancer in Black women focus on recommended guidelines intended for the general population. These recommendations highlight “a gaping difference in racial incidence and an ominous prognosis for young Black women with breast cancer” (Johnson, 2002, p. 152). In spite of biological differences, often blamed for higher morbidity and mortality in young Black women, studies have shown that if cancer were detected earlier in Black women, their outcomes would be similar to those in the general population (Johnson, 2002).

Breast Cancer Disparity

Meaning of disparity in health. According to a report from the Institute of Medicine, despite improvements in the health of Americans, there are still disparities in the health status of racial/ethnic minorities that differ from the overall population (Nelson et al., 2002). The report goes on to say that “the health status of Blacks—a racial-ethnic group already burdened with deep and persistent history-based health disparities—has been recently characterized as stagnant and deteriorating” (Nelson et al., 2002, p. 455). Racial and ethnic disparities in healthcare are well documented, but the sources of such disparities remain elusive (Nelson et al., 2002). Many scholars indicate that while health disparities are a reflection of differences in socioeconomics and access to care, recent

evidence indicates that not only do racial, ethnic, class, and gender biases exist, direct and indirect discrimination are also key influences on health disparities (Nelson et al., 2002).

Differences in population characteristics such as race/ethnicity, class, culture, and gender are thought to be related to many of the current disparities within healthcare. When considered from the perspectives of racial/ethnic worldviews, however, these variations have “generated group identities and self-awareness, racial mythology, group interaction, stereotyping, competition, conflict, a corpus of critical theory, accommodation, and in some instances, assimilation and integration” (Nelson et al., 2002, p. 456). The interplay of these elements has undoubtedly contributed to a cultural gap that places such individuals outside of the mainstream, thus contributing to further health disparities.

In the cancer arena, many medical advances have contributed to the development of effective prevention, early detection, and treatment measures. However, these medical advances have not been shared with all strata of society. Freeman and Chu (2005) argued that “not everyone in the United States has shared sufficiently in these interventions and has not benefited as well with respect to declining mortality rates” (p. 655). Disparities in cancer care can be attributed to three major determinants of health disparities: culture, poverty (i.e., low socioeconomic status), and historical dynamics of social injustice (Freeman & Chu, 2005). Culture is defined as a shared communication system between individuals or communities, and it encompasses physical and social environments, common beliefs, values, traditions and world view, and similarities in lifestyle, attitude, perceptions, and behavior (Freeman & Chu, 2005). Poverty refers to a lack of resources, inadequate information and knowledge, substandard living conditions, and risk-promoting lifestyle, attitudes, and behaviors (Freeman & Chu, 2005). Social

injustice, such as racism and racial discrimination, infer that various population groups are subordinated by social, economic, and political entities. When taken as a whole, all of these determinants of health disparity impact the entire spectrum of cancer care—prevention, screening, early detection, diagnosis, treatment, and rehabilitation (Freeman & Chu, 2005).

Breast cancer in Black women and impact of disparity. In considering one aspect of cancer—mortality—researchers have cited various potential causes for lower survival rates among Black women, such as variations in treatment, high prevalence of comorbid conditions, poor eating habits, lower rates of screening, and late diagnosis (Vastag, 2003). Researchers studying this phenomenon point to a “single demographic curiosity driving the disparity” (Vastag, 2003, p. 1838). Black women under 50 years of age who are diagnosed with breast cancer have more aggressive, hard-to-treat tumors. The statistic is even more alarming when considering that breast cancer survival rates are nearly the same for Black women and White women aged 65 and older (Vastag, 2003).

While an exploration of the causes of health disparities is beyond the scope of this study, there are several implications for how health disparities impact the attitudes and beliefs of Black women toward breast cancer. First, the prevailing environment around breast cancer and the contradictory nature of messages women receive may lead to a sense of ambivalence among Black women regarding their potential risk for breast cancer. Because Black women may have different experiences and beliefs, they “do not see their reality mirrored in breast cancer communications” (Barg & Grier, 2008, p. 337). Second, cultural beliefs may preclude actions related to cancer screening, which may influence an individual’s desire to engage in breast cancer screening (Thomas, 2004). Third, while socioeconomic factors have been shown to have an impact on the stage at

which women are diagnosed with breast cancer and may explain some of the racial disparities in cancer mortality, socioeconomics may be only partly to blame. According to Thomas (2004), “few studies have investigated cancer and cancer screening beliefs and behaviors of Black women from a variety of socioeconomic levels” (p. 296). Finally, the manner in which societal influences shape an individual’s perceptions of health may play a key role in how Black women experience the concepts of disease and breast cancer through the media.

Social Construction of Breast Cancer

People draw upon information, experiences, and associations to help make sense of the world around them. Cultural representations (such as those found in advertising, promotional materials, and mass media) are a component of social reality that influences people’s fears, hopes, and concepts of self (Sulik, 2011). In the U.S., the understanding of breast cancer has been shaped by pink campaigns and their attendant imagery that is friendly, optimistic, and attractive (Sulik, 2011). By viewing health campaigns through a critical lens, one can understand how social forces like advocacy groups, nonprofit organizations, government agencies, corporations, and the media have come to shape the public discourse surrounding breast cancer (Kasper & Ferguson, 2000).

Health campaigns designed to encourage women to engage in breast cancer detection screenings not only raise awareness of the disease, but also act as a catalyst to influence behaviors of those targeted by these campaigns. These campaigns drove the rise in media attention toward breast cancer during the 1970s, creating a larger platform for advocacy groups to address women’s health issues (Kasper & Ferguson, 2000). By 1990, baby boomers were entering midlife, having been exposed to information about mammography screening by the American Cancer Society’s pervasive media campaigns

of the 1980s. It was at this time in the 1980s that popular magazines increased coverage of breast cancer, despite the fact that at the time lung cancer was the leading cause of cancer death. As a result of the prominence of these messages, breast cancer was framed as a women's health priority (Kasper & Ferguson, 2000).

Beginning in the 1970s and 1980s, these conditions led to the growth of a breast cancer culture fueled by advocacy groups and corporations, starting with the pink ribbon campaign that “helped shaped the meaning of the ribbon as a symbol of innocence and unquestionably good intention in order to elicit identification and support for their cause” (King, 2006, p. 43). The breast cancer movement was forged by a “cancer control establishment” (King, 2006, p. xviii) that consisted of groups like the American Cancer Society, the National Centers for Disease Control, and pharmaceutical and biotech companies. Since the advocacy movement was comprised of mostly affluent White individuals with access to insurance coverage and medical care, a large segment of the population effectively was disenfranchised from taking part in the medical advances and the broader conversation around breast cancer underway in the U.S.

The emergent social construction of breast cancer in the U.S. as a young, professional White woman's disease has had implications across the breast cancer spectrum—from risk to incidence, screening, diagnosis, treatment, survival, and mortality. When a significant portion of the population impacted by the disease is excluded from the breast cancer dialogue, the onus of inclusion rests on society as a whole. Health communicators have an opportunity to expand their role significantly by considering the potential diversity of the target audiences for such campaigns. The Institute of Medicine suggests three ways in which communicators can address this issue: (a) develop campaigns with “common-denominator messages” (Freimuth & Quinn,

2004, p. 2054) that are relevant to most audiences; (b) develop an overarching campaign with variable messaging that can be targeted to different audience segments; and (c) develop distinctly different messages for each audience segment (Freimuth & Quinn, 2004).

As previously noted, breast cancer has been cast as an illness that impacts White, middle and upper-middle class, heterosexual women, who are more likely to make health visits, to be insured, and to mirror the stereotypical image of the U.S. female population. However, breast cancer does not discriminate when it comes to race, social class, age, sexual orientation, or geography. Those involved in the breast cancer movement, and society as a whole, are faced with the challenge of presenting a more realistic picture of the actual characteristics of those with breast cancer. According to Kasper and Ferguson (2000), “it is not enough to have the faces of minority women on government reports and breast cancer brochures” (p. 364). In the current review of the media and organizations shaping the national dialogue on breast cancer, it is clear that the widely distributed imagery, messaging, and activity do “not reflect the illness experience of millions of diagnosed women who do not fit neatly into the pink breast cancer box” (Sulik, 2011, p. 12).

Health Communication and Cancer

The importance of health communication. It has been estimated that 50 to 65 % of American lives could be saved in a year from cancer death if current knowledge of more healthy lifestyles, screening guidance, and patient-centered communication were integrated into the healthcare experience (Hesse, 2009). The field of health communication encompasses “the study and use of communication strategies to inform and influence individual decisions that enhance health” (Centers for Disease Control,

2016). From social marketing awareness campaigns designed to communicate awareness of prevention and early detection, to health stories in the national news media that translate the complexities of cancer science, health communication plays a significant role in reducing the risks for cancer.

Health communication has been defined as “the study and use of methods to inform and influence individual and community decisions that enhance health” (Freimuth & Quinn, 2004, p. 2053). According to the National Cancer Institute, health communication can do the following:

[It can] increase the intended audience’s knowledge and awareness of a health issue, problem, or solution; influence perceptions, beliefs, and attitudes that may change social norms; prompt action; demonstrate or illustrate healthy skills; reinforce knowledge, attitudes, or behavior; show the benefit of behavior change; advocate a position on a health issue or policy; increase demand or support for health services; refute myths and misconceptions; and strengthen organizational relationship. (Freimuth & Quinn, 2004, p. 2053)

Health communication’s influence can be felt through various channels, such as television, the Internet, and magazines. It is delivered by multiple sources, such as media outlets, corporations, advocacy groups, and government organizations. Health messages are pervasive in today’s society and can range from self-help information to disease-specific education on prevention, diagnosis, or treatment, and to promotional messages from healthcare organizations.

Depictions of women and breast cancer in the media. Studies indicate that the general public relies on mass media as a primary source of health information and that media messages strongly contribute to a person’s overall health knowledge (Atkin, Smith, McFetters, & Fergusson, 2008). Active retrieval channels, such as newspapers, magazines, and the Internet, are the primary sources for health-focused individuals; passive channels, such as television and radio, are used by people who are less health

conscious (Atkin et al., 2008). In spite of the proliferation of health and illness content in the mass media since the early 1980s, researchers have found that “health-related content in popular media is not likely to facilitate understandings helpful to individuals coping with health challenges; at the same time, popular media is likely to perpetuate social and political power differentials with regard to health-related issues” (Kline, 2006, p. 44).

Mass media influence perceptions of health-related issues and individual behavior. Kline (2006) reviewed health and illness content in the media, including advertising, journalism, and entertainment from 1996 to 2006. In her work, she tested previous research findings that questioned whether the media accurately or appropriately represented health challenges. She found that “media representations are still suspect—fraught with inaccuracies, misleading and problematic themes, and images that stereotype and stigmatize” (Kline, 2006, p. 46). Because breast cancer prevention, diagnosis, and treatment are some of the most pervasive challenges facing society, messages to motivate women to increase prevention and detection efforts are prevalent in mass media. In a study to determine the most frequent sources of breast cancer messages, Smith, Nazione, Laplante, Kotowski, and Atkin (2009) found that the media were the primary source. Table 2 depicts findings by Smith et al. (2009) revealing that of the memorable breast cancer messages recalled by study participants, 36% were from the media, 23% from friends, 21% from family members, and 15% from healthcare professionals.

Table 2

Memorable Breast Cancer Messages by Source

Media Source	Percentage of Mentions
Media	36
Friends	23
Family Members	21

Healthcare Professionals	15
Other	6

(Smith et al., 2009)

Table 2 (continued)

This study underscores the wide influence the media have in delivering breast cancer messaging to women. In an analysis of news coverage in local and national newspapers, television, and magazines, Slater et al. (2008) examined cancer coverage and found that breast cancer was the most mentioned cancer for U.S. newspapers, magazines, and TV newscasts. Table 3 shows that in newspapers, treatment was the most frequent topic covered, followed by causes and death, with prevention and detection the least frequently covered. Treatment was the second most mentioned topic in television and magazines, with detection/diagnosis most mentioned by magazines and death most mentioned by television (Slater et al., 2008). The researchers concluded that “the greater emphasis put on treatment and lesser emphasis on detection, screening, and prevention suggest a public conceptualization of cancer as something to be addressed after it occurs, not before” (Slater et al., 2008, p. 535).

Table 3

Cancer Topic Coverage Frequencies by Media (first three mentions)

Newspaper Topic %		Magazine Topic %		Television Topic %	
Treatment	17.4	Diagnosis	26.3	Death	29.5
Causes	16.8	Treatment	24.6	Treatment	20.5
Death	15.4	Causes	17.5	Prevention	12.8

(Slater et al., 2008)

Atkin et al. (2008) similarly found that only one-third of leading media outlets addressed prevention and risk reduction, and these articles focused primarily on the use of pharmaceuticals such as hormone replacement therapy. Treatment was the most mentioned topic, followed by detection and prevalence. The majority of the stories

featured personal narratives as opposed to statistical figures, and two-thirds cited experts such as medical professionals and researchers. Atkin et al. (2008) concluded that the lack of coverage on prevention and risk reduction may limit opportunities for audiences to learn about other lifestyle practices that reduce risk.

Andsager and Powers (2001) examined how women's magazines framed breast cancer. Framing refers to what stories are covered and how they are presented and is important to understand as it influences public understanding of an issue (Andsager & Powers, 2001). The authors found that articles generally focused on coping and its effects, personal experiences, and risk factors, and they noted that the articles did not reflect the interests of all women. Only one article discussed the fact that Black women are more likely than White women to develop breast cancer and die from it. A review of four women's magazines over a 7-year period revealed the accompanying illustrations only depicted one woman of color. This omission represents "a gap between readers and Black women's experience, which may reduce the ability of Black readers to make sense of the increased risk they face" (Andsager & Powers, 2001, p. 181).

A study of 1,100 magazines over a 6-year period found that magazines focused on certain types of breast cancer information (Walsh-Childers, Edwards, & Grobmyer, 2011). This focus might not cover topics medical professionals deem to be most relevant, however, such as breast cancer risk increasing with age or the importance of mammography for women over 40. Of four key factors identified by medical experts, risk factors and screening appeared in 5% of articles (Walsh-Childers et al., 2011). The authors also found a low rate of accuracy in the information included about mammograms and clinical breast exams (Walsh-Childers et al., 2011).

Petersen, Soucar, Sherman-Slate, and Luna (2004) studied popular press articles that targeted Blacks compared to those that targeted Whites to understand how the media contribute to health disparity. The researchers looked at cancer articles to determine whether Black-targeted articles used more fear and fewer hopeful messages than articles targeting White women, and whether mainstream publications encouraged readers to actively engage in early detection and treatment more often than Black magazines encouraged its readers to do so. Critical discourse analysis revealed key themes that highlighted differences between mainstream and Black print publications. Table 4 illustrates these thematic differences.

Table 4

Thematic Differences Between Black and Mainstream Publications

Black Publications	Mainstream Publications
Threat/fear laden	Reassurances
Dire urgency in the language	Reassurances in the language
Emotional appeals	Rational appeals
Hope comes through faith and persuasion	Optimism comes from solid facts based on understanding
Dying with cancer	Living with cancer
Cancer must be fought	Challenge rather than fight
No quality of life images or information	Quality of life is possible and here is what some are doing

(Petersen et al., 2004, p. 212)

A review of breast cancer articles in popular women’s magazines from 1913 to 1996 revealed the theme of personal responsibility as related to breast cancer. “By focusing responsibility on women, media messages effectively shift our focus away from larger social, environmental, political, and economic issues surrounding breast cancer and, instead, blame individual women for their illness” (Fosket, Karran, & LaFia, 2000, p. 304). Placing the onus of breast cancer on women further adds to their role as family

caregivers, and in many instances, as individuals who work outside the home. The model of womanhood in magazines examined in a study by Fosket et al. (2000) repeatedly painted a picture of women as being “White, middle class, heterosexual, slender, young, and happy” (p. 305). In representations of breast cancer in the magazines reviewed, the researchers found the following:

Two profoundly significant absences in the magazine articles are race and social class.The absence of discussions of race and social class is particularly striking because it is well known in the United States that while white women of high socioeconomic status are statistically more likely to get breast cancer, Black women and poor women are more likely to die from it. (p. 319)

In this way, breast cancer is depicted as relevant for White women while excluding issues of access to care, discrimination, and inequality (Fosket et al., 2000). Petersen et al. (2004) found that, overall, themes of fear and anxiety dominated Black-oriented articles, contrasted with themes of empowerment from the articles targeting White women. The Black-targeted articles “were fervent in their conviction that cancer is another battle that must be won in a more large-scale war against poverty, racism, and drugs” (Petersen et al., 2004, p. 220).

Nowhere is messaging to women on health more prevalent than in women’s magazines. In addition to promoting social messages, popular women’s magazines serve as an influential vehicle to communicate society’s ideal representation of what it means to be a woman. Depictions of breast cancer consist not only of medical information, but also act “as sources of cultural messages and ideologies about women, their bodies, and disease and illness” (Fosket et al., 2000, p. 303). Even magazines exclusively targeted to Black women lack a robust discussion of the relevance of breast cancer to Black women (Ryan, 2004). Researcher Cynthia Ryan (2004) studied three popular Black women’s magazines to examine how issues relevant to Black women “influence the representation

of breast cancer by and for members of this community, how the disease is ‘represented and lived through’ a particular cultural lens” (Ryan, 2004, p. 131). Ryan’s (2004) study focused on editions of *Ebony*, *Essence*, and *Black Elegance* published between 1990 and 1999, a period when breast cancer was a prominent issue discussed in the media. She found that the number of articles was minimal in all three of these publications in comparison to popular White women’s magazines published during the same period. She concluded that “the myth of breast cancer as a white woman’s disease may have influenced editorial decisions to preclude extensive coverage of the disease” (Ryan, 2004, p. 135).

Two recent stories—one national and one local—illustrate the media’s continued bias toward portraying breast cancer as a young White woman’s disease. The stories of well-known women with breast cancer frequently appear in the media. Angelina Jolie received the attention of the national media when in 2013 she announced in a *New York Times* op-ed piece that she had both of her breasts removed to prevent cancer because she had a specific BRCA1 mutation that results in a high risk of cancer (Martin, 2013). Several other White celebrities, including Christina Applegate, Suzanne Sommers, Cynthia Nixon, Giuliana Rancic, and Sharon Osbourne, have also gone public with their breast cancer experiences. According to Laurie Kirstein, a breast surgical oncologist at Rutgers Cancer Center of New Jersey, “one misconception unintentionally perpetrated by celebrities is that the BRCA gene, known as the ‘breast cancer gene’ is common” when in fact, only five to 10 percent of breast cancer is a result of the gene” (Martin, 2013). It is also striking to note that while the majority of these high profile stories feature White women, the fact remains that more Black women die of breast cancer than White women do.

In a local story out of Kentucky, the *Louisville Courier-Journal* followed a White, 38-year-old, breast cancer victim, Jill Conley, for 2 1/2 years and featured more than a dozen articles (Ungar, 2016). While Conley's story is courageous and her transparency regarding her journey will undoubtedly help other women who may be going through the same experience, breast cancer incidence and mortality rates in Kentucky are higher in Black women than in White women. From 2008 to 2012, the Kentucky breast cancer incidence rate in White women was 121.6 (cases per 100,000 women) versus 133.2 in Black women. The breast cancer mortality rate in Kentucky in White women was 22.1 versus 33.7 in Black women (American Cancer Society, 2015b, p. 3). In both the Jolie and the Kentucky cases, the media contributed to the stereotype of the breast cancer victim as a young, White, affluent woman.

Public breast cancer awareness campaigns. While the media serve as an influential conduit for delivering health messages, health promotion campaigns in the U.S. created for the purpose of social marketing generate awareness of health issues from a population health standpoint. Historically, health campaigns were planned and implemented by voluntary associations, the mass media, and the federal government (Paisley, 2001). In recent years, additional stakeholders have entered the fray, including foundations, trade unions, and corporations (Paisley, 2001). These campaigns focus on a group's efforts to change another group's beliefs or behavior. Campaigns include a variety of tactics such as brochures, posters, advertisements, commercials, billboards, mascots, issue icons, and messages that appear in conventional, as well as unusual, places (Paisley, 2001). Campaigns may also involve special events, public relations, media sponsorships, Internet elements, and social media messaging.

This discussion will focus on significant social marketing campaigns undertaken by U.S. advocacy groups, nonprofit/public health service/government organizations, and corporations. It will also include organizations specifically targeted to Black women, in order to illustrate how they shine a light on breast cancer. The discussion explores five key elements of each campaign as they relate to its impact on educating and influencing Black women around breast cancer detection, including: (a) target/s, (b) objectives, (c) activities, (d) messages, and (e) impact (see Table 5). There is also an examination of Black women's organizations to determine if and how breast cancer messaging is addressed.

Advocacy groups. The breast cancer movement can trace its origins to women's advocacy groups via women's self-help groups in the 1970s. In 1971, the book *Our Bodies, Our Selves* (OBOS) gave women evidence-based information on a spectrum of women's health issues. This book is credited with inspiring women affected by breast cancer to take action (Porroche-Escudero, 2014). OBOS "embodied the second-wave feminist principle that 'the personal is political,' which became a cornerstone of the breast cancer movement and began to shape the way in which empowerment would be envisioned and awareness campaigns would be formulated" (Porroche-Escudero, 2014, p. 80). This straightforward approach to providing women with accurate and clear medical information allowed women to begin to take control of their own health and laid the path for an era of social change in women's healthcare.

The primary goals of most breast cancer advocacy groups are to raise awareness and solicit funds to support breast cancer research and education. The types of health advocacy these groups focus on include encouraging women to have mammograms, educating them about treatment, and providing a support network (Moffett, 2003).

Despite years of efforts to raise awareness, “the breast cancer movement is still limited in its effectiveness in serving and advocating for a wide range of women...Most breast cancer organizations have goals and approaches that benefit a largely white and middle-class population” (Moffett, 2003, p. 288). Researcher Patricia Kaufert (1999) noted the following:

The middle-class women of the breast cancer movement tended toward reform rather than revolution. These women wanted access to information, a more supportive care system, and acknowledgement of their psychosocial needs. Above all else, they wanted a cure and they expected this would come through medical research. These are very middle-class goals, displaying middle-class faith in the power of scientific knowledge, an assumption that should a cure be found it would be available to them, and the luxury of taking access for granted and focusing on a more "user-friendly" model of care. (p. 303)

The breast cancer movement appeared to be out of touch with the unique needs of women who were not insured, White, or middle class, those women who had a drastically shorter survival time after being diagnosed with breast cancer (Kaufert, 1999).

As breast cancer advocacy emerged in the late 1990s, activists portrayed breast cancer as a disease that primarily touched women who were “white, straight, middle and upper class, urban, educated, professional, and conservative” (Cartwright, 1998, p. 123). This representation omitted the lifestyles and concerns of women who did not meet this conceived notion of breast cancer victim and “marginalized women who are poor or working class and/or less well educated (and who are less likely to have access to information and treatment)” (Cartwright, 1998, p. 123). This omission of a large group of women from the conversation about breast cancer no doubt contributed to the current state of health disparity suffered by Black women and other ethnic minorities.

Breast Cancer Action (BCA) is an activist watchdog organization focused on systemic interventions that look at the root causes of disease. The organization is critical

of pink ribbon awareness campaigns because they do not address systemic issues of breast cancer (Breast Cancer Action, 2015). While the organization targets government agencies and private organizations, its activities are widely publicized and are open to the public. BCA works to achieve its objective of health justice for all women at risk for or living with breast cancer through educational forums, webinars, national media coverage, and meetings with corporations and government agencies and community leaders. BCA launched the “Stop the Distraction” campaign in 2014 to highlight ways the pink ribbon culture distracts from meaningful progress on breast cancer. Its “Think Before You Pink®” campaign gained national media attention in 2012 when it called for transparency and accountability from companies that participated in breast cancer fundraising. The organization’s messaging is critical of corporations that “make billions of dollars off of breast cancer yet there has not been enough progress in treatment, prevention, survival, and inequities” (Think Before You Pink, 2015). While this organization focuses on issues such as research, funding, access to care, and other areas that can have an impact on health disparities, it does not directly address specific minority groups in its outreach efforts. As such, the impact to Black women appears to be minimal, although the organization does acknowledge that Black women are more likely to die from breast cancer than White women are.

The Susan G. Komen Foundation is one of the most well-known advocacy groups. Founded in 1982 by Nancy Brinker, whose sister Susan G. Komen died of breast cancer at the age of 36, the foundation targets breast cancer survivors and those who are impacted by breast cancer. The organization endeavors “to save lives and end breast cancer forever by empowering others, ensuring quality care for all and energizing science to find the cures” (Susan G. Komen, 2015). The foundation is most known for the Susan

G. Komen Race for the Cure®, a 5K fundraising event started in 1983 that now boasts more than 150 races with 1 million participants across four continents. In addition to other fundraising activities, Komen provides grants for research and government advocacy. The organization's communications focus on the idea of it being an empowering movement that is working to end cancer. Messaging is targeted to Black women through a comprehensive tool kit for communities on ways to educate Black women. Black women and their stories are prominent in their media, advertising, and outreach efforts aimed to directly impact Black women.

The National Breast Cancer Coalition (NBCC), founded in 1991, is a collaborative effort of activists, survivors, researchers, policy makers, grassroots groups, and national organizations. NBCC aims to end breast cancer through action and advocacy by fundraising to augment federal research funding and provide seed grants for breast cancer research projects (National Breast Cancer Coalition, 2015). Its blueprint for Breast Cancer Deadline 2020® focuses on primary prevention and deterring the spread of cancer. In a review of the organization's online presence, there do not appear to be communications targeted to Black women, thus the impact to this audience is limited.

Nonprofit and government organizations. Both nonprofit and government agencies in the health arena focus on research, education, and advocacy. The American Society for the Control of Cancer (ASCC), the precursor to the American Cancer Society, began running breast cancer campaigns in the 1930s (American Cancer Society, 2015k). Positioning breast cancer as a domestic war, the ASCC created the Women's Field Army (WFA), a voluntary organization that shared women's messages about breast cancer with other women through meetings and communication materials such as flyers and brochures. In the 1950s, the American Cancer Society (ACS) disbanded the WFA, but

the American Cancer Society is still in the business of disseminating information to the public about cancer.

The American Cancer Society (ACS) is a national, nonprofit, community-based, voluntary health organization dedicated to eliminating cancer through research, education, advocacy, and service (American Cancer Society, 2015k). A national series of walking events raises funds and increases awareness of breast cancer. The first Making Strides Against Breast Cancer®, a network of national breast cancer awareness walking events, was organized by cancer survivor Margery Gould Rath in 1984. Today, the event is held in more than 270 communities across the country and raises more than \$460 million to fight breast cancer (American Cancer Society, 2015j). The ACS also funds 90 evidence-based interventions at the community level, such as educational outreach, screening resources, and follow-up care, to address breast cancer screening disparities. In terms of applied research, the ACS assesses the specific needs of Black breast cancer survivors through focus groups and surveys toward better educating survivors (American Cancer Society, 2015k). Additionally, research is conducted on treatment delays and the types of treatment received by Black women, in order to improve breast cancer outcomes. The potential impact to Black women is high due to the ACS' outreach efforts tailored to the community to educate and influence detection, treatment, and outcome behaviors (American Cancer Society, 2013).

The Centers for Disease Control and Prevention (CDC) is a major operating component of the U.S. Department of Health and Human Services, and it is recognized as the nation's premiere health promotion, prevention, and preparedness agency. The CDC has three targeted breast cancer campaigns designed to reach young women, Black women, and women with disabilities (Centers for Disease Control, 2015c). The Bring

Your Brave® campaign was launched in 2015, targets women 18 to 44 with a family history and background that predispose them to a higher risk for breast cancer, and produces targeted materials for ethnic groups (Centers for Disease Control, 2015b). The Right to Know® campaign targets women with disabilities and features educational materials that can be customized for Black women for use by community organizations (Centers for Disease Control, 2015d). Due to its many targeted health campaigns, the CDC's impact on Black women in terms of education and influence is high.

The African American Women and Mass Media (AAMM) campaign ran as a pilot program in Savannah and Macon, Georgia, from August 2008 through July 2009 (Centers for Disease Control, 2015a). The campaign included rotating public service announcements on radio and also live radio shows featuring breast cancer survival testimonial on R&B and gospel radio stations. Live radio interviews were conducted monthly with healthcare providers and community breast cancer survivors. Print materials were distributed in Savannah at Black venues and popular community events. The campaign call-to-action asked women to call a 1-800 cancer line to get information about a breast cancer screening program and referral to the local health department. Campaign findings indicated that the campaign reached the intended target audience of Black women age 40 to 54, and that Black radio is an effective way to reach Blacks with important health messages. During this period, calls to the 1-800 cancer line increased by 27% in Savannah and 42% in Macon (Hall, Rim, Johnson-Turbes, Vanderpool, & Kamalu, 2012).

Corporations. Social marketing for a cause is a way for corporations and brands to implement corporate social responsibility campaigns to support a particular cause. As it relates to breast cancer, these campaigns focus on increasing awareness of the

importance of diagnosing breast cancer in the earliest stages. Cause-related marketing typically involves a partnership between nonprofit and for-profit organizations to promote a product or service to the benefit of a cause by increasing awareness and financial contributions through sales, then donating a portion of profits to the nonprofit organization. Because the business goal for cause-related marketing is to increase profits, corporations look for partners that appeal to the company's customer base (Harvey & Strahilevitz, 2009).

Evelyn Lauder can be credited with launching the pink culture of breast cancer awareness (Associated Press, Fox News, 2011). Soon after the Susan G. Komen Foundation launched the inaugural Race for the Cure® in 1990, Estée Lauder, a women's cosmetics company, joined the effort in 1991 by launching a national pink ribbon campaign by distributing pink ribbons at cosmetic counters throughout New York City. Estée Lauder's Breast Cancer Awareness campaign, first launched in 1992, is focused on defeating breast cancer through education and medical research (Estée Lauder, 2015c). The current campaign, "Every Action Counts," is a global digital experience that encourages people to upload a video, photo, message, or social media post depicting how they take action. For each action, the company will donate up to \$25,000 for research (Estée Lauder, 2015a). The campaign message carries through the theme of "We're Stronger Together" and features the company's breast cancer awareness global ambassador Elizabeth Hurley, a White British actress. Pink ribbon products are also sold to support 16 Estée Lauder Breast Cancer Research Foundation projects (Estée Lauder, 2015b). It can be argued that the impact is somewhat limited due to the lack of representation of Black women in the campaign as well as products with prices that may be cost-prohibitive for all Black women.

AstraZeneca is a global biopharmaceutical company that develops prescription medications for the treatment of cardiovascular, metabolic, respiratory, inflammatory, autoimmune, oncologic, infectious, and neuroscience diseases. The company's foundation was created in 1983 and focuses funding efforts on cardiovascular health and breast cancer (Astra Zeneca, 2015a). National Breast Cancer Awareness Month (NBCAM), held every October, is a corporate social responsibility campaign created in 1985 by a partnership between the AstraZeneca Pharmaceutical Healthcare Foundation and the American Cancer Society. The awareness campaign, recognized by the American government in the early 1990s, is designed to promote public awareness, public education, knowledge sharing, and greater access to breast cancer services (AstraZeneca, 2015b). Activities related to NBCAM are fractured due to the hundreds of organizations that participate through the month of October. A review of numerous websites, advertisements, and promotional materials, indicates that messaging appears to be inconsistent and no strong themes emerge targeting Black women.

NBCAM's goal is to encourage regular breast examinations to diagnose breast cancer at an early stage. Researchers Jacobsen and Jacobsen (2011) evaluated whether the campaign's promotion of breast cancer screening in October was effective at increasing the number of diagnoses of breast cancer in November (considering the 1-month lag time between screening and diagnosis) by examining monthly diagnosis patterns across time (Jacobsen & Jacobsen, 2011). The researchers found that NBCAM was initially successful at increasing diagnoses of breast cancer in the following month. More recently, however, the increase in routine screening has decreased the overall impact of this promotional campaign (Jacobsen & Jacobsen, 2011). The authors suggested the following:

Well established health campaigns may be most effective if they direct their efforts at outcomes other than increased diagnoses, such as increased fundraising or enabling patient support groups, once there is evidence of widespread general awareness of the disease and adherence to recommendations for use of routine screening tests if they are available. (Jacobsen & Jacobsen, 2011, p. 60)

The impact of NBCAM on Black women is unclear, and additional research would need to be conducted with this population to determine the impact.

Avon, a beauty products company, was founded in 1886 by David H. McConnell when he recruited women as sales representatives to sell products door-to-door (Avon, 2015b). Today, the company sells products worldwide, including color cosmetics, skincare, fragrance, fashion, and home-related items through six million independent sales agents. The Avon Foundation was formed in 1955 to promote and aid charitable, scientific, educational, and humanitarian endeavors that improve the lives of women and their families (Avon, 2015d). The Foundation's current mission is to eradicate breast cancer and end domestic violence. The Avon Breast Cancer Crusade® was launched in 1992 and funds research at leading cancer centers as well as healthcare services at community breast health programs. The AVON39 Walk to End Breast Cancer® is the company's largest fundraising effort and takes place in eight cities annually from April to October. In addition to the AVON39, the Walk Around the World for Breast Cancer® program raises money and builds awareness of breast cancer in 50 countries around the world. A portion of Avon "Pink Ribbon" product sales also funds research (Avon, 2015a).

In 2014, the Avon Foundation published a national study in partnership with the Sinai Urban Health Institute. The 2014 Racial Disparity in Breast Cancer Mortality Study found a Black-White disparity in breast cancer mortality in 39 of the most populous U.S. cities (Avon, 2015c). The Avon Foundation website

(www.allforthebreast.avonfoundation.com) provides information on breast health and features articles on racial disparities in breast health as well as stories from breast cancer survivors. Avon's global ambassador is Fergie, a White, multiplatinum singer, songwriter, fashion designer, actress, and creator of five Avon fragrances. In examining the company's online presence, catalogs, and magazine advertising, Avon gets high marks for featuring Black women in some advertising, but the impact on education is moderate.

Every October during National Breast Cancer Awareness Month, the National Football League (NFL) supports breast cancer with the Crucial Catch: Annual Screening Saves Lives® campaign (National Football League [NFL], 2015c). The campaign was launched in 2009 by Tanya Snyder, whose husband, Daniel Snyder, bought the Washington Redskins in 1999 (NFL, 2015e). She collaborated with the Zeta Tau Alpha sorority from northern Virginia that first year, and the campaign was adopted by the league, becoming partners with the American Cancer Society. In addition to featuring coaches and referees who wear pink on the field, sales of “pink” products support the American Cancer Society's Community Health Advocates Implementing Nationwide Grants for Empowerment (CHANGE) program that provides outreach and breast cancer screenings to women in underserved communities (NFL, 2015b). Think Before You Pink® has been highly critical of the effort, saying “the NFL has no business providing medical advice to women” (NFL, 2015d). Additionally, if NFL pink products are purchased from a retailer, none of the funds are donated other than the NFL's royalty percentage. All of the proceeds from products purchased directly from the NFL are donated, which amounts to over \$8 million since the inception of the program (NFL, 2015a). Sunday Night Football's female viewership is led by women aged 18 to 49.

Women make up 45% of the NFL's more than 150 million American viewers and are a highly sought after demographic by the league's advertisers (NFL, 2015f). The NFL's breast cancer campaign has the opportunity to reach a large segment of the population with its awareness message. However, it remains to be seen if the corporate social responsibility campaign will have a positive impact on the NFL in light of recent controversies (NFL, 2015f). The impact on educating and influencing Black women as a result of this campaign is, therefore, at best moderate.

Black women's organizations. According to its website (www.bwhi.com), "the Black Women's Health Imperative (BWHI) is the only national organization dedicated to improving the health and wellness of our nation's 21 million Black women and girls—physically emotionally, and financially" (Black Women's Health Imperative, 2015b). Founded by healthcare activist Byllye Avery in 1983, the BWHI focuses on advocacy, education, and training, serving as a voice for social change, mobilizing women and organizations, promoting evidence-based lifestyle changes, and disseminating information on Black women's health research (Black Women's Health Imperative, 2015b). Moving Beyond Pink to End Breast Cancer Disparities® is a national campaign designed to mobilize resources and address breast cancer disparities. Its theme ("Detect. Diagnose. Decide.") focuses on making sure Black women benefit from advances made in early detection and treatment. The BWHI is a campaign that does the following:

[It] challenges the status quo, raises hard questions about treatment and care, and places the health needs of younger Black women who experience breast cancer in more deadly forms at the center of our call for a commitment to make breast cancer disparities a priority now. (Black Women's Health Imperative, 2015a)

Through advocacy, policy, and national and community-based initiatives, the BWHI educates women on early detection and timely diagnosis by promoting routine

breast self-exams, clinical breast exams, and mammograms. The organization advocates for screening guidelines that are responsive to the health needs of Black women and pushes for increased access to the most up-to-date screening and diagnostic tools as well as treatment services. Additionally, BWHI supports policies that call for early education and screening among younger women (Black Women's Health Imperative, 2015a). This is a high impact organization when it comes to educating and influencing Black women.

Sisters Network is the nation's only Black breast cancer survivorship organization that addresses the needs of Black women by increasing local and national attention to the impact of breast cancer on the Black community (Sisters Network, 2015b). The organization was founded in 1994 by Karen Eubanks Jackson, a breast cancer survivor who turned her challenge into an organization that now provides educational programs, support, and empowerment. In 2010, the Sisters Network "Stop the Silence Walk®" was launched in Houston with a portion of the proceeds going to the Breast Cancer Assistance Program offering assistance to cancer survivors currently in treatment and who face financial challenges. Sisters Network's Teens 4 Pink® is a program to educate young girls ages 12 to 16 about the importance of breast health. The Young Sisters Initiative focuses on Black female survivors under age 45. The Gift for Life Block Walk® allows breast cancer survivors to partner with volunteers and canvass door-to-door in Black communities to distribute breast health education and resource materials. The Pink Ribbon Awareness Initiative® is a national faith-based education outreach program that reaches women in church to encourage mammograms and increase knowledge of breast cancer (Sisters Network, 2015a). This is another high impact organization that provides education and influence for Black women.

Table 5 is a breast cancer campaign analysis. It includes the organizational type, sponsorship organization, campaign title, campaign or organization start date, target audience, African-American targeting, objectives, activities, messages, and impact of the organizations discussed in the preceding section of this chapter.

Table 5

Breast Cancer Campaign Analysis

Organization Type	Sponsoring Organization	Campaign Title	Organization/ Campaign Start Date	Target Audiences	African American Targeting	Objectives	Activities	Messages	Impact		
Advocacy	Breast Cancer Action	Stop the Distraction (2014) Think Before You Pink (2002)	1990	Government agencies and private organizations	No specific campaign messages other than to call out that Black women are 40% more likely to die from breast cancer than White women.	To achieve health justice for all women at risk of and living with breast cancer.	Educational forums and webinars, national media attention, meetings with corporations and government agencies and community leaders	Corporations make billions of dollars off of breast cancer yet there has not been enough progress in treatment, prevention, survival, and inequities.	Low		
Advocacy	Susan G Komen	Susan G. Komen Race for the Cure® (1995)	1982	Breast cancer survivors and those who love them	Targeted messaging and attention to disparities and African American women; comprehensive tool kit to educate African American women.	To save lives and end breast cancer forever by empowering others, ensuring quality care for all and investing in science to find the cures.	Fundraising, grants, research funding, community activities, advocacy.		High		
Advocacy	National Breast Cancer Coalition	Breast Cancer Deadline 2020*	1981	Public officials, the philanthropic community, breast cancer advocates, the general public.	None noted	To end cancer through the power of action and advocacy.	Fundraising, research seed grants.	Blueprint for breast cancer deadline 2020* focus is on primary prevention and preventing the spread of cancer.	Low		
Non-profit/ government	American Cancer Society	Making Strides Against Breast Cancer	1984	General public	Research is targeted to African Americans	To eliminate cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.	Nationwide series of walking events to raise funds and awareness		High		
Non-profit/ government	Centers for Disease Control	Bring your Brave Campaign (2015)	Founded as the Communicable Disease Center in Atlanta in 1946.	Women under age 45	None noted	To protect American from health, safety and security threats by detecting and responding to health threats and promoting healthy and safe behaviors.	Campaign targeting women 18 to 44 with a family history and background that predisposes them to a higher risk	Campaign that tells real stories about young women whose lives have been affected by breast cancer	High		
		African American Women and Mass Media Campaigns (2008 - 2009)		African American women age 40 to 64	AAMM campaign					Campaign pilot in Georgia targeting African American women using radio and print media	Encourages African American women to get mammograms to find breast cancer early
		The Right to Know Campaign		Women with disabilities	None noted					Campaign materials include brochures, flyers, fact sheets, and other educational materials	Encourages women with disabilities to make screening a part of their regular health care
Corporate	Estee Lauder	Every action counts	1992	General public	None noted	To defeat breast cancer through education and medical research.	Global digital experience: encourage people to upload video, photo, message or social media post on how they take action; Estee Lauder to donate for each action submitted up to \$25,000.	"Let's defeat breast cancer. We're stronger together" platform.	Low		
Corp	Partnership between AstraZeneca and American Cancer Society	National Breast Cancer Awareness Month	1985	General public	None noted	To focus attention on screening mammography	October designated as National Breast Cancer Awareness Month	Messages are fractured and inconsistent across the many organizations that participate; primary messages appear to be on mammography.	Low		
Corporate	Avon	The Avon Breast Cancer Crusade	1992	General public	2014 breast cancer conference on Black-White disparities in breast cancer	To lead efforts to eradicate breast cancer.	The Walk to End Breast Cancer; grant funding; conferences; public education; partnerships		Medium		
Corporate	NFL	Crucial Catch Campaign	2009	General public	None noted	To remind women about the importance of getting a mammogram to find breast cancer early.	Awareness by featuring pink apparel worn at NFL games.	A crucial catch: Annual screening saves lives	Medium		
African American Women's Organization	Black Women's Health Imperative	Moving Beyond Pink to End Breast Cancer Disparities	1983	African American women	African American women focus	To advance health equity and social justice for Black women across the lifespan, through policy, advocacy, education, research, and leadership.	Campaign designed to advocate for early detection, ensure access, convene national and community breast cancer education and research sessions, serve as a clearinghouse for Black women; advocate for policies and legislation.	Detect. Diagnose. Decide.	High		
African American Women's Organization	Sisters Network	Stop the Silence Walk (2010)	1994	African American women who are survivors of breast cancer	African American women focus	To address the needs particular to African American women by increasing local and national attention on the devastating impact that breast cancer has in the African American community.	Stop the Silence Walk: Organization provides standardized educational programs, support, empowerment and hope.		High		

Gaps in the Literature

Breast cancer mortality, particularly in young Black women, remains higher than in White women because this population presents with more advanced stages of the disease (Thomas, 2004). According to Thomas (2004), these differences in mortality rates have been ascribed to several issues, including social class, biological characteristics (such as tumor grade and aggressiveness), later stage at diagnosis, inadequate access to medical care due to socioeconomic factors, and delays between the

time of diagnosis and treatment. This health disparity has been linked to socioeconomic status, but studies have shown that differences in cancer knowledge and beliefs persist even when educational and socioeconomic measures are statistically controlled (Consedine, Magai, & Neugut, 2004). In a study of 42 Black and 98 White women, Stein, Fox, Murata, and Morisky (1992) found that Blacks had less knowledge about breast cancer even when controlling for difference in education, sex, and age. Another study of 220 women from Donovan and Tucker (2000) showed a similar trend in that Blacks had significantly less knowledge of breast cancer than White women did, despite the absence of socioeconomic or educational differences between the groups. This suggested that “while cognitive variables are important to breast cancer screening behavior, they are only part of the picture, and we must look to alternative models for increased understanding” (Consedine et al., 2004, pp. 65-66).

Because disparities exist regardless of educational and socioeconomic factors, health communicators have an opportunity to evaluate additional elements that may impact knowledge of breast cancer differences among Black women. According to Kreuter and McClure (2004), there is increasing recognition that culture plays an important part in health communication and may enhance the development of more effective strategies to reduce health disparities. Kreuter and McClure (2004) underscored the need for further research, stating that “the evidence base of supporting (health communication’s potential) is currently undeveloped” (p. 450).

The literature offers relatively few new models for health campaigns, as suggested by Consedine et al. (2004). This study proposes to explore cultural dynamics and the role played by media representations of breast cancer from the perspectives of young, insured

Black women. The research seeks to develop a more effective and culturally nuanced framework for tailoring health communications to this at-risk population.

Theoretical Framework

A conceptual, or theoretical, framework provides a model for discovery and “explains either graphically or in narrative form, the main things to be studied—the key factors, concepts, or variables—and the presumed relationship among them” (Maxwell, 2005, p. 33). A framework helps tell “an enlightening story about some phenomenon, one that gives you insights and broadens your understanding of that phenomenon” (Maxwell, 2005, p. 42). A theoretical framework is grounded in theories that serve to provide a set of constructs and the relationships among them, thus functioning to create a model of why the world is the way it is (Maxwell, 2005).

This study examined the perspectives of young, insured Black women on breast cancer detection messaging constructed and promulgated by health campaigns. Research on breast cancer screening among ethnic minority women from lower socioeconomic groups is extensive, yet there are limited studies that investigate breast cancer screening among young Black women for whom socioeconomic and access barriers are not a concern. In order to explore the potentially complex dynamics involved in how young Black women come to construct meanings about breast cancer, this study required a theoretical framework that took into account elements of culture, individual risk perceptions, and self-efficacy. Given the greater breast cancer incidence and mortality in young Black women versus White women, this theoretical structure coupled cultural models theory with the RPA framework to address how health campaigns influence the behaviors and breast cancer detection experiences of Black women. Through the use of cultural models theory and a qualitative research design, the study attempted to identify a

cultural model of breast cancer held among young Black women. The RPA framework provided insight into the degree to which health campaigns influence this audience’s perceptions of their breast cancer risk as well as their feelings of efficacy in exhibiting self-protective behaviors (Figure 1).

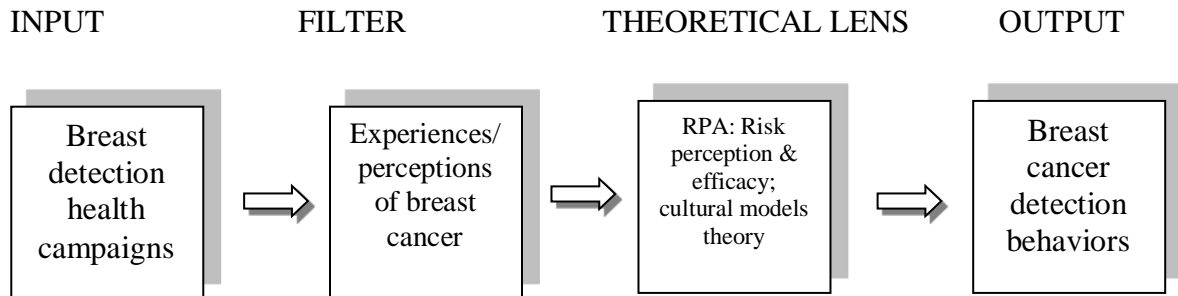


Figure 1. Theoretical framework.

The current study examined young, insured Black women’s perceptions of breast cancer in order to understand their relative congruence with health campaigns that shape prevailing popular discourses about breast cancer circulating in U.S. culture. Developing a cultural model can help researchers better understand potential disparities among prevention behaviors in response to health communications. Just as culture shapes health experiences, so too does an individual’s response to communication campaigns.

Risk perception attitude framework. According to Rimal, Flora, and Schooler (1999), stimulating information-seeking behaviors that remain in effect over the long-term is a primary outcome of public health campaigns. The RPA attempts to determine the likelihood of an individual’s attitude toward maximizing health and self-protective behaviors (Rimal & Real, 2003). The RPA framework posits that when risk perceptions are low, people rely on efficacy beliefs to determine an appropriate course of action. According to Turner, Rimal, Morrison, & Kim (2006), “feeling confident about one’s

ability to enact a particular behavior and believing that enacting the behavior will result in positive outcomes—characteristics of those with high efficacy beliefs—tend to motivate people to initiate challenging tasks, set realistic goals, persevere in the face of setbacks, and restructure their social environments to make them conducive to healthy behaviors” (p. 132).

In their study, Rimal and Real (2003) demonstrated how perceived risk and efficacy beliefs could be used to categorize individuals into different attitudinal groups. For a given health domain at a specific point in time, individuals can be aligned to one of the four attitudinal groups—responsive, avoidance, proactive, and indifference—in order to study how they are motivated, how they go about seeking information, and the degree to which they enact healthy behaviors. The primary application of their findings is that public health campaigns can use the RPA framework as an audience-targeting tool to increase the effectiveness of communications (Rimal & Real, 2003).

The current study examined how health campaigns inform young, insured Black women’s understandings of breast cancer and contribute to a shared cultural model. Using a qualitative approach, this research explored these beliefs through the lens of the RPA framework to understand how communication campaigns influence this audience’s perceptions of their risk for breast cancer and their feelings of efficacy in undertaking breast cancer detection behaviors.

Health behavior research has focused primarily on measures that individuals undertake to prevent disease. Perceptions of risk to a disease are thought to be reliable predictors of individuals’ propensity to take preventive action, as outlined in a number of theories of health behaviors such as protection motivation theory (Rogers, 1975), health belief model (Rosenstock, 1974), and extended parallel process model (Witte, 1994).

The belief that one is vulnerable to a disease, or perceived risk, has been shown to be a significant predictor of self-protective behavior (Rimal & Real, 2003). Whereas the extended parallel process model (EPPM) addresses the effects of threat and efficacy contained in a message, the RPA framework was developed to explain how the constructs of EPPM might be used to identify groups of people who could be targeted for health campaigns (Rimal & Real, 2003). The RPA framework conceptualizes perceived risk as a motivator for change. This motivation, however, needs to be coupled with the belief that something can be done to avert the threat, or that individuals feel they have the ability to change (Rimal, Bose, Brown, Mkandawire, & Folda, 2009).

According to the RPA framework, perceptions about the risk for a disease are usually not enough to motivate people to take preventive action; however, when high risk perceptions are coupled with strong efficacy beliefs, people are motivated and able to engage in self-protective behaviors (Rimal et al., 2009). When people do not believe they are at risk, they are not motivated to act. As such, whether they believe that they can take action does not impact their behavior. When people believe that they are at risk, they are motivated to act but can only do so if they believe they have the ability (Rimal & Real, 2003).

The RPA framework categorizes individuals into four attitudinal groups used to predict health information seeking and other behaviors: responsive (high risk, high efficacy), avoidance (high risk, low efficacy), proactive (low risk, high efficacy), and indifference (low risk, low efficacy). The framework posits that “when risk and efficacy are made salient, people’s risk perception guides most of their subsequent actions” (Rimal & Real, 2003, p. 370). The RPA is distinguished by its ability to segment individuals into groups, enabling the development of health campaign messages specific

to the needs of each target audience. Based on various levels of perceived risk and efficacy, the RPA categorizes individuals into one of four attitudinal groups, as seen in Table 6.

Table 6

Risk Perception Attitude Framework Constructs

Attitudinal Groups	Perceived Risk & Efficacy	Self-Protection Likelihood
Responsive	High risk/high efficacy	Likely to enact protective behaviors
Avoidance	High risk/low efficacy	Perceive inability to enact preventive behaviors; less motivated to engage in self-protective behaviors
Proactive	Low risk/low efficacy	Deny vulnerability to health threats; may be motivated to act due to need to avoid health issues
Indifference	Low risk/low efficacy	Least motivation to perform self-protective health behaviors

(Rimal & Real, 2003)

Responsive attitudes consist of high perceived risk with strong efficacy beliefs. These individuals are most likely to enact protective behaviors (Real, 2008). Avoidance attitudes also entail high perceived risk, but when combined with weak efficacy beliefs due to the perception that they cannot effectively enact preventive behaviors, these individuals should be less motivated to engage in self-protective behaviors (Real, 2008). Proactive attitudes are comprised of a low perception of risk in addition to strong efficacy beliefs. These individuals do not believe they are vulnerable to a particular health threat; however, they may still be motivated to adopt healthy behaviors because of their need to feel they are avoiding health threats (Rimal & Real, 2003). Indifference attitudes involve low risk perceptions and weak efficacy beliefs. These individuals exhibit the least motivation to perform self-protective health actions (Rimal & Real, 2003).

Individuals engage with information through several means, including that which they seek out specifically, that which is scanned as part of day-to-day routines, and that which they are exposed to by happenstance (Rimal & Juon, 2010). Information seeking behavior falls along a continuum of three positions of active engagement with information, as depicted in Figure 5. On one extreme are information-seeking behaviors, which, according to Niederdeppe et al. (2007), are “active efforts to obtain specific information outside of the normal patterns of exposure to mediated and interpersonal sources” (p. 155).

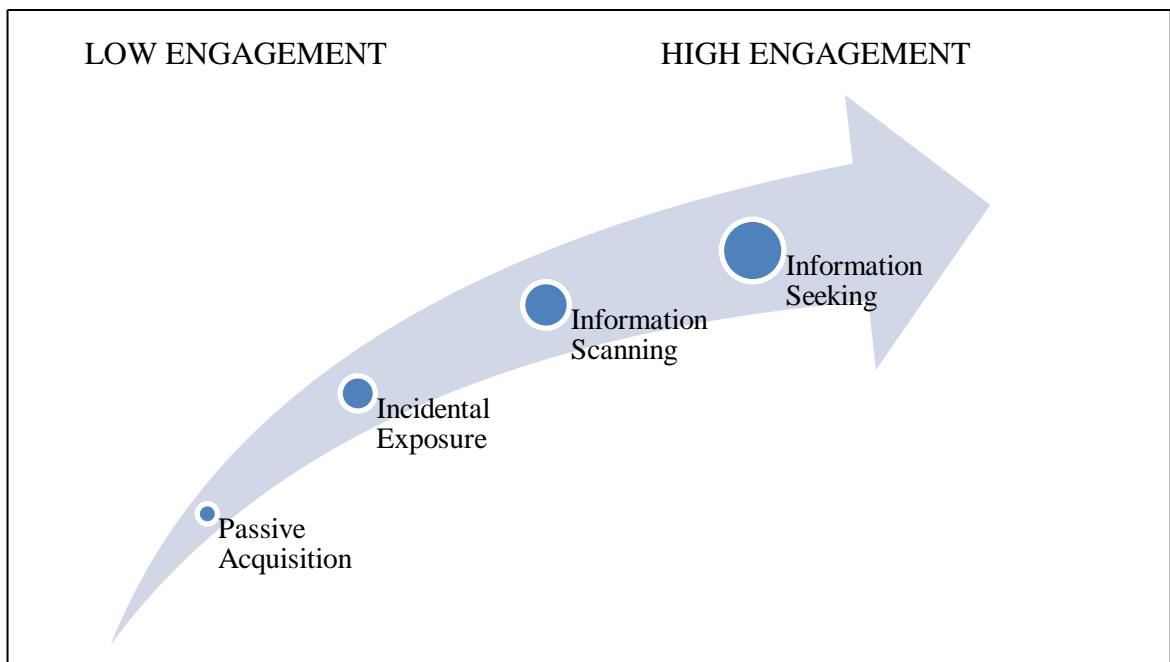


Figure 2. Information-seeking behavior levels of engagement.

Information scanning is defined as “information that is gathered incidentally from sources in the environment (that is thought to) occur as a person’s normal flow of information” (Shim, Kelly, & Hornik, 2006, p. 158). This tends to take place more frequently and across more sources than information seeking (Niederdeppe et al., 2007).

On the continuum of active engagement with information, scanning can be placed between information seeking and incidental exposure to information. The final behavior, called passive information acquisition (Berger, 2002), is used to denote the process by which individuals encounter information without having made an active effort to do so (Hornik, 2002) (Figure 2).

The RPA framework's effectiveness has been demonstrated in a variety of applications, including HIV/AIDS prevention (Rimal et al., 2009), skin cancer (Rimal & Real, 2003), diabetes-related information seeking (Turner et al., 2006), healthy eating (Sullivan, Beckjord, Rutten, & Hesse, 2008), workplace safety (Real, 2008), food safety (Kennedy, Worosz, Todd, & Lapinski, 2008), avoidance of texting and driving (Dillow, Walsh, Spellman, & Quirk, 2015), and breast cancer prevention (Lee, Hwang, Hawkins, & Pingree, 2008; Rimal & Juon, 2010). In the area of breast cancer detection, Rimal and Juon (2010) looked at Indian immigrant women, particularly older and recently immigrated women, who tend to have low rates of mammography utilization. According to Rimal and Juon (2010), "Little is known, however, about the perceptions, beliefs, and practices that make them vulnerable to breast cancer" (p. 287). In their study, the authors sought to understand the extent to which immigrant Indian women's engagement with breast cancer information and their breast cancer prevention behaviors were associated with their beliefs about personal efficacy and perceptions about personal vulnerability (Rimal & Juon, 2010).

Four key results arose from the Rimal and Juon (2010) study. First, relative immigration status was shown to play a role in breast cancer screening behaviors. Women who had recently immigrated were more likely to lack education, knowledge,

and efficacy. Second, perceptions of individual susceptibility to breast cancer were low across the board. The RPA framework indicates the following:

A combination of high risk perception and strong efficacy beliefs is likely to result in the most positive outcomes. The implication here is that health campaigns must target audiences according to their levels of perceived risk and efficacy beliefs and supplement what is lacking. (Rimal & Juon, 2010, p. 304)

Third, participants' knowledge about breast cancer screening guidelines was a consistent predictor, meaning that health campaigns should include efforts to promote knowledge. Rimal and Juon (2010) posited that "even though there is widespread acknowledgement in the larger health communication literature that our focus should be on promoting behavior change, improving knowledge can also have beneficial effects, especially if enhanced knowledge is accompanied by improvements in efficacy" (p. 304). Fourth, the research underscored the need to improve efficacy beliefs of the target audience (Rimal & Juon, 2010).

Studies have suggested that women who feel vulnerable to breast cancer are more likely to receive a mammogram (Aiken, Gerend, & Jackson, 2001; Katapodi, Lee, Facoione, & Dodd, 2004; McCaul, Branstetter, Schroeder, & Glasgow, 1996). Black women usually consider themselves to be at lower risk for developing breast cancer than do White women (Gerend & Pai, 2008). This can be seen even among Black women with a family history of breast cancer. Low risk perceptions may translate into low perceived need for a mammogram or delays in seeking treatment for a breast abnormality. One factor that may contribute to this relative perception of invulnerability is a cultural norm against discussing breast cancer that exists within the Black community (Gerend & Pai, 2008). This norm could inhibit communication among Black women,

thereby reducing the salience of marketing related to breast cancer screening, follow-up, and treatment (Gerend & Pai, 2008, p. 2917).

Culture and Factors Contributing to Health Disparities

Culture is a system of elements that function with a purpose for a social group and is not merely a collection of traits. Culture includes environment, economy, technology, religions/world views, language, social structures, family structure, individual and cultural beliefs, and values (Kagawa-Singer, Dadia, Yu, & Surbone, 2010). Culture “frames attitudes toward gender roles, concepts of health and suffering, meaning of body parts, and decisions about life, illness, death, religion, and world view” (Kagawa-Singer et al., 2010, p. 18).

Culture influences individuals’ perceptions of cancer risk, their trust in cancer professionals and institutions, and their approach to cancer treatments, (Kagawa-Singer et al., 2010). Many Blacks have a general mistrust of the healthcare system that is based on a history of experimentation and abuse endured over centuries in the U.S. A mistrust of the predominantly White healthcare system in the U.S. may impact decisions about seeking care, interactions with medical professionals, and satisfaction with healthcare (Gerend & Pai, 2008).

Cultural factors may also play a role in promoting racial disparities in breast cancer screening, diagnosis, treatment, and mortality. A group’s norms, beliefs, and attitudes about cancer can have an impact on their decisions about breast cancer (Gerend & Pai, 2008). According to Gerend and Pai (2008), social and cultural barriers “may serve as risk factors for the development of breast cancer tumors and may partially explain the poorly understood crossover in incidence rates observed for Black and White women (that is, the incidence of breast cancer is higher in Black women than White

women younger than 45 years, but this pattern reverses among women older than 45 years)” (Gerend & Pai, 2008, p. 2918). Understanding how these barriers impact the behaviors of young Black women may enable health communicators to create more culturally relevant health campaigns that educate and inform this population about breast cancer detection measures.

A combination of socioeconomic factors and cultural beliefs and practices may account for the notably advanced stages of breast cancer identified in Black women. Cultural factors that influence stage at diagnosis include “perceived risk for cancer, breast cancer knowledge, healthcare utilization patterns, folk beliefs, religious beliefs, beliefs about relationships with men, and confidence in surgery as a treatment for breast cancer” (Lannin, Mathews, Mitchell, & Swanson, 2002, p. 422). A study by Lannin et al. (2002) found the following:

Black women and White women see the world quite differently; and these differences persisted even when the data were statistically adjusted for income level and education level. Unfortunately, many of the beliefs common in Black women are those that we have shown to be associated with late stage breast cancer. (p. 422)

White women and Black women often have different beliefs about breast cancer. For instance, some Black women believe that minor trauma to the breast or having large breasts can increase a woman’s chances of developing breast cancer. Black women are also more likely to believe that a lump on the breast that is not painful is not likely to be cancerous (Gerend & Pai, 2008).

Cultural beliefs related to mammography screening include fear of cancer discovery, doctors, or treatment; a fatalistic view about the inevitability of death once diagnosed; and lack of prioritization of preventive health practices (Gerend & Pai, 2008). Commonly-held folk beliefs about causes of cancer in Black women include ideas that

surgery spreads cancer and that cancer is caused by a bruise or sore (Gerend & Pai, 2008). For instance, Black women are more likely than White women to believe that cutting into a cancerous tumor or exposing it to air may cause it to spread more quickly (Gerend & Pai, 2008).

In addition to religious beliefs, which have been found to play a key role in the health behaviors of Black women, various other cultural traditions can impact health behaviors. According to Russell, Monahan, Wagle, and Champion (2006), “there is confidence in folk remedies and nontraditional cancer treatments, and social networks, collectivism, and racial pride have been found to influence breast cancer health-seeking behavior” (Russell et al., 2006, p. 387). When compared to White women, Black women are more likely to lack understanding and have fatalistic beliefs about breast cancer treatment, as well as have less confidence in Western medicine (Russell et al., 2006).

Identifying cultural beliefs common among Black women may allow better understanding of the racial gap in breast cancer mortality. More importantly, “it may allow us to provide focused, culturally sensitive educational messages that encourage early detection of breast cancer in a manner consistent with the underlying beliefs of the population” (Lannin et al., 2002, p. 422).

Cultural models theory. Cultural models theory, derived from the field of cognitive anthropology, contributed to the study’s theoretical framework. In healthcare, cultural models have been used to study osteoporosis prevention and treatment (Otmar et al., 2012), urinary incontinence, (Bradway, Dahlberg, & Barg, 2010), coronary artery disease in Blacks (Dressler, Bindon, & Neggers, 1998), and breast cancer in Blacks, among other phenomena (Barg & Grier, 2008). Health behavior models assume that individuals operate within the parameters of rational thought, which presupposes that

patients are highly motivated to maintain what is deemed to be good health. As such, if women are educated and reminded about appropriate screening to detect disease, then they are expected to follow through with help from medical professionals. Barg and Grier (2008) asserted the following view:

It is tempting to use these models in research and practice because they do, in fact, explain much White, middle-class health-seeking behavior. However, these models encourage a perspective on disease prevention as a purely individual phenomenon. By ignoring environmental, cultural and social factors that contribute to disease, these models treat as external to the model the most important structural conditions which constrain care seeking. (p. 336)

Culture plays a key role in health and health behaviors—not only encompassing race/ethnicity, but also reflecting intergenerational learned and shared beliefs, norms, and methods of communication (Kreuter & McClure, 2004). Individuals create mental associations, or schemas, based on these beliefs. When shared among members of a social group, these schemas become cultural. Cultural models consist of these shared mental associations and include beliefs about areas such as health and illness (Barg & Grier, 2008).

Cultural models about breast cancer would, therefore, include a range of associations about cancer at a macro level, and about breast cancer at a micro level. While members of a cultural group have shared experiences, they may also share schemas about illness, such as breast cancer. Barg and Grier (2008) explained what happens when these shared schemas are not reflected in breast cancer communications:

The lack of congruence between the message that is transmitted and the model that low-income Black women have for breast cancer might help to explain why some Black women would think that messages urging early detection do not apply to them. (p. 336)

Because shared schemas may obliterate key messages intended to influence breast cancer detection behaviors, understanding the role they play is crucial for health campaign

developers. Illuminating the shared understandings of breast cancer among Black women can provide insight into the lack of agreement between their lived experiences and messages about the disease (Barg & Grier, 2008).

When an individual woman receives a message about breast cancer detection—such as a mammogram reminder, a newspaper article promoting Breast Cancer Awareness Month, a television show, a discussion with a friend—her breast cancer schema is activated, helping her determine whether, when, and how to seek assistance for breast problems. Cultural cues that are integrated into social marketing may then motivate individuals in unintended ways. This amplifies the importance of gleaning insight into cultural models when developing persuasive breast cancer communications that could potentially lead to the reduction of health disparities (Barg & Grier, 2008).

Barg and Grier (2008) conducted semistructured interviews to identify a cultural model for breast cancer among low-income Black women with and without breast cancer. They found that these Black women shared a cultural model of breast cancer based on perceptions of “difference.” This experience of difference centered on the idea that breast cancer is stigmatizing and shameful, which leads to withdrawal and social isolation. This is in sharp contrast with the marketed model for breast cancer portrayed in breast cancer communications—specifically, that White women with breast cancer can and must “fight and win.” According to Barg and Grier (2008), “this suggests dissonance with popular/mass communication messages that are rooted in a dominant, White, middle-class model” (p. 339). This disagreement between the two models makes breast cancer prevention and early detection messages less salient for Black women. Consequently, Black women have “a sense of being outside in the breast cancer world

because they are Black and because the primary way they find meaning and peace in the world is left unacknowledged” (Barg & Grier, 2008, p. 339).

Bradway et al. (2010) examined the cultural model constructed by women living with urinary incontinence (UI). They found that the women’s perceptions were significantly different from the model assigned by most healthcare providers. Women do not feel that they have control over the outcome of UI and believe it is an inevitable female condition. This view conflicts with the biomedical model where healthcare providers and advertised UI treatments are shown to have the ability and power to fix UI (Bradway et al., 2010, p. 1534). The authors concluded with the following:

Cultural models theory is relevant for this study, as women are likely to have both individual and shared experiences as a result of and associated with long-term UI. Thus, cultural models theory and cultural anthropology provided a framework for answering questions about how individuals construct models that inform their lives. (Bradway et al., 2010, p. 1534)

This study was an endeavor to determine if the cultural models dimension has an impact on how young, insured Black women perceive their risk of breast cancer. These perceptions about breast cancer detection can help define future health campaigns targeted to this population.

Chapter 3

Methodology

Introduction

Communication researchers are focused on performances, or the transference of messages, and practices of human communication. Health communication research is concerned with aiding healthcare professionals in identifying and overcoming communication issues that impact their ability to deliver health services. Such issues can be interpersonal, organizational, media related, or technology related (Lindloff & Taylor, 2011). Many health researchers use quantitative methods, such as surveys, to predict attitudes and behaviors based on interventions created to achieve a particular health outcome (Lindloff & Taylor, 2011). As Hinyard and Kreuter (2007) contended, health communicators have typically focused on the use of “statistical evidence, probability, and appeals to logic and reason to persuade and motivate people to adopt behavioral changes” (p. 777). This approach leads to an incomplete picture of the social phenomenon in question due to a failure to capture variability as well as the reasons beneath social realities. Another criticism of this approach is that the quantitative method focuses on the biases of medical professionals to the exclusion of patients’ lived experiences. With qualitative research, patient perspectives on their medical encounters are able to come to light (Lindloff & Taylor, 2011).

Research Design

Qualitative researchers not only study events and behaviors of a particular phenomenon, but also examine how participants make sense of the phenomenon and how this influences their behavior. This line of study does not focus on variance in terms of how one variable causes variance in another, but on how one observation plays a role in a

particular action. The qualitative emphasis is on understanding processes and mechanisms, as opposed to demonstrating regularities in relationships between variables (Maxwell, 2005).

Qualitative research is uniquely suited to health behavior inquiry as health behaviors are not necessarily based on rational processes alone, but may also be intrinsically emotional.

According to Ferrer, Klein, Lerner, Reyna, and Keltner (2014), many health behaviors are enacted to reduce the risk of disease, and emotion may benefit or hinder choices about disease prevention through its influence on risk perception. Decisions about avoiding disease or illness involve understanding information about risks and benefits through the lens of personal preferences, values, and priorities (Ferrer et al., 2014). Pope and Mays (1995) stated the following view of how people react to questions about health:

People are, on the whole, more complex than the subjects of the natural sciences, there is a whole set of questions about human interaction and how people interpret interaction which health professionals may need answers to. Experimental and quantitative methods are less well suited to answer these questions. (p. 43)

Qualitative research methods can allow researchers to explore participants' narrative communication, yielding useful insights into complex issues such as morality, religion, personal values, meaning in an individual's life, social relationships, and other topics where reason and logic are limited (Hinyard & Kreuter, 2007). Through a qualitative approach, researchers are able to understand shared experiences of a phenomenon such as the complexities of social identities and experiences (Creswell, 2007). A qualitative research approach "emphasizes the role of gender, class, and racial identities in the co-construction of profound—and often conflicting—cultural meanings

for embodied conditions of illness, pain, suffering, and death” (Lindloff & Taylor, 2011, p. 19). As part of the qualitative process, researchers use interviewing, observation, and textual analysis to capture “the ground truth” (Lindloff & Taylor, 2011, p. 20).

A logic model (Figure 3) was used to frame this research study. A logic model is a “graphic way to organize information and display thinking” (Knowlton & Phillips, 2012, p. 4) that, in the case of the present study, demonstrates the relationships among breast cancer detection health campaigns that participants may or may not recall, the health experiences and perceptions of research participants, how those health experiences and perceptions are viewed through the theoretical lenses of the RPA framework and cultural models theory, and the output, or impact of each element in relation to the participant's health behavior.

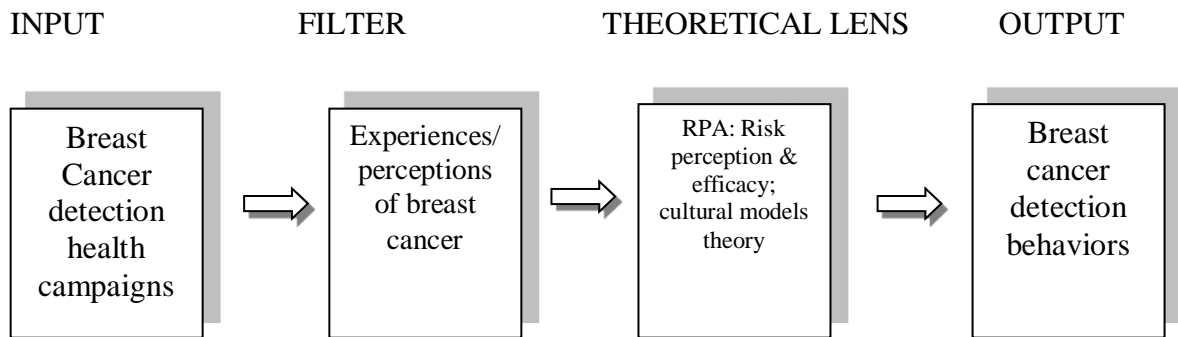


Figure 3. Logic model

Research Questions

The following research questions guided this study:

RQ1: What is the nature of young Black women’s perceptions about breast cancer detection and its relevance to their lives?

RQ2: How do young Black women experience mass media communications regarding breast cancer prevention and detection?

Data Sources

Semistructured interviews can be used to gain an understanding of consumer marketplace experiences and responses to marketing activities (Barg & Grier, 2008). This research study used semistructured, one-on-one telephone interviews to explore the experiences of breast cancer and related messaging among a group of young Black women. Open-ended interview questions were designed to encourage discussion about breast cancer in an attempt to identify shared meanings.

A variety of research strategies can be used to key in on prevailing cultural models. Barg and Grier (2008) used a qualitative interview technique to identify a cultural model of breast cancer shared by Black women, which revealed how the subjects did not perceive the disease as particularly relevant to them despite prevailing media messages. Thus, cultural models can help to illuminate both the superficial and deeper meanings attributed to phenomena within a bounded community. Identifying these shared meanings can contribute to the development of dominant cultural models held by a particular community that can then be used to inform the development of targeted social marketing messages and campaigns.

The study sample included young Black women between the ages of 30 and 40 who have not had breast cancer and who are insured. In this study, the designation of race is described as Black to mean all women of color and includes women of African American descent as well as women of color whose parentage is derived from Belize and the Dominican Republic. All of the women in the study were born in the United States, therefore it is assumed that study participants experienced similar cultural influences.

Participants were asked to describe their visceral reactions to the idea of breast cancer and to any breast cancer experiences of family and friends, as well as their thoughts on seeking help for breast cancer. An intrinsic dimension considered in this research was the socioeconomic status of the participants. According to Thomas (2004), while previous studies have focused on Black women who have been diagnosed with breast cancer, few studies have investigated cancer and cancer screening beliefs and behaviors of Black women from a variety of socioeconomic levels. Socioeconomic factors have been shown to influence the stage of disease at diagnosis and may explain some racial disparities in breast cancer mortality (Thomas, 2004). By examining young Black women with health insurance, this study broadened the current scope of inquiry to consider both cultural influences and socioeconomic status in relation to enacting health behaviors to detect breast cancer. Insurance status was a key component of the participant profile, as few studies have addressed the relationship between cultural values and insurance status in healthcare decision-making.

Sampling Design

For the current study, criterion sampling was used to identify Black women from Louisville, Kentucky, between the ages of 30 and 40 who have not had breast cancer and who have health insurance coverage. Criterion sampling allows the researcher to select participants based on specific criteria (Lindloff & Taylor, 2011). Five pilot participants were recruited via an existing Black networking group from a Fortune 100 company located in Louisville, Kentucky. Snowball sampling was used to recruit 22 participants using a revised questionnaire based on pilot study feedback. Snowball sampling is useful in studying social networks, subcultures, or people with similar attributes (Lindloff & Taylor, 2011).

Data Collection

In accordance with University of Kentucky graduate school guidelines, Institutional Review Board (IRB) nonmedical review and approval was obtained. Upon approval, contact was made via email with a member of the African American Network Resource Group (AANRG) at a Fortune 100 company located in Louisville, Kentucky. This company was selected due to the researcher's former employment with the company, knowledge of the AANRG, and association with members of the AANRG. The primary AANRG contact distributed an email to members of the group to request participation in the pilot study.

AANRG members who consented to participate were scheduled for a prescreening telephone call to determine if they met the research criteria. Those who met the criteria received the University of Kentucky's IRB informed consent form via email. A one-hour interview was as scheduled at that time. A confirmation email was sent to the participant noting the date and time for the phone interview.

Participants met the following criteria: female, of African American descent, between the ages of 30 and 40, with private health insurance, employed full-time, and never been diagnosed or treated for breast cancer. Additional information collected at the time of each interview included occupation and highest level of education.

For the pilot study, semistructured, open-ended interviews (Appendix A) via telephone were conducted for approximately 45 minutes with participants. The participants were informed that should additional information be required, a follow-up appointment would be scheduled. Interviews were recorded using a digital Another Call Recorder via Android cell phone. At the conclusion of the interview, each digital

recording was transferred to a computer hard drive for storage for one year. All interviews were transcribed by the researcher.

Based on the five pilot interviews, the research questionnaire was revised (Appendix B) to include more in-depth questioning on media recall and cultural elements. Participants for the study interviews were recruited through snowball sampling from the pilot study participants. Interviews were scheduled with 22 participants via email. A confirmation email was forwarded to participants, along with the informed consent form. At the conclusion of each interview, participants were sent a \$50 incentive via PayPal.

Data Analysis

All interview transcripts were reviewed manually to discern patterns and themes. Analysis of a total of 27 interviews was done by organizing verbatim transcripts by each interview question. For each question, responses were listed according to the most common responses. Themes were identified for each element of the logic model (see Figure 6) based upon common responses to interview questions. According to the logic model, Black women's awareness of breast cancer health campaigns, coupled with their experiences and perceptions of breast cancer, provides insight into their awareness of breast cancer detection. These behaviors are impacted by elements seen through a theoretical lens that identifies their perceptions of their own risk for breast cancer, as well as cultural influences, such as the media and learned health behaviors from family and friends.

Content analysis was used to analyze the text data from transcripts. According to Hsieh and Shannon (2005), "research using qualitative content analysis focuses on the characteristics of language as communication with attention to the content or contextual

meaning of the text” (p. 1278). Through content analysis, subjective interpretation of content text data is derived by a process of coding and identifying themes or patterns.

Hsieh and Shannon (2005) described three methods of content analysis, including conventional, summative, and directed. Conventional content analysis is used when existing theory or published studies on a phenomenon are limited. Instead of using predetermined categories, the researcher allows categories to emerge from the data. Summative analysis is used when the researcher identifies certain works on content in text with the aim of understanding the contextual use of words or content (Hsieh & Shannon, 2005).

The current study uses a directed content analysis process. Directed content analysis validates or extends a theoretical framework or theory. It is guided by a more structured process, and data are collected through interviews using open-ended questions about predetermined categories. According to Hsieh and Shannon, “because the study design and analysis are unlikely to result in coded data that can be compared meaningfully...the use of rank order comparisons of frequency of codes can be used” (pp.1282-1283). In this way, the theory guides the discussion of the findings. In the current study, a logic model (see Figure 6) using the theoretical foundation of the RPA framework and culture theories model drives the analysis of findings.

Themes were developed based on a statement that offered understanding of how participants experienced the phenomenon. These themes were used to write a description of what participants experienced. Creswell (2007) described these themes as textural descriptions that are used to write a narrative of how the participant experienced the phenomenon, called structural descriptions.

Based on the textural and structural descriptions, a composite description was written that focused on the essence of the phenomenon, or the essential, invariant structure (Creswell, 2007). This description focused on the common experiences of participants.

Reliability and Validity

In qualitative research, strategies of reliability and validity are used to evaluate the quality of the research. Reliability addresses the consistency of data collection procedures and can be achieved through the research instrument design, such as a standard questionnaire. Validity involves the truth value of the findings and involves internal, conceptual, and external elements (Lindloff & Taylor, 2011). For this study, semistructured interviews helped ensure consistency across all participant interviews, and the open-ended interview format served to avoid researcher leading or bias.

Reliability and validity in data analysis may be achieved through convergence, or by determining recurring themes in the data (Patton, 2002). These themes, or patterns, can be sorted into categories based on internal homogeneity and external heterogeneity. Internal homogeneity involves data within a specific category and how it holds together in a meaningful way. External heterogeneity focuses on the ability of the data to exhibit clear differences. Categories may be tested for completeness by examining consistency, completeness, reproducibility, and credibility (Patton, 2002).

Noble and Smith (2015), offer several strategies to ensure the credibility of study findings including accounting for personal biases; acknowledging biases in sampling; meticulous record keeping that demonstrates how decisions and interpretations were made; establishing a comparison case; including rich and thick verbatim descriptions by

participants; inviting participants to comment on final themes and concepts, and; triangulating data.

Researcher Bias

Researcher bias is “the tendency for the researcher to see what is anticipated” (Morse, 2015, p. 1215). In the case of the current study, the researcher was influenced by previous studies with Black women that revealed a cultural model of breast cancer created by Black women of breast cancer as a White woman’s disease (Barg & Grier, 2008). In an attempt to reduce bias and encourage neutrality of analysis, a logic model was created to guide the research instrument. While it is possible that the design of this instrument was biased toward the researcher’s point-of-view, questions were open-ended. Throughout the interviewing process, follow-up questions were intended to probe for deeper meanings, such as “tell me more,” or “why do you say that?” In this way, participant responses were recorded without judgement.

An additional bias may be revealed through data analysis. Due to the nature of the semistructured research instrument, deductive coding was used informed by the framework of a logic model. This approach was designed to test the constructs of the model and, as such, “the onus is on the researcher to be strongly vigilant about such comparisons and conclusions, maintaining an inductive perspective” (Morse, 2015, p. 1216).

Another element of consideration is the concept of researcher as instrument, meaning, how the credibility of the researcher affects the findings (Patton, 2002). The primary researcher in this study is a marketing professional with experience in consumer research. Care was taken to develop rapport with each study participant at the beginning of each interview. Throughout the interview, the researcher set a tone of concern for

each participant, thus encouraging openness and nonjudgement in their responses. In this way, the researcher could be perceived as “caring about and interested in the people being studied, but neutral about the content of what they reveal” (Patton, 2002, p. 569).

Chapter 4

Findings

Introduction

The primary purpose of this study was to address the high breast cancer mortality rate among young Black women, thus informing strategies to increase awareness of risk and encourage prevention activities. As such, the study examined the linkages between mass media campaigns and cultural influences and the impact such linkages have on the perceptions and behaviors of young, insured Black women. Data were collected by administering pilot interviews with five participants followed by 22 in-depth, semistructured, qualitative interviews of one hour each via telephone for a total of 27 study participants. To understand how breast cancer health campaigns inform young insured Black women's experiences and perspectives about breast cancer, the following research questions served as a guide for inquiry:

RQ1: What is the nature of insured young Black women's perceptions about breast cancer detection and its relevance to their lives?

RQ2: How do insured young Black women experience mass media communications regarding prevention and detection?

The present study was grounded with two theoretical concepts: cultural models theory, and the risk perception attitude (RPA) framework. *Culture* is defined as a shared communication system between individuals or communities. It encompasses physical and social environments, common beliefs, values, traditions and world views, and similarities in lifestyle, attitude, perceptions, and behavior (Freeman & Chu, 2005). The current study was an examination of how young Black women's perceptions contribute to

a shared cultural model. This model, consisting of cultural beliefs and practices, informs young Black women’s perceptions of their risk for breast cancer and their feelings of efficacy in undertaking breast cancer detection behaviors. The RPA framework provides insight into the degree to which health campaigns influence this audience’s perceptions of their breast cancer risk as well as their feelings of efficacy in exhibiting self-protective behaviors (Rimal & Real, 2003).

Demographic Analysis

The current study participants consisted of Black women who were between the ages of 30 and 40, and were employed full-time. Each individual had private health insurance and had no previous history of diagnosis or treatment for breast cancer. In addition to the participation criteria, occupation and the highest level of education were recorded. Table 7 represents demographic data collected prior to each interview. All participant names are pseudonyms to protect their privacy. While education and professional affiliations were not criteria for this study, the majority of participants had a high level of education and were employed in a professional setting.

Table 7

Participant Demographic Information

Participant	Age	Occupation	Education
Cassandra*	40	Business consultant	Some college
Rebecca*	37	Registered nurse	Bachelor’s degree
Susanna*	37	Social worker	Master’s degree
Trissa*	36	EDI analyst/system tester	Bachelor’s degree
Violet*	35	Social worker	Master’s degree
Laquita**	33	Executive assistant	Bachelor’s degree

Nina**	39	Customer service representative	Associate degree
Devon**	35	Social worker	Master's degree
Juliet**	32	Social worker	Master's degree
Amber**	38	Social worker	Master's degree
Chelsea**	37	Financial account manager	Bachelor's degree
Kelsey**	33	Health insurance account manager	MBA
Monique**	31	Social worker/therapist	JD
Coleen**	30	Education consultant	Master's degree
Gail**	31	Staffing coordinator	Bachelor's degree
Valentina**	33	Nonprofit coordinator	Master's degree
Zandra**	35	Administrative assistant	Master's degree
Breyann**	39	Business consultant	Some college
Jillian**	35	Business consultant	Master's degree
Lucinda**	34	Retail manager	Master's degree
Ranisha**	30	Paralegal	Some college
Shaniqua**	31	Bill collector	Bachelor's degree
Camella**	35	Residential counselor	Some college
Karah**	31	Mortgage servicer	Bachelor's degree
Jacy**	30	Revenue collector	Some college
Liana**	30	Staffing coordinator	Bachelor's degree
Malaya**	38	Customer service representative	Some college

* Pilot participant

** Participant

Table 7 (continued)

The principal investigator for this study collected data using open-ended semistructured interview questions with a small pilot group of five Black women (see Appendix A). Upon completion of pilot interviews, an expanded questionnaire (see Appendix B) was created to probe for more in-depth responses to questions related to media awareness and cultural influences. Participants were interviewed for one hour via telephone. Interviews were audiotaped and transcribed verbatim by the principal investigator.

Transcripts were separated by nine research categories: awareness/recall of breast cancer detection communication; relevance of breast cancer messaging; general health practices; family health history; health knowledge; breast cancer knowledge and perceptions; mammography knowledge and perceptions; information seeking behaviors; and cultural influences on health practices. These primary categories correspond to the logic model (Figure 6) which served as a guide to answering the primary research questions.

After ordering each transcript by category, verbatim transcripts were organized according to each research question. A grid was created that captured brief answers to each question by participant. For each question, majority responses were tabulated and clustered according to similar themes. Themes and passages were compared among all participants and recorded.

Key Themes and Individual Participant Discourse Summaries

Black women's knowledge and beliefs about breast cancer were probed as well as their personal perceptions of susceptibility about being diagnosed with breast cancer. Aims of the study included illuminating the interplay between culture and health belief systems on participants' understanding of breast cancer messaging, which is designed to

invoke health behaviors. The logic model in Figure 4 illustrates the thought process that supports nine subject areas for interview questions. A logic model is a “graphic way to organize information and display thinking” (Knowlton & Phillips, 2012, p. 4) that, in the case of the present study, demonstrates the relationships among breast cancer detection health campaigns that participants may or may not recall, the health experiences and perceptions of research participants, how those health experiences and perceptions are viewed through the theoretical lenses of the RPA framework and cultural models theory, and the output, or impact of each element in relation to the participant's health behavior. Chapter 4 contains *inputs*, *filters*, and *theoretical lenses*. Chapter 5 includes a discussion of *outputs*.

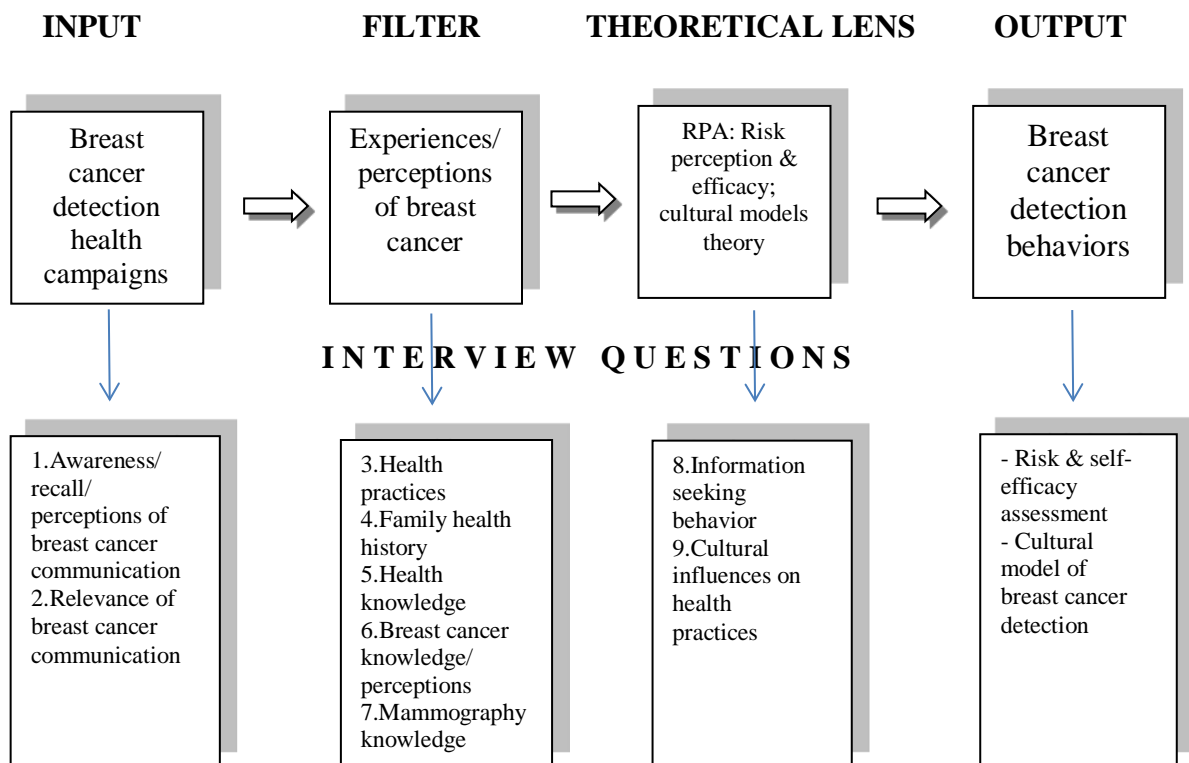


Figure 4. Logic Model: Theoretical framework and associated interview questions.

Each section of the interview questionnaire was intended to illicit responses that would inform an understanding of participants' perceptions and experiences as it relates

to breast cancer. Taken together, the nine subject areas provide insight into the impact of culture, participants' assessment of their risk for breast cancer, and their feelings of self-efficacy in performing breast cancer screenings as a preventive measure against breast cancer. The following section outlines the intention of each interview questionnaire section.

Awareness/ recall of breast cancer detection communication. Awareness and recall were probed without providing any stimulus materials to participants. In this way, participants were able to respond with their best recollection of what they had observed about breast cancer in the media.

Relevance of breast cancer messaging. Based on what participants recalled seeing in the media about breast cancer, relevance questions probed not only for understanding of the messages recalled, but of the degree to which the information observed resonated with participants.

General health practices. It is important to understand participants' practices in relation to their health to assess their health behaviors in general. The concept of health consciousness was first introduced by Gould (1990) when he attempted to develop a health consciousness scale. This scale included four factors: (a) health self-consciousness, (b) health alertness, (c) health self-monitoring, and (d) health involvement.

The study participants were asked to define the concept of health consciousness and to assess their own level of health consciousness. In describing health consciousness, participants answered in one of four ways: (a) eating healthy, (b) being proactive about health, (c) practicing preventive care, and (d) being aware of what the body is exposed to.

Family health history. Continuing with the discussion on health concerns, participants were asked if anyone in their family had a health condition. Because all of the women indicated they received an annual well-woman exam from a gynecologist, participants were asked if their mother had a gynecologist and received an annual exam to determine if they were influenced by their mother's health behaviors.

Health knowledge. Blacks have higher rates of diabetes, hypertension, asthma, and heart disease than other groups. Regarding cancer, Blacks experience higher incidence and mortality rates from many cancers that are amenable to early diagnosis and treatment (Center for American Progress, 2015). Questions in this section probed for participants' knowledge of health conditions known to impact Blacks more than other races, as well as their concern for their personal health as it relates to these conditions.

Breast cancer knowledge. Little is known about how various ethnic group members in the U.S. form ideas about breast cancer, and whether these ideas are congruent with the implicit messages related to consumer behavior which underlie breast cancer communications. In order to contribute to the creation of effective messages that motivate Black women to undertake breast screening or seek medical care, breast cancer knowledge questions represented an attempt to understand how Black women think about breast cancer.

Mammography knowledge. Because the participants in this study were all under the age of 40 and most likely had not undergone a mammogram, this section probed for their understanding of the screening test and thoughts on the effectiveness of the procedure.

Information-seeking behaviors. The RPA framework posits that when risk perceptions are low, people rely on efficacy beliefs to determine an appropriate course of

action. Rimal and Real (2003) categorized individuals based on perceived risk and efficacy beliefs into one of four attitudinal groups – responsive, avoidance, proactive, and indifference – to study how they are motivated, how they go about seeking information, and the degree to which they enact healthy behaviors. Information-seeking behaviors were identified through this line of questioning.

Cultural influences on health practices. Discovering how cultural and social forces influence Black women’s awareness of breast cancer is vital to making an impact on health behaviors that lead to greater prevention and early detection of breast cancer. Research has demonstrated that consumers who are members of different groups construct meanings from media messages based on their own cultural and social experiences (Barg & Grier, 2008). A cultural model for breast cancer has emerged that posits breast cancer as not having any particular relevance to Black women, who may perceive breast cancer to be something that affects White women. The model also suggests that Black women perceive other health threats such as hypertension as more salient than breast cancer (Barg & Grier, 2008). These questions focused on participants’ knowledge and awareness of health conditions that are most prevalent among Black men and women, as well as their assessment of their risk for these conditions. To ascertain the level of influence culture played in the participants’ health practices, questions focused on family, friends, media, religious beliefs, and partner relationships.

Semistructured interviews were conducted to uncover participants’ shared meanings of breast cancer. Semistructured, or semistandardized, interview questions “can reflect an awareness that individuals understand the world in varying ways...[and] researchers, thus, approach the world from the subject’s perspective” (Berg, 2007, p. 95). Keeping in mind the effects of researcher bias as well as the concept of researcher as

instrument, the researcher attempted to maintain a tone of professionalism and responsiveness to the participants. Participants were asked to discuss highly personal issues thus it was important to exhibit empathy as well as neutrality throughout each interview. To ensure precision and readability, quoted responses were not edited for grammatical exactness. Repetitive or filler words were not included with the participants' quoted responses.

Six key themes emerged from analysis of each question's verbatim response (Figure 5). Each theme links back to an element of the logic model and explains how young Black women experience breast cancer through the media and how they perceive breast cancer's relevance to their lives:

Theme 1: The absence of knowledge of risk and prevention factors limits breast cancer preventive measures.

Theme 2: Lack of comprehensive media information may contribute to higher mortality.

Theme 3: Personal experiences drive perceptions of who gets breast cancer.

Theme 4: Youth and culture are breast cancer risk factors for young Black women.

Theme 5: Low perceived risk and strong efficacy beliefs drive health behaviors.

Theme 6: Young Black women tend to take responsibility for their health.

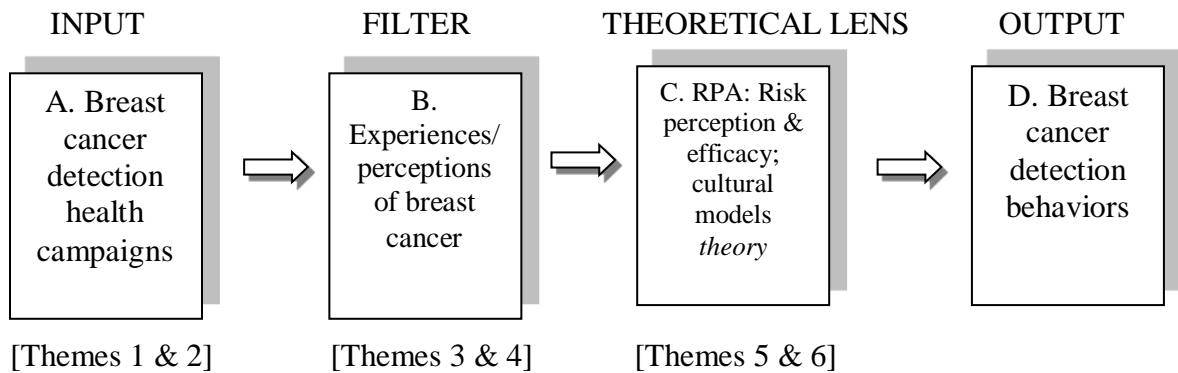


Figure 5. Logic model: Theoretical framework and associated themes.

The following represents key theme supporting data collected for this study through in-depth semistructured interviews.

Themes 1 and 2. Following the logic model (Figure 7), Themes 1 and 2 focus on participants' observations of breast cancer detection health campaigns. These inputs inform participants' understanding of breast cancer as well as their perceptions of personal risk for breast cancer.

Theme 1: The absence of knowledge of risk and prevention factors limits breast cancer preventive measures. Participants exhibited a knowledge deficit regarding the relevance of breast cancer as it relates to their health. Because of their lack of awareness of how they might be at risk they were unable to articulate ways to manage their health to prevent breast cancer. To better understand their perceptions of risk, participants were asked to discuss various health conditions and the risk associated with these conditions as a way to probe for general feelings of self-efficacy as it relates to preventive measures in general.

When asked what health conditions Blacks are more likely to get than other races, the most common conditions mentioned by participants were (in order of frequency): diabetes, high blood pressure, heart disease, cancer (with four mentioning breast cancer),

high cholesterol, sickle cell anemia, kidney disease, AIDS, and lupus. In light of the incidence of breast cancer among Black women, it is interesting to note few mentioned the condition which serves as an indicator of their lack of knowledge about their risk for breast cancer.

Camella posited this: “based on what I hear in the media, I would say high blood pressure, diabetes, and heart disease. I actually do know a few people right now with a heart condition, my father-in-law included.” Violet mentioned diabetes.

It seems that more [African Americans] have more diabetes in particular. I know more African Americans, just not my family, but I’m also a social worker. And right now I’m in a world that is closely aligned with the health care profession, and that is my perception from even my professional work.

Ten participants mentioned food in connection with the incidence of diabetes in Blacks. Gail surmised this:

I know way too many people that have diabetes, but if you notice how they prepare their food you’re like "I can see why." They tend to use a lot more seasoning, like salt, when cooking and are really into sweets. I even know people who like sugar in their spaghetti, things people normally don’t do.

Cassandra confirmed Gail's comments:

Diabetes is probably the number one thing to me in African American communities. I think a lot of it can be avoided because it’s related to unhealthy eating habits and weight gain. So I think that, as a culture, one of the things we do, we celebrate when there’s something major going on in the family, and how we celebrate is with food.

Nina discussed her grandfather and his unwillingness to alter his eating habits for his health:

My grandfather, he’s older and has health issues, gout, but he still eats his fried foods with salt on everything because that’s just what he was raised to eat, so he doesn’t change his eating habits. He keeps eating what he wants to eat. I think that’s the thing. We know what food can do but we eat it anyway.

The family norms associated with unhealthy eating habits expressed by Gail, Cassandra, and Nina inform their perceptions of their risk for contracting diseases for which they have a family history. According to the RPA framework, their perceived risk of being vulnerable to conditions such as diabetes as a result of unhealthy eating in the family is a predictor of self-protective behavior.

Intergenerational learned behavior regarding food is a key component of Cultural Models Theory, which says that individuals create mental associations, in this case with the relationship between food and health, based on familial norms. Food and health appeared to be inextricably linked as numerous other participants mentioned history and things handed down in the family as it related to food.

Monique said “I think the food they [African Americans] eat is a lot of fried and greasy foods. And I think there are a lot of African Americans who are obese. I think there’s just history, really.” Chelsea asserted this:

We’re horrible eaters. We just eat what we want to, some of that carried down, like you put ham in everything, or pork, and bacon, when that’s not the best for us. So I think we eat what we want to and then we suffer the consequences instead of being conscious about it up front.

Zandra thought that health conditions Blacks are faced with today are the result of societal issues:

I believe some of it is genetics. I believe a lot of it is predisposed from society, from things we deal with as far as going back generations and things we had to deal with in society as far as racism and discrimination and prejudice. So I think some of the things like sickle cell disease, diabetes, and heart issues are more so because of the stress and type of food that’s been passed down to generations.

Zandra echoed previous participant sentiments as it relates to food “passed down to generations.” Through family experiences and observations, many participants created

a food-health connection that supports the concept of cultural models having an impact on how individuals perceive their risk for certain diseases.

To further determine participants' knowledge of conditions most prevalent among Blacks, they were asked to name health conditions they were concerned about and felt they needed to prevent. The most mentioned conditions that concerned participants included (in order of frequency) diabetes, cancer, high blood pressure, heart disease, and high cholesterol.

Gail said this:

I would say high blood pressure and diabetes. I try to watch what I eat so I don't develop those. Granted, I'm fairly healthy now but that doesn't mean I'm immune to them. I still have to be very cautious about the decisions that I make. Because I'm not invincible.

Diabetes was also a concern for Laquita:

I was recently reminded about how sugar is in everything. And that even a starch breaks down into sugars. I used to be a big bread eater but I'm not eating as much bread now. I don't eat as much sweets as I could, but I definitely love sweets. I've done better with drinking more water versus juice and pop, just trying to find easy first steps for me to cut out sugar as much as possible.

Chelsea was concerned about heart disease, "especially because it runs in my family." She acknowledged this: "My grandmother died of a heart attack in her 40s and my father in his 50s, so I definitely need to be conscious."

Juliet's focus was high blood pressure:

My mother has [high blood pressure] and I believe my great grandmother did and I have an aunt that has it as well. That's one of the reasons why these salty foods kind of concern me because I really love salty foods. That, and high cholesterol. I have some older women in my family that have that. My great grandmother had a heart attack so I try to pay attention to doing cardio and things to keep my cardiovascular system strong.

Participants continued to express a food-health connection when discussing health conditions that ran in the family. In addition to their perceptions of risk, several commented on activities they engage in to prevent these diseases, such as changing their eating habits or exercising, thus exhibiting self-efficacy in their attempt to reduce risk.

Of the seven participants who had a family history of breast cancer, three mentioned that they were concerned about preventing breast cancer. While eating a healthy diet was mentioned to prevent conditions such as diabetes and heart disease, it was not associated with breast cancer. A lack of knowledge of risk factors and preventive measures for avoiding breast cancer was exhibited by participants as a healthy diet and weight have been shown to reduce one's risk for breast cancer (American Cancer Society, 2015c).

According to Jacy, whose great grandmother had breast cancer, "My main concern is breast cancer considering that it is of high risk in my family. My mother told me not to take birth control because that increases the risk and I do check myself sometimes." Kelsey, who also had a history of cancer, expressed her concern: "Just because I have a grandma who died of colon cancer and my aunt that died of breast cancer, so I have a lot of cancer history in my family."

Three participants with a history of breast cancer in the family were more concerned with preventing other conditions and did not mention breast cancer. According to Cassandra, who has a history of breast cancer on her mother's and father's side: "Diabetes and blood pressure are things I think should be checked on a regular basis. Many things drive that up and down." Similarly, Laquita's grandmothers on her mother's and father's side had breast cancer; however, her primary health concern was diabetes. "Sugar is in everything.... I'm trying to be extra cautious of that."

It is interesting to note that those participants who had a history of breast cancer perceived themselves to be invulnerable to the disease. Gerend and Pai (2008) posit that this phenomenon may be due to the cultural norm against discussing breast cancer within the Black community. Both Cassandra and Laquita indicated that health issues were not discussed in great detail in their family, which may support Gerend and Pai’s theory.

While breast cancer was not mentioned as part of family history, two participants were concerned about prevention and exhibited strong self-efficacy behaviors. Ranisha worried: “Breast cancer is something that concerns me. I’ve been telling myself I need to do more homework as far as these statistics of women who have breast cancer in their family versus the statistics of women who don’t.” Jillian was also concerned about breast cancer and was “just doing my self-exam to make sure that I’m okay there.”

Table 8 references each participant’s response including whether they have a family history of breast cancer.

Table 8

Family Health History of Breast Cancer with Unaided Response

Participant	Family history of breast cancer	Family member	Unaided mention
Cassandra	Yes	Grandmother, aunts	No
Laquita	Yes	2 Grandmothers	No
Kelsey	Yes	Sister, aunt	Yes
Gail	Yes	Mother	No
Jillian	No		Yes
Ranisha	No		Yes
Jacy	Yes	Mother, grandmother	Yes

According to the RPA framework, perceived risk is a motivator for change. This can be seen in the information seeking behaviors of these participants. The fact that these participants search for information is a demonstration of self-efficacy and self-protective behavior that may translate to other health conditions, such as breast cancer, if the perceived risk is great enough.

When it comes to preventing the health conditions participants are concerned about, the majority believed that there were things that could be done for prevention, which demonstrates a high level of self-efficacy. With certain conditions, however, many felt that genetics played a part, and that these conditions could not be controlled.

Camella was concerned with high blood pressure, diabetes, and heart disease, and she said she thought she could prevent those conditions “if I stay on the path that I’m on right now with a better diet and exercise. I feel like it’s something I can stay away from. I believe that the healthy eating and exercise stuff does really work.” Shaniqua agreed and said this:

I think that a lot of it is related to food, diet, exercising and lifestyle. Maybe environmental might be a little bit out of your control, but I do think you have a greater opportunity to be in control of some of those things yourself.

Ranisha expressed these beliefs about prevention:

I truly believe that if you eat healthy and if you go to the doctor and just make sure that everything is okay that you can be cancer free. I do believe that there are foods that are healing for your body. It’s eating healthy and working out and detoxing your body. I do believe your body can heal but it’s just what you are putting in. You are what you eat.

Jillian, who was concerned about breast cancer, had the following ideas about prevention:

Some things are hereditary, so I know I’m susceptible to certain things based on my family history, but there are things you can do to prevent it like eating healthier, getting more active, making sure you go for your annual check-up. I do not think it is out of my control.

The theme of healthy eating as a means of prevention was reiterated in the following statements from Valentina:

I think there is potential for the full health and well-being of a person to have some impact on the potential for cancer. I don't necessarily know if it would be preventative by changing a person's diet or stress level, but I think part of the reason I went to the vegan lifestyle was also because of that fear of not having the healthiest lifestyle. What can I be opening myself up to?

Several participants did not feel they could prevent disease if genetics were in play. Zandra was concerned about diabetes, which "runs pretty rampant within my family." When it came to prevention, she noted this:

I'm sure there's stuff I can do to prevent it as far as getting the weight down and eating better and light. But also too I know that some of the stuff is genetic. So it's one of those things where with genetics there is not really much control I can have.

Jacy, whose mother had breast cancer, said that keeping a watchful eye to catch cancer early was critical.

I don't think there's any kind of preventative measures you could take, is there? I don't think so. I think this is something that you could start to stay on top of so when it does happen you'll catch it before it is too serious.

Those participants who indicated prevention was possible when it came to managing health conditions were able to articulate specific preventive actions they could take to manage or avoid disease, such as eating a healthy diet and exercising. This high level of self-efficacy is most likely due to participants' knowledge of the conditions mentioned, including high blood pressure, diabetes, and heart disease. It stands to reason that if they were educated about breast cancer in a similar manner that their behaviors would mirror the preventive actions they are currently taking for other diseases. In contrast to those participants who indicated prevention was not out of their control, two voiced concern that preventive measures were limited. For instance, while Zandra was

concerned about diabetes she indicated that genetics would outweigh any preventive actions she could take. Likewise, Jacy's strategy to prevent breast cancer was to catch it early before "it is too serious." This limiting viewpoint can be ascribed to the absence of knowledge of each condition and indicates the women in this study either had lack of exposure to health campaigns or messages failed to provide ample information to educate them.

Participants were probed to understand their general knowledge about cancer. They showed a lack of understanding of the causes of cancer which was reflected in their responses. This further impacts their understanding of their risk for breast cancer and limits preventive actions they might take if they had more complete knowledge. They listed a multitude of causes of cancer, including the following (in order of frequency): processed food/steroids in food, lifestyle, environment/pollution/pesticides, genetics, electronics, don't know, vaccines, hormonal imbalance, household products, deodorant, mammograms, products (smoking/drinking), sugar. Many of these factors were listed in combination; participants did not feel that one single element was the cause of cancer.

Rebecca suggested this:

I think about it a lot because back in the day you never really heard your grandparents speaking of cancer or your mom.... It's either what we're eating or there's a lot of electronics that we are using like microwaves and cell phones and computers and laptops and iPads. So initially I think of those things as well as the steroids they're using in the chicken we eat and the vegetables that are grown with pesticides.

Trissa said she researched the issue and believes the environment is the cause.

I noticed a lot of people in the 40211, 40210 zip code in Louisville, they have a higher percentage of colon cancer and breast cancer. I'm going to say 60% environmental and 40% of things we have control over like smoking and obesity. [Note: 40211 and 40210 are located in the west end of Louisville, where a majority of the population is Black and where several large manufacturing plants are located.]

Many participants asserted that chemicals in foods contributed to cancer. Juliet stated this: “I don’t know the names of them, but I see different things about how those particular chemicals, if they’re heavy in your diet, it could increase the likelihood.”

Devon also mentioned chemicals in food, and she said the following: “I think a lot of things trace back to things that’s in our food.... Just look at a bowl of cereal that has cleaning agents, chemicals that they use in cleaning agents mixed in with it.” Gail identified processed foods as a cause of cancer:

I feel like a lot of the processed food we eat nowadays that, even when I was growing up, cancer wasn’t as prevalent as it is today. Our food isn’t being cooked at home, it’s more like thrown into the microwave, grab it on the go. I feel like that is what’s leading to a lot of the issues we’re having.

Breyann was among those who mentioned chemicals in food, and she posited this:

Some people say it’s the food, especially organic versus the processed or non-organic. Some of the pesticides and things that people are exposed to, they’re linking it back. So it’s a host of things like household products, bleaches and things that you touch. Pesticides and some of the things they use to treat the grass and things in the air.

Zandra mentioned radioactivity, as well as a hormone imbalance, as potential causes of cancer.

I will have to say that’s where I see the influence from the media because there’s always something in your face. So you can get cancer possibly from cell phones and radioactivity. And I even heard that cancer comes from a hormone imbalance in your body.

Camella also identified multiple factors as possible causes of cancer:

At this point I think the air we breathe, the water we drink, the food we eat. I feel that we just live in a world that is so polluted. I don’t feel like people can truly eat 100% organic and exercise five times a week and not get cancer. I feel like the only way that people can beat cancer is through finding out early and then get treatments. I’m not even sure what causes cancer anymore and it’s practically everything. I feel like our bodies have just gotten to this point where it’s all mutations.

Several participants said they were unsure of the causes of cancer. They included Laquita, who stated this:

I have no idea, just to be honest. I think it's very mysterious to me even as many times that I've heard about different types of demographics and the rate of how they are being affected by different types of cancer, because it doesn't really make sense to me how cancer gets there.

Nina, who was also unsure of the causes of cancer, said the following:

I don't know what. I'm still trying to figure out where my mom's cancer came from. Nobody in my family had cancer. I don't think it could be genetic. It could be something that's just predestined and predetermined. I can't really say where cancer comes from.

None of the participants in this study could definitively identify the primary causes of cancer. According to the American Cancer Society (2015e), cancer is a group of diseases that involve the uncontrolled growth and spread of abnormal cells. Known causes include external factors such as tobacco, infectious organisms, and an unhealthy diet. Internal causes include inherited genetic mutations, hormones, and immune conditions. A report issued by the American Institute for Cancer Research (2015) found that most Americans do not know the causes of cancer and incorrectly identify risks such as pesticides, food additives, genetically modified foods, stress, and hormones in beef. The women in this study mentioned causes such as chemicals, electronics, radioactivity, and pesticides, all of which have not been shown to cause cancer. The plethora of media reports on cancer causes may be the source of many of these misconceptions. Misunderstandings of the causes of cancer fuels the lack of knowledge of risk and prevention factors which poses a threat to the health of the women in this study.

When discussing breast cancer, the majority of participants did not distinguish between other cancers and breast cancer as having different causes. A number of participants responded similarly to Zandra, when she said "I feel kind of bad saying this,

but I don't know for sure." Some participants mentioned genetics as the cause, as well as deodorants and birth control.

Nina indicated she thought that there were multiple causes of breast cancer. "I know I've read on it and some say it's genetics, some say it's things we eat or stuff we do to our body that can cause breast cancer, but I really don't know."

Two people mentioned deodorants as causing breast cancer. Juliet, who was one of them, suggested this: "I've heard certain deodorants aren't good to use, I guess antiperspirants, some kind of chemical in those can raise the likelihood." Ranisha also mentioned deodorant and said "the deodorant and aluminum that you're putting into your body. At one point in time I actually stopped using regular deodorant because I was paranoid and used natural deodorant."

Birth control was another cause mentioned. Breyann speculated: "Some of the people that had it were on birth control. I don't want to say that but it seems like all the people that I've known to have gotten breast cancer have had some type of birth control."

Heredity was mentioned by a few participants. Valentina stated this: "cell abnormalities and then the potential for it to be hereditary, or running in the family line." Kelsey echoed the same idea when she said "it's hereditary. You can't get it from your bra being too tight."

Breyann mentioned that she had heard mammograms could potentially cause cancer and said "I know some people say when you press two bodies of tissue it presses a tumor and can cause the cancer to erupt. That's been a main concern but I don't really know if it's true."

While most of the women in this study indicated they did not perceive causes of breast cancer to differ from those of cancer in general, several mentioned factors not

known to cause breast cancer such as deodorant, birth control, and mammograms. Known causes of breast cancer include consumption of alcohol, high body mass index, weight gain, early menarche, late natural menopause, not bearing children or first pregnancy over 30, radiation, and hormone therapy (American Institute for Cancer Research, 2017). Heredity is also a cause of breast cancer mentioned by several participants. The hereditary link is often overstated by the general public because as many as 95 percent of the cases of breast cancer occur in individuals who do not possess cancer genes (American Institute for Cancer Research, 2015). In addition to misconstrued information that may be seen in the media, many of the misconceptions of the women in this study may be due to lack of attention to breast cancer messages or the absence of discussion with their physician due to the belief that they do not need to be concerned about breast cancer due to their young age.

The majority of participants said they learned about breast cancer through the media, followed by their doctor, friends and family, health fairs, personal research on the Internet, people with breast cancer, or work. The researcher assumed going into the study that the majority of participants would have learned about breast cancer primarily through the media. This assumption was due to the fact that the women were younger than the prescribed age for a mammogram thus leading to a lack of awareness or interest in breast cancer prevention or detection. The variety of sources contributes to a plethora of misinformation about the causes of cancer and how to prevent it thus further reinforcing participants' lack of knowledge of risk factors or preventive measures.

Gail said she learned from a combination of sources.

I would say a mixture. I learned a lot when my mom had it and I'd always try to come to her appointments and ask questions, because when I want to know something I'm going to ask questions. Then I've talked to friends who had family

members who went through it, and just reading and seeing what's going out there in the media.

Liana mentioned the media as her main source of information about breast cancer.

“Various forms of media. No one thing stands out as the general awareness of breast cancer has been raised publicly over the years.”

Amber said this: “I've been given information from my doctor, my gynecologist, and then [my workplace] provides us with lots of information.” Karah also got information from her doctor. She said this:

I do personal research along with talking to my doctor about it. When I go to my gynecologist sometimes we'll discuss it or just my own firsthand research. I have heard a few things in the media, but honestly I don't really put too much faith in the media.

Jacy learned about breast cancer from her family.

The first I heard about breast cancer was through family when my great grandmother was diagnosed. Then when I got older you have health class, but I did not really try to Google or get any understanding until my mother was diagnosed.

Breyann credited personal relationships with her breast cancer knowledge:

I've learned a lot over the past couple of years because I've had two or three friends with it. I've had two friends who passed from it and then a friend who is still living with it. So it's a lot of information from that.

Valentina, who also had knowledge from a friend, said “I had a family member of a friend who passed away from breast cancer a couple of years ago, so I learned quite a bit from her.”

Laquita had received information through health fairs at her university or church, while Jillian was informed through her workplace. Jillian made these observations:

Last year we had a speaker come to [my workplace] to talk about breast cancer and treatment, preventative things like taking steps to figure out what your chances are of getting it if your mom had it. I get it from work and different conferences where there's some kind of video you watch or you hear someone's

story and then social media through friends talking or telling the story of somebody that experienced it.

Malaya said she did not feel she knew that much about breast cancer. "I don't know if I have learned too much about it. I do know to do your annual breast exam, which I don't do, or your breast self-exam. But that is about it."

As expected, the majority of participants learned about breast cancer either through the media or through personal experiences. In both instances there is potential for wide knowledge gaps due to misinformation. In addition to confusing or incorrect information broadcast in the media it is highly likely that women who have breast cancer do not understand the causes of their cancer.

To further understand participants' knowledge of breast cancer they were asked to name the symptoms of the disease. The majority of participants mentioned that a lump in the breast or under the armpit and nipple discharge were symptoms of breast cancer. Other symptoms mentioned (in order of frequency) included discoloration, inward nipple, breast pain, uncomfortable tissue, dizziness and headaches, dimpling breast, breast tenderness and soreness, rash, and itching and burning. One participant was unable to name any symptoms of breast cancer, and one indicated there were no signs.

Gail said she had recently researched the symptoms and reported that "I know if your nipple starts to go inward, of course, a lump, if they feel a hardness, if your nipple is oozing, dimpling in the breast."

Jillian related a story about a friend in college who had ignored symptoms.

I had a best friend in college that got diagnosed pretty young with breast cancer. For a while she felt her breast being hard and not doing anything about it. So by the time she went she's at Stage 2. She was not paying attention to herself. Carrying on with life and not putting your health as a priority. She did not even go until she spoke with her mom and her mom was like "your breast is not supposed to be that hard." So that's when she ended up going.

Kelsey was not aware of signs of breast cancer and said “I mean there are no true symptoms but other than you might feel you have a lump or you might have pains in your breast, but it’s not going to be oozing or anything from your nipples.” Devon was unsure and said “perhaps a lump. This is sad, I don’t know. I don’t personally know anybody that really experienced it.”

All of the participants believed mammograms were good at finding cancer, but one participant voiced concern about the actual mammogram procedure. Breyann said that “Sometimes people think it might cause cancer because they might already have tumor that may have been dormant, but with the machine it tends to squeeze so much typically.”

Scientific research has identified various known causes of breast cancer as well as preventive measures that can be undertaken to prevent the disease. While many women assume that breast cancer is hereditary and that nothing can be done to prevent it, medical science has determined that only 5 to 10 percent of cases of breast cancer are due to genetic factors (American Institute for Cancer Research (2015). The women in this study are basing their health decisions on little to no accurate information about risk and prevention factors for breast cancer. Much of this misinformation can be attributed to media confusion in reporting about breast cancer as well as personal experiences where little is known about the specific etiology of the individual’s breast cancer. All of these issues limit the women in this study in their efforts to enact behaviors which may lessen the chances of contracting breast cancer. The finding of little knowledge of breast cancer and misunderstanding of the causes was expected as this has been discussed in the literature from studies with older Black women.

Theme 2: Lack of comprehensive media information may contribute to higher

mortality. When asked to describe information they may have seen in the media about breast cancer, participants mentioned several motifs, including (in order of frequency) mammography screening, strong women fighting for survival, Susan G. Komen, the color pink and pink ribbons, encouragement to get checked, hair loss from treatment, urging for early detection, breast cancer affecting many people, signs and symptoms, a hospital that treats cancer, fundraising walks, “anybody can get it” messages, and information not related to self. Nina made the following comment:

Most of the images I think of have been positive images. They’re warning people, women should be aware. They’re trying to put it on women that they should go ahead and get mammograms, go to the doctor if you feel any type of pain or lumps. Please go early, like cautioning, please go get it checked out. They wanted us to be better safe than sorry. So most of the stuff I’ve seen as far as media has been very informative.

Coleen indicated that: “I think the messages I’ve seen have been trying to get people to make sure they go and get the mammograms. They’re aiming for people over 40 mostly.” Breyann also mentioned mammograms, and “a lot of the stuff that I’ve seen are using support groups, encouraging the mammogram, self-exam, things like that.”

Several participants remarked that strength and survival were stressed in the messages seen in the media. Jillian mentioned the following:

The images that I see, they show you the survival part of it. So they’ll show someone who had cancer. But there’s little coverage on the fight. They’ll tell you you’re going to get diagnosed, but what happens after you get diagnosed. What kind of treatment? We know that you’ll do chemo, but not showing the fight, and I think the whole not showing that, kind of prevents some people from taking it seriously.

Karah echoed the idea of strength and survival.

What I’ve seen has been women who have handled it pretty well and have gone through the process, gone through the chemo, came out cancer free. You know, just living their life. I’ve rarely seen any images of a woman that is depressed or

down and out because she found out she had breast cancer. It's mainly just the image of strong women that have conquered it, overcome it, have survived it, and now they are an advocate for it and they are just making sure they get the word out to get checked.

Shaniqua also took away the message of survival.

My main image was a survivor image of races of women who have overcome something that was supposed to be a negative or something that took them out of the game, and they're not only not out of the game, but they're in the game and they're still fighting.

These images of strength and survival create a mental schema, or cultural model, for those who have not experienced breast cancer in a personal way. Media images imply that strength equals survival which may lead to feelings of invulnerability among young Black women, thus making messages about prevention and detection less salient.

The Susan G. Komen foundation's charitable walk was mentioned by a few women. As Cassandra recalled: "I've seen things on TV, billboards, and again, because I work for a health insurance company, have seen a lot of information...some of the ads they were running were for the Making Strides campaign or the Susan G. Komen campaign." Zandra also mentioned the walks: "The Susan G. Komen is the first thing that pops out of my head and the ribbons, the pink ones, they wear for breast cancer awareness and doing the walks, that's what comes to my mind."

Imagery, such as the color pink, was prominent for several people. While this "branding" image had strong connotations for participants, no one could associate specific knowledge about breast cancer with the pink imagery, such as prevention or detection methods. It was expected that participants would have a somewhat vague awareness of "pink" messages seen in the media as few images of Black women are shown in the majority of the activities associated with pink campaigns. When asked what she remembered seeing in the media, Rebecca responded in this way:

Nothing is hitting me, besides what I might see on social networks with somebody posting a pink ribbon. I can't specifically recall anything on television with regards to breast cancer awareness besides social media and at work where one of the sites at work mentioned something about breast cancer awareness.

While the media has done an admirable job of broadcasting that women should "get checked" women who do not see themselves as candidates for breast cancer find no relevance or resonance with the message. This is another example of the scant information parlayed by the media about breast cancer that leaves a wide knowledge gap for those most impacted by the disease.

Laquita noted this: "I've seen commercials about getting checked, doing your yearly check with the doctor. That's all I can really recall." Amber also remembered the "get checked" message:

I see a lot of commercials of women – are you aware of this killer that's affecting a lot of women? A lot of the commercials that I see about lung cancer are more scare tactics, trying to scare you to stop smoking or you're going to die. But I noticed with the breast cancer commercials in social media it's more of a woman saying "please just go get yourself checked up."

Images of women with hair loss came to mind for several participants. Gail acknowledged this: "Usually pink is the color...the color association. Usually it's someone with breast cancer who's been through chemo. Someone who has had hair loss." Chelsea recalled a message that said this: "'Donate to breast cancer research' or showing women without their hair saying that 'You're still beautiful even if you don't have hair.' "

Valentina remembered fundraising campaigns as well as a local newspaper series about a cancer victim.

The things that I remember most about breast cancer in the media are typically fundraising campaigns or breast cancer awareness. Campaigns for different runs and walks that happen in different cities. I don't feel like I typically get good

medical kind of information about breast cancer in the media. The local paper in Louisville followed a [White] woman here who was probably my age, physically young, and she was diagnosed with breast cancer and they followed her for a year before she passed away. I remember being struck about that. [I related] in the sense that she was somewhat young, she was a mother, so I definitely empathized.

Jillian responded that what stood out the most for her was the message of

“anybody can get it.”

I think of one of the commercials where it’s a bunch of ladies that have on undergarments and they all have said, “I have breast cancer, I have breast cancer.” And it is a different range of height, size, or shape. And it kind of makes you think, man, anybody can get it. You kind of think about it for maybe 15 minutes and then something else comes on, your show comes on, and it’s back to what you were doing.

Camella did not feel that anything she saw in the media about breast cancer related to her experience or worldview.

When I was younger I did not think that everybody had breast cancer. I thought that people like White, blonde women get breast cancer... Later on I realized that breast cancer can hop into a real breast, and not just people that have had some type of [breast augmentation]. Now we know that every culture, every color of people are doing surgeries to enhance their bodies, but it wasn’t something that was very popular amongst my family and the people who looked like me growing up. Maybe that’s why I thought that. Now that we are talking about it, it doesn’t really seem to me that I have ever seen anything to do with African American or Latino women on breast cancer or breast cancer survivors or any type of cancer, as a matter of fact. I don’t even really think I can specifically say that seeing these things in the media is specifically related to me.

When asked to name the first image or message that came to mind about breast cancer in the media, the participants in this study focused on messages about getting a mammogram, strength equals survival, charitable walks, the color pink, and the idea that anyone can get breast cancer. None of these messages or images remembered by the women in this study is targeted to a specific segment of the population, but provides a generalized message. The approach does little to actually address some of the key issues about breast cancer, such as what causes it, how to prevent it, and who is most

susceptible. As such, media exposure to messages that promote survival or that express a message that “anybody can get it” lack cultural relevance for the women in this study because they do not see themselves in the images portrayed. This supports the researcher’s initial suppositions as it relates to the lack of relevance of media messages for the participants in this study. Selective information found in the media about breast cancer does not explain the high mortality rate for young Black women nor thus making the messages irrelevant to them.

Participants were asked if what they saw in the media made them feel that they needed to do anything about their own breast health. Those that did not feel influenced reiterated Laquita's sentiments: “I don’t think right off, but subconsciously I’m sure it affected me. I do get my yearly. I’m like, ‘well, I’m already doing it,’ I guess that’s what the thought is. So I don’t think the commercials make an additional effect on me.”

Several participants mentioned their lack of family history of breast cancer as a reason for not feeling they needed to take action based on what they saw in the media. Karah felt that “I do the self-check every month. Because I don’t have any type of family risk I don’t feel like there’s anything else I should be doing other than the main things my doctor tells me to do, to be proactive, I just keep doing that.”

Shaniqua did not feel that she was a candidate for breast cancer, but said she may have been affected: “...in a very surface way, not very, very deep. I don’t think they really affected my personal breast health concerns because I did not think I was the target that needed to be concerned with that, not yet.”

Many participants, while they had some level of concern about the messages they saw, did not believe they could do anything to prevent getting breast cancer. Monique contended this:

I want to make sure that I'm doing what I need to do to make sure I don't get cancer, but at the same time I think I could do all these things to help me not get cancer but if I'm going to get it, I'm just going to get it. I mean, I hate to be like that, but I feel like I could do all these preventive measures to not get it, but if I'm going to get it, I'm going to get it. Where do I go from here?

Several mentioned they did not think the messages gave enough information for them to take any sort of action. Susanna indicated the following: "It's a little bit concerning because I would like to know the risk factors for my culture and other cultures as well. What other cultures are being affected and if we could all be depicted given the statistics; that would be great information to know as well."

Susanna's reaction underscores the need for media messages to contain more explicit information that would provide enough information to encourage viewers to take action other than getting a mammogram. While screenings are an important preventive measure there is a lack of messaging about how to prevent breast cancer that applies to all ages and races of women.

Participants were asked to recall what they saw in the media and to indicate who would be the most likely candidate to get breast cancer. The researcher initially assumed that participants would mention White women as the primary recipients of breast cancer, and, as suspected, the largest majority of participants felt that White women were portrayed more than any other race, and this led them to believe that White women were more likely to get breast cancer. Zandra noted that, "From the media aspect completely it does seem like more White women do get breast cancer." Gail reiterated the sentiment of seeing older White women: "Honestly, the person you see with breast cancer is the Caucasian woman. Like, you really see an older Caucasian woman, like in her 60s, 50s to 60s."

Amber recalled the following:

A lot of the commercials you see White women. I mean, you don't see a lot of African American or Asian or Black female people in all these commercials. A lot of them are White women. I have a little bit more knowledge...but if I was someone that did not have full access to medical care and did not really have anybody telling me about it, I think I'd probably be angry because I feel like it does affect Black women just like it does White women and why not make Black women more aware of it, or any other culture more aware, that it could potentially happen to you too.

Monique did not remember seeing a mix of races: "It's all White people. I don't see a lot of minorities really. On these commercials, I just see a bunch of White people with bandanas over their heads because they've been going through radiation and they don't have no hair. I mean, I'm being real."

The media focus on White women most likely reflects the fact that more White women are diagnosed with breast cancer. What the emphasis on White women fails to address is the higher mortality rate among Black women versus White women. Because the women in this study do not see themselves in these messages they are likely to ignore information about breast cancer.

As noted, several participants said the images they saw did not reflect their own race, but because of personal experience this did not influence how they thought about who acquired breast cancer. This indicates that a strong cultural model of breast cancer affecting Black women has been created by Black women who have experience with breast cancer that excludes a large portion of this population who have not had personal exposure to the disease.

Cassandra noted the following:

Most of the campaigns don't look like me at all. I guess because there has been a history [of my mother with breast cancer], I can't say I turn a blind eye to it. But because there has been history, I don't pay attention to who they are targeting it for. I pay attention to, it's not time for my annual but I need to make sure I get it. I need to make sure that, "hey mom, did you schedule?", "hey granny, did you

schedule?" As far as commercials I've never listened to African Americans on why they die of breast cancer, never paid attention to that.

Further lack of comprehensive information in the media was reinforced by the images of middle-aged White women seen by many participants. Jillian stated this:

To be honest I rarely see a Black woman or a Black lady being on those commercials or those ads. It's normally a middle-aged White woman. But even so, I think it's a mother, a wife. It still personalized it, but it would be better if I saw someone that looks like my mother or my grandmother.

Kelsey reiterated this sentiment: "Essentially if you're over 40, or significantly over 40, maybe 50 or 60, it's mostly women they portray, the silver haired people."

Zandra did not feel that what she saw was relevant to her because the images did not look like her.

What comes to my mind, and I hate saying it, but it's the truth, is that it affects White women more. Because that's what you see out front, the first picture I see is a White woman...When you asked me earlier why you think that you couldn't get it, subconsciously my mind is like, well, that affects them more than it affects me.

Several women saw younger women, some Black, and others of various races. While these images do indicate that breast cancer impacts a wide range of women, the images alone do not impart crucial information that singles out women who are most at risk, such as young Black women. Karah said "Really, for me it's been mixed races. I have seen African American women. I don't really think I have seen so many Hispanic women, but mainly just Caucasian and African American women."

As it relates to information they may have seen in the media, most of the participants said they were drawn in when they saw ads about breast cancer. Breyann said "I'll probably wonder if anything like that could happen to me." Valentina shared the

following thoughts on seeing a story in the local newspaper about a young White woman with breast cancer:

It resonated with me because that was around the time that a friend passed away from breast cancer and shortly after my father passed away from cancer.... I guess it was kind of disheartening to me because my friend was a very public figure, she had done a lot in the community and worked in radio, and for the paper to portray this young White woman in a series and not highlight the African American women who were also patients with these issues was a little disheartening.

Jillian gave the following summary representing what she had seen in the media about breast cancer:

Usually on the emotional side. But I'm very analytic so if I saw numbers, like comparing, we have more White women being diagnosed, but more Black women dying. If a thing like that was said, we're going to listen and look and think, "okay, I need to fix this. I need to take this serious and I'm in that number." I think that would push me to pay more attention and then do some research to see what else I can find out. But when you do it on emotions, I have the feeling it's not me and I carry on. So I think if we do the numbers on Black people it'll be more effective.

Amber gave this description of her reaction to the information she sees:

[It] causes me to be more conscious. With the lung cancer thing you see the trach in the throat and losing their hair, or you see horrible images they put across for those. I don't see those same images for commercials about breast cancer. If you see these women that might have a bald head or something like that, the images are not as graphic as what you see for lung cancer. It makes me feel like I really need to make sure I stay on top of it. But I hate that's kind of reality, but when I see it on the news or see a commercial a lot of times it doesn't make me feel anything and it doesn't affect me because it's White people on TV.

Gail, whose mother had breast cancer, asserted this: "I'm definitely super hypersensitive to it, so it catches my attention right off the bat. It's kind of like that commercial with the sad dog face. It's going to get you."

Juliet said she is drawn into a lot of the commercials she sees.

As far as the woman with the mastectomy, it draws me in because it give me a sense of hope, as far as the perspective of being in that situation because at first I thought it could be scary and just thinking of that as possibility, but to see them that kind of makes you feel hopeful if you were ever in that situation, you can

persevere through it.... It draws me in not because I'm so unhopeful, but because I guess it's just the sadness of those that just found out and those that are going through it, sadness and sympathy. Hearing the personal accounts when they're sharing how they feel, I can relate to where they're coming from because I can only imagine how I would feel in those type of situations.

The emotional appeal of many breast cancer communication messages in the media does have an effect on some of the women in this study in spite of the fact that the women portrayed may not be young or Black. While this indicates that participants in this study are capable of showing empathy it misses the mark when it comes to encouraging them to take action about their own health. Jillian's comment about being more analytical may offer a more hard-hitting approach that would have greater impact and more long-lasting memorability.

Laquita, whose two grandmothers had breast cancer, said she couldn't recall any breast cancer commercials, but remembered "the ones for smoking where there are the scare tactics where a lady is talking about the way she found out and the one that has the trach or the teeth in the sink."

Gail said that a lot of the images she sees are White women, but

even though that's what's portrayed in the media I've seen cases where there's been people even younger than me who's gotten it. I mean, that's what the media would make you think. The media do have the gift of persuasion, but I never thought that since that's what's being portrayed that I'm in the clear. I don't think anybody's ever in the clear when it comes to anything.

Liana reiterated Gail's sentiments, and she also made the following comments:

Based solely on just what I see in the media I wouldn't necessarily feel like 'okay this is something that is going to impact me.' But based more so on just personal experience of the people I've known who've been impacted by it, I definitely know I could be in that number.

Events such as the Race for the Cure® or Breast Cancer Awareness Month in October are widely covered by the media, and virtually every participant was familiar with these types of activities. Juliet remembered this:

I usually take away a sense of knowing that, you know, that fight is still going, because of course there are many forms of cancer but you don't really hear about the others as much. I wish all of the forms had that much support because there during breast cancer month it's everywhere and I think that's beautiful that that many people get together to show support and stay in solidarity with them.

Lucinda commented that although these types of events give people information and educate them,

I just feel it's more commercialized than it should be. It really should be more important. It should be, this is how you do a breast exam. I know what breast cancer awareness is but I don't think it totally educates.

Zandra asserted that although she knows these types of events are designed to raise awareness, she doesn't feel that the Black community is part of them. "I want to say it doesn't come off as if it is. Also, the majority are White women. But we want to be inclusive, that one can be a part of it too."

Chelsea explained why breast cancer events draw her in:

It's an emotional topic. So I definitely look and think 'can I donate, can I volunteer?' I do the breast cancer walk, like what can I do to help?.... I think it can be anyone, I think it can affect me on this. I want to find out more about it, are there preventative methods?

While many participants felt there was a lot in the media about breast cancer, the majority of participants did not believe the message of Black women being at risk for breast cancer was getting across, as was assumed by the researcher. Juliet said: "I think it does a good job of bringing awareness to it. I don't think that there's much out there that really targets African American women to make them aware of just how at risk we are."

Shaniqua was in agreement when she said this:

Based on what you've told me I would say no, because I had no idea. I'm actually pretty shocked. This conversation wasn't anything that I've seen in the media. I plan to look a little further into my own personal health and talk in-depth to my doctor.

Devon responded this way:

I don't think so. I'm not so into some of the things being shown in media or TV, but some of the things I see I think do a good job of painting this broad scope of who it affects but doesn't necessarily hone in on younger people and the fact being something they need to consider, or to a certain race. No, I wouldn't say they do a good job of saying it affects all women, not necessarily any specific age or race, not from what I've seen.

Several women felt that while mainstream media does not typically promote breast cancer awareness to Black women, Black media was doing a better job of getting some information out. Valentina determined this:

I would say specifically with some of the Black media. In the back of my head is some stuff, I'm not sure what channel it was on, but it was basically Black women doctors trying to have conversations with people about mammography for breast cancer in the African American community.

Amber was in agreement with Valentina's assessment of mainstream versus Black media.

Not in the mainstream. I don't feel like in the mainstream, like on your regular basic channels that you watch every day, in your primetime shows. I think there should be more information that's put out there. As a Black woman, unless I'm sitting here watching BET you don't see those messages at all. There's a lot more opportunities that should use their platform to let us know.

According to Gail, however, there are some Black publications that do cover breast cancer.

To be honest, I've never really seen an ad unless it's an African American publication. I don't think that I have ever seen the generalized commercial like that come on TV that says "African American women, this is for you." They make general commercials for women in general but then again that's when you come across that Caucasian woman who's in her 50s or 60s.

Several participants were concerned that the media has not done a good job of presenting the facts and figures about Black women and breast cancer. Monique said this:

If you don't see it and they don't show it – information that you gave me about African Americans – that we are the ones who die from breast cancer most, I wouldn't have known that. I want to know that, but they don't ever show it.

Coleen indicated her agreement when she contended this:

We're dying at a faster rate. We're finding out so much later. It's like one of those out of mind kind of things, and if it wasn't out of sight, out of mind for us, if it was put more in our face, like statistics for African Americans, they would pay more attention to it.

Lucinda felt diabetes awareness was more prevalent in the media for Blacks than breast cancer was.

I'm a numbers and a facts person. So I think if they show numbers and facts like—African Americans have a higher risk of dying with breast cancer than any other race – that is something important for people to know. I think we are pretty educated as far as diabetes in our culture because it's being pushed – African Americans have a very high chance of getting diabetes – but I don't feel it's being pushed for breast cancer.

It is not surprising that the message has not gotten out through the mainstream media that Black women, particularly young Black women, have a higher mortality rate from breast cancer than other races. However, it is rather perplexing that Black media outlets have not taken a more aggressive stance in getting the word out. The women in this study appeared to have had enough exposure to the media to recall breast cancer messaging at some level. As it regards Black media, it appears this is a missed opportunity to educate Black women, and young Black women in particular, about the causes of breast cancer and preventive measures that can be taken to reduce risk.

Although there is more awareness of breast cancer in general, Zandra thought the personal touch was needed to get the word out:

I'll say yes just because I feel like there's more awareness out there and there's more African American women that are being put out there are representatives, whether it'd be survivors of breast cancer or it will be a family member who's a survivor of breast cancer. But I'll say no because basically the buck stops there. You don't see representatives from Susan G. Komen coming out to African American churches on a regular basis or reaching out to African American sororities and wanting to be functioning in conjunction with one another. I don't see that.

Breyann indicated she thought social media did a better job of communicating about breast cancer.

I would say so, in a sense. Some people may not, because there's only so much information you can put out. Now maybe if it's Facebook you might be a little more engaged more so than if you see something on TV. Yes, I think so, from some of the conversations I see, some of the ads or awareness that are on Facebook that all people tend to engage in.

Laquita felt that the media did a good job of informing women about breast cancer, as did Karah. Laquita believed this:

Yes, I think so, because it's just so much more prevalent. All the radio, it's on social media, it's on the TV. So we are the generation of technology, so it's always there on the forefront and makes you more aware.

Karah expressed a similar point of view.

I think so because of the images that are portrayed of the women that have overcome it and survived it from the support of family, friends, their doctors, and even strangers who have reached out. There's different programs. There's different events that occur. There's different things to help them along the way of going through the chemo process.

In spite of heightened awareness, Chelsea maintained this: "No, because I don't think it's specifically geared, it's general, but it's not specifically geared to women of color." Jillian agreed with this assessment. "No, the stories are never targeted to African Americans. It's more of a general message on getting tested but it never goes to the African American women."

Although several participants did believe the media did a good job in getting the word out about breast cancer they did note that media messages targeted to Black women were essentially nonexistent. Even though the awareness of breast cancer is high, in general there appears to be no specific focus in the messaging other than to get a mammogram. This lack of comprehensive information, such as causes and risk prevention messaging, was noted by the women in this study despite their level of awareness of breast cancer.

Participants had several suggestions about getting the word out to young Black women about their risks for breast cancer. Social media was the most mentioned method, followed by including the message in television shows, and outreach through schools, health fairs, churches, and community events.

These were Amber's comments:

We're in an age of social media, and I think that is the easiest way for it to spread out and go viral. I mean, honestly, I'm on my phone or my laptop more than television. But for the younger generation, I think that's probably the quickest and easiest way to get a message out, through social media.

Lucinda thought celebrities could bring attention to social media messages.

With social media get maybe celebrities that a lot of the younger generation follow. Because if I see a doctor on my page I just going to keep scrolling. If I see something that I am familiar with I have more of a chance of stopping and reading it.

Integrating a storyline about breast cancer into television shows was also suggested.

Coleen speculated about it:

Probably now it'd have to be through social media, or, to be honest, their favorite TV show. People love Empire. Maybe Cookie could have breast cancer or something. It'd have to be something like that where people will constantly see on their favorite show.

Laquita indicated her agreement when she said “I’m sure that even in Blackish that could be part of their show to bring it home, remind us of everyday issues.”

Valentina suggested getting community organizations to spread the word.

I would think health fairs are probably effective in some regards. Or schools having information in high school classes or colleges having that information available for everyone, and churches too. Places of worship. I feel like TV and radio you can change the channel, so those are probably the best ways.

In addition to community organizations, Zandra thought working with Black media to spread the word would be effective.

I think getting out in the African American community just in general. Like going to community centers and having programs or functions that bring awareness to it. Also being more inclusive with the Black media because there’s African American radio stations and TV shows. So being more inclusive that way, being more involved and having a relationship by going through those organizations and people.

The women in this study were media savvy and articulated several noteworthy methods of improving the depth and breadth of breast cancer messaging for Black women. Since the mainstream media has done a poor job of filling in the gaps, more targeted methods such as social media, as mentioned by participants, appears to be a viable alternative.

Because participants did not feel the media presented a comprehensive picture of who is at risk for breast cancer, several leitmotifs emerged when participants were asked what young Black women should know about breast cancer, including (in order of frequency): (a) it can happen at any age to anybody, (b) the risk is high for Black women, (c) need to know the cause, and (d) need to be knowledgeable about breast health.

The idea that breast cancer affects everyone and not just those portrayed in the media was stressed by Gail:

It's not just the lady on the TV. I mean, it could be anyone.... I'm sure at this point, somebody knows somebody who's had it. Even if it's not your immediate family, you know or have met or have come in contact with someone who's had experience with that. So you can kind of glean, "Oh well, this person doesn't look like that media portrayal." So you're likely to say, "Oh, breast cancer can look like this."

Because breast cancer can happen to anyone, being proactive was important to Karah:

It can happen to anybody. There is no age limit. I think it should be relatable to the younger generation to make them understand the importance of getting checked, the important of staying on top of it making sure you know if it runs in your family. Just being proactive versus reactive. Make sure you do your own stuff like the self-exam every month.

Following the "it can happen to anybody" theme, staying on top of screenings was important to Amber:

That it can affect anybody and it's very important to make sure you stay on top of your exams and your screenings. It can affect you even though you feel like you're immune to it and a lot of us feel like it would never happen to us.

Knowing your risk was another important issue participants felt young Black women should be aware of about breast cancer. Juliet made the following remarks:

I would say knowing how at risk we are. When you asked who do I see when I think of someone with it, I thought of younger White women I guess because they're diagnosed more. That might be why we see it a little more, but when you see something a little more than others that tends to put it in the back of your mind that it's not as common for me as an African American women, but that's obviously not the case....We're dying from it at large numbers so that's something we don't really know.

Devon said she hears more about her risk for diabetes as opposed to breast cancer:

The risk, the fact that, the shock factor that being younger. That shock factor kind of wakes people up, to listen, to be more alert and aware, to bringing it home in terms of how serious it is. Because sometimes we think "oh, I'm fine. My chances are not that likely" or you may just dismiss it as something to even think about. From my experience and all the women in my family, the main thing I hear about is diabetes and high blood pressure, but not necessarily the risk or likelihood [of breast cancer] or how it impacts us younger.

Valentina noted that even if you are not genetically predisposed to breast cancer, there is still a risk.

It's important for them to know that you can never be too sure. I think even with my own knowledge about it, even if it doesn't run in your family, there's still the potential that you are at risk for it. So you should get checked out if you need to.

Shaniqua said that she looks to her doctor to inform her about health risks.

I think you don't do anything because you don't know you're at risk. If my doctor is the professional and I'm the patient, for instance, when I take my car to the car place I'm expecting you to give the report on what needs to be done or not done. Same with my doctor. Unless I have a symptom or something that would make me want to push this further with you, I'm going to take your word for it.

When it comes to knowing the cause of breast cancer, Laquita indicated this feeling: "The fact that I don't know what causes it, I think that would be the number one thing. It's hard for you to stop something if you don't know what's causing it." In her comments, Chelsea also focused on the cause: "Causes, what you can do to prevent it. Can you quit smoking, can you eat healthier, less alcohol? Just information like that."

Zandra indicated that she was also unclear about the causes of breast cancer:

Like myself, I believe I've realized that I'm naïve and unaware with a lot of how you can get breast cancer. How can you possibly prevent breast cancer, what steps can you take to have a more active role in preventing it?

Being knowledgeable was a key factor for Breyann and Jillian. Breyann made the following statements:

Basically just stay up on your self-exams. Do your own research. The more you know I think the more prepared you'll be. I can't say prepared, but more knowledgeable you'll be in case anything comes up in your own health.

Jillian was insistent: "More of us are dying. Just knowing that we're not getting ahead of the problem early. We're dying from it. So just educating about the need to get in front of the problem." Violet was in agreement and concluded this way:

Everyone knows someone who has been affected by it, but when you start to describe a lot of the statistics that are relevant to our population specifically, I think that can be very motivating. It's saying "hey guys, you need to go and talk to a doctor about a mammogram."

Camella mentioned the lack of health insurance coverage:

The fact that women can get it and it's not just one specific demographic. I think it would help African American women and women in general to let the story out about the 22- and the 25- and the 28-year-olds that do have breast cancer. I think the biggest misconception is that because your health insurance doesn't pay for your mammogram until you are 40 that you don't have to worry about breast cancer until you are 40.

While the women in this study were aware of breast cancer messaging in the media, the communication they have been exposed to is lacking in providing a full picture of the disease. In the mainstream media the primary message appears to focus on getting a mammogram so it is highly feasible that many White women do not know what causes breast cancer or risk reduction strategies. Because more White women are diagnosed with breast cancer, the simple message of getting checked resonates with that population to a greater degree than for Black women. And while mammograms have been shown to be an effective preventive measure for White women, because Black women present with more advanced cases of breast cancer at a younger age, further education through more targeted comprehensive messaging is needed to reduce the high mortality rate of this group.

Themes 3 and 4. As participants experience breast cancer detection health campaigns, these observations (Themes 1 and 2) are filtered, or influenced by, their personal experiences (Themes 3 and 4) with breast cancer. Themes 3 and 4 represent their lived experiences and how they are influenced by what they see, hear, and believe about breast cancer messages in the media.

Theme 3: Personal experiences drive perceptions of who gets breast cancer.

When asked if they knew anyone who had breast cancer, nearly all indicated they knew someone who had been diagnosed with breast cancer. Among those who knew someone, it was either a family member, a friend, a friend's family member, a coworker, or a church member. This experience of knowing someone who has suffered from breast cancer colored their view of the disease.

Those who observed someone with breast cancer indicated that those diagnosed showed strength in the face of adversity.

Chelsea, who said that a 34-year-old Black coworker had breast cancer, shared these comments:

I think for being so young she handled it very well, had a positive attitude, was upbeat, just really strong. I don't know if I could be that strong, but she came through and she was really positive about the whole thing.

Coleen's sister was diagnosed with Stage 4 breast cancer at age 31, and this is what Coleen remembered:

She fought. She was a fighter. She handled it well. I don't think she knew how bad it was at the beginning, but she fought. I'm sure she was devastated and knew she wasn't going to see her kids much longer. She lived about a year and 2 months or so.

Juliet's friend's sister was diagnosed at age 30, and Juliet described her friend's sister's behavior after the diagnosis this way:

It was really hard on her. She kind of went into depression where she was isolated and not really wanting to talk to people. When she started to go through treatment she was really sensitive to certain things so she had to be away from people because she couldn't take the noise.

Ranisha reported that a coworker had breast cancer:

She had just found out, and I remember one day she just broke down and I said "don't worry about it, I'll take care of your workload." Just seeing her going through that we became very close and I would pray with her and ask her how she was doing. Until this day I still check up on her and thank God she is in remission. Not a lot of people were very empathetic with her and just seeing her going through that alone at the workplace, it was hard to see it and I know she was a fighter. She has a strong personality, but she's a very sweet woman and she was still very gracious.

The concept of women with breast cancer being a "fighter" was mentioned throughout the interviews with study participants. The "fight and survive" motif was noted by scholar Annette D. Madlock Gatison (2016) when she said

Black women are fighting ever-present stereotypes that they must look and behave like a strong Black woman in America regardless of how unwell they may be. I contend this is detrimental to Black women's breast cancer recovery and long-term survivorship. In addition it also impacts the prevention of breast cancer and other diseases in Black women because they are perceived as being able to handle anything that comes their way, even when their lives are in jeopardy. (pp. 11)

In addition to being strong, participants mentioned that the women they knew with breast cancer were "positive." This goes to the practice that is prevalent in Black families about not discussing illness (see Theme 4) in a realistic way or trying to cover up the true nature of an illness. Strength and positivity are most likely generational norms passed down from mothers to the women in this study who are daughters, thus creating a cultural model that says to survive one must be positive and show strength in the face of adversity. In fact, according to Gatison (2016), "there is a faith tradition that also silences perceived negative talk about illness" (p.39).

Again, based on personal experience, when asked what age women were most likely to get breast cancer, the majority of participants felt that women most likely were diagnosed with breast cancer from age 40 to 50, followed by 30 to 40. A few said age 50 to 60, and several said any age. Chelsea said that "You see women in their 20s and 30s

now but we've always been told to get your mammogram when you're in your 50s. But obviously women of all ages are now getting cancer." Nina had these thoughts:

I don't think cancer, breast cancer, or any cancer, is based on age. I mean, most of the women that I hear that had it are usually older, like 30 or older. But I know that there are younger women that get it too.

Experience with survival also influenced participants' views of breast cancer. For instance, most participants felt women who have had breast cancer had a good chance of surviving if caught early enough, or due to advances in medicine and technology. This finding is in contrast to the researcher's initial assumptions of fatalism, as has been shown in previous research with older Black women. As Gail said, "I feel like as technology advances and people become more aware, yes. Then it all depends on the stage it is caught at. If you catch it and you're the end stage there's not really much you can do." Laquita agreed, but had these observations:

I'm going to say yes, because I've seen so many women that have survived now. Also, unfortunately, I've seen too that there have been people who've gotten it again, and sometimes the second time around it comes back stronger or it spreads, and then they don't survive that. But yes, they can survive.

Coleen, whose sister died from breast cancer at age 31, expressed worries:

I don't think they've found the source or even close to finding the source and treatment for it. I don't think the treatment is as defined as it should be. If it's Stage 4, they can't take you down to Stage 3, 2, and 1. I don't think they have the technology or the medicine to get it back down or to get rid of it.

To understand the influence the media had on participants when it came to the image of women with breast cancer, because of their experiences with women who have had breast cancer, most participants did not have a particular age or race in mind when asked what a woman with breast cancer looks like. However, several mentioned White women of various ages, and a few mentioned Black women. "I don't have a particular

image,” said Laquita, “because cancer just affects everybody.” Amber made a similar remark: “I don’t think there is one. I think it affects everybody, Black, White, Asian, young, old. I mean anybody could be affected. I don’t think there is a race for it.”

Monique said “I always think of some White woman with breast cancer. I mean, it’s not the truth though. It doesn’t matter what color cancer is – cancer has no color.”

Gail also had no specific image in mind, but she said this:

I feel like a person with breast cancer could be anyone, any race. And I don’t see an older person, I see a person middle-age or my age – I don’t see older or younger. I see the person who plays in a Maybelline commercial. I don’t see any specific demographic or people. It knows no race, color, or ethnicity.

Shaniqua said she sees multiple races of women. “Honestly, I was thinking of Angelina Jolie. There was something about her I saw in the news last year. But I think women with breast cancer, I see all shades of women with that.” Liana saw people across the spectrum.

I see someone who has lost her hair, someone who’s sort of thin, who’s frail, someone middle 40s. I don’t necessarily see a particular race. I guess the one that stands out mostly in my mind is African Americans because that’s my grandmother.

Breyann also saw a range of ages and races.

I have seen a variety. I have seen younger. I’ve seen older. It used to be older for me. That’s how I used to see it until I guess it started getting close to home and see people your age or younger getting it. I believe I’ve mostly seen Black women get it. That’s not to say there aren’t others out there, but that’s all I’m seeing now.

In contrast, Lucinda said she saw a 40 to 45-year-old Caucasian woman because “that’s mostly what I see. I can recall seeing obviously other races but I want to say probably that’s the more predominant in most commercials or ads, mostly in social media.” Camella, who also saw a Caucasian woman, said this:

I have known so many people that had breast cancer, breast cancer survivors. But when I thought about breast cancer just now for some reason I thought about a White, blonde woman, just like in every commercial shows you a White, blonde woman with breast cancer.

Zandra also drew her image from the media, and she noted this:

It's funny because, from the media the first thing I actually think of will have to be a White woman that is pretty frail and she's baldheaded from the chemo treatment. I wouldn't necessarily say she's old, so I would assume she's around 40.

When study participants did not rely on the recollection of women they had seen in the media with breast cancer they were able to respond with a more realistic view of who is impacted. This experience-based image of women with breast cancer was in contrast to the primarily White women depicted in media communication. From their perspective, breast cancer has no age or color, but is a ubiquitous malady inflicting women of all types.

Theme 4: Youth and culture are breast cancer risk factors for young Black women. A variety of topics were discussed to determine personal beliefs and cultural factors that come into play as it relates to participants' perceptions of breast cancer. Statistics from the American Cancer Society on breast cancer diagnosis and mortality were discussed, including the fact that more White women are diagnosed with breast cancer, but more Black women die. Among Black women, more under age 40 die. Participants were asked why they thought more young Black women died from breast cancer. The most frequently mentioned reasons for more young Black women dying from breast cancer were a youthful mindset and cultural issues. Other reasons cited include lack of awareness, lack of access to good doctors, mammography guidelines, lack of health insurance, not getting annual check-ups, type of breast cancer, historical medical testing with Blacks, and hair products.

Regarding the youthful mindset, Laquita said this:

I was wondering if that was because maybe we still have that youthful mindset, that "I'm young and it doesn't affect me" and by the time it's caught it's later in the game and it's harder to treat once it's gone far past.

Karah made a similar comment:

Some people when they are young feel like they're invincible so they don't need to go to the doctor as much as maybe an older person may need to. So I think not catching it early enough...is really the main cause of it."

Malaya said that "We don't think it is us...it's not a young person's disease." Lucinda also discussed the youthful mindset as a contributor.

I think education because I think a lot of African American women that are probably around my age think "I don't have to worry about it," or they don't even go to the doctor, so they just skip the whole thing. "I don't need to go and get a pap smear. I'm good." So until they get to that point where something is wrong and it's too late at that point. So they are not getting the yearly check.

The women in this study exhibited a dichotomy as it relates to who is likely to get breast cancer. When speaking in generalities, participants indicated that they thought breast cancer could affect any race or age, but when referring to women their age they blamed the lack of awareness of breast cancer on youth and said "it's not a young person's disease." This presents a challenge for health educators as years of ingrained images of older White women must be overcome to convince younger Black women that breast cancer is not their mother's disease anymore.

Culture plays a key role in health and health behaviors – not only encompassing race and ethnicity, but also reflecting intergenerational learned and shared beliefs, norms, and methods of communication (Kreuter & McClure, 2004). Culture encompasses physical and social environments, common beliefs, values, traditions and world views, and similarities in lifestyle, attitude, perceptions, and behavior (Freeman & Chu, 2005). Cultural Models Theory, which focuses on shared meanings, indicates that the women in

this study created a shared meaning of the phenomenon of breast cancer in young Black women that includes the following four key areas: (a) lack of access to resources and insurance, (b) generational effect of not taking care of health, (c) familial taboo of talking about health, and (d) familial norm of not wanting to know about health issues.

Regarding access, Amber expressed these thoughts:

When you are in an urban area, and I came up in an urban neighborhood, they did not have access to healthcare or doctors. I had a medical card for a while for myself and kids and just noticed a huge difference of how you are treated when you've got Medicaid versus insurance. A lot of times you are walked into the doctor's office and dismissed. They don't do a thorough exam like they probably should. I feel like there's definitely a separation there.

Nina also mentioned a lack of insurance.

I think it's the fact that a lot of people don't have any insurance. So once you get your diagnosis, you're like "what do I do now? I don't have money to go and pay for any type of treatments." So a lot of women just suffer with it and deal with it in private.

From a generational standpoint, Juliet made these observations:

I have a higher education level than my parents, and as far as my salary, a little higher of status than they were at my age. Of course they learned from their parents. My grandparents on one side were farmers and then on the other side it was housekeeping. So growing up under them and not having certain access they might not have realized how important it was. Just like me, although I know it might be important and I have the access, I'm still not fully acting on it. I have the means to, but I haven't had a mammogram and I don't know if I'm supposed to have one by now. I think that when you look at the generational effect that even those of us now might have access to it but still might not know the importance because those before us did not have access and therefore they did not really teach the importance of it.

Health disparities, such as access to care, are well documented and undoubtedly contribute to higher breast cancer mortality rates among Blacks. Juliet's insights into generational learned health behaviors are notable and likely play a part in how young Black women approach their health today. The longstanding issues of lack of access and

lack of insurance have created a burden that many young Black women must overcome through self-education and self-efficacy.

Another phenomenon that several participants mentioned was the lack of willingness in Black families to talk about health issues. Jillian noted:

It's not something you talk about. Yes, I've talked to my mom and my mom talked to me. I talked to my sister, but, like I said, we don't talk about it with our friends. We don't have the means to influence someone that has an issue. And I feel like White women will talk about it. We just don't talk about this. That stuff is personal. So we walk around with it and don't get diagnosed and die.

Lucinda said the issue of talking about health is cultural.

My mom doesn't really talk about it and I know she gets it. I've heard her mention, "yeah, I've got to go get my mammogram," and she doesn't make it sound fun and she doesn't really say anything other than "I have a doctor's appointment today." So I know my mom has never told me how to check for it. I pretty much learned when I went to my first gynecologist appointment.

Nina said that health matters are handled privately:

They'll deal with it and deal with the pain and they won't talk to anybody. People are like "are you okay. You look like you're hurt." And they'll say "oh no, I'm fine." They won't talk about it because they don't want anybody to feel sorry for them. I don't know, just a lot of Black women have to be strong and won't get help from anybody.

Going beyond talking about health means actually admitting there is a health issue. "I have two uncles that had cancer," said Jillian. She continued this way:

Two of them have gotten treated and are in remission and everything. But I have an uncle – and my dad has been tested and the results came out successfully and everything. I have an uncle that refuses to go. He says he doesn't want to know. If he dies, then he's lived a great life. And so it's that attitude that we have to change, is the not wanting to know.

Amber also said family members often do not want to deal with the health consequences of their actions.

I don't know how many times that a lot of people in my family, oh my gosh, they'll be eating something and they'll say "here comes the food police" to me. You used to be brought up on cornbread and all the fried foods and just don't

think about the long term effect. So I'm just speaking of my family. I think that we kind of look the other way and think that is not going to happen to us.

The taboo against talking about health or not wanting to delve too deeply into health matters is another phenomenon that young Black women will need to overcome as they manage their health and wellness. The women in this study are independent and educated and appear to have the strength of will to pursue health differently than their elders. They must be prepared to talk openly about health concerns and be proactive in addressing their health needs if they are to change the generational patterns that have led to the increased morbidity and mortality among Black Americans.

In addition to cultural issues, Shaniqua mentioned lack of awareness and exposure to good doctors as factors that affect health-related behavior.

I think lack of awareness and hesitation that we're a prime demographic. And then I think of the other critical part about more White women get cancer but more Black women die because of a privilege factor of being exposed to good doctors and getting the preventive measures. African American people tend to wait too long and less can be done when it's Stage 4.

Lack of information or education was another issue mentioned. "I think probably just knowing more," said Amber. She continued this way:

I can honestly say that, me personally, if I did not have the current job that I have I don't think I would be as conscious of it as I am. Now, it's kind of just thrown my face in everything with what I do at [my workplace]. It's such a health conscious company.

Coleen thought the guidelines for getting mammograms after 40 could be contributing to more young Black women dying. "They think they can't get it because they're only requiring people 40 and older to get checked and they don't think it affects them." Gail also mentioned being told not to get a mammogram until age 40.

Probably because the way the media portrays it. Because you think, "oh, you don't have to check" and probably don't think anything about it. With our high stress lives that we lead I'm sure it's like a thousand factors as to reasons why we

don't pay attention to it, about checking up on ourselves too. I think probably the lack of health insurance and the lack of knowledge. There's several things going on there.

Cassandra also mentioned insurance as an issue for younger Black women.

"Maybe it's because we're not established in our careers well enough to have insurance, or good enough insurance." Valentina mentioned financial considerations:

I say for me even, I consider myself to be extremely health conscious, but I still feel the tug on my wallet every time I think about going to the doctor and have to decide if this is something I can afford right now, is it super necessary?

Another issue mentioned was not getting annual check-ups. Amber said "I think that I'm guilty of that myself. You're supposed to do it routinely, get your mammogram and get your pap smears done. I think we just don't stay on top of it like we should."

Chelsea indicated that she thought the type of breast cancer Black women get might be the cause.

I think it was on the radio they were talking about wanting women to donate cells to do a biopsy because they were finding more aggressive breast cancer in African American women. And it was just aggressive. As soon as it was diagnosed, the chances of survival were slim.

Monique described information a nurse practitioner told her about African Americans and cancer.

She said when it comes to African Americans getting cancer or whatever type of illness to the body, our body has been put through the most because they tested it [medications] on minorities. I hate to say, but White people gave it to minorities first to see how it would react in the body. So our body is more resistant to certain stuff.

Zandra mentioned hair products as a contributing factor.

There have been links in studies that fibroids have been known to be more so in Black women because of the relaxer that they're getting on their hair, so maybe that's something to do with that, chemicals or products that we use that are causing that.

Participants in this study expressed a myriad of reasons to explain why more young Black women die of breast cancer. Many of these causes appear to be historical in nature, such as lack of access to good doctors or medical testing done on Blacks. This rationale has become a cultural norm among Black individuals that, while not to be forgotten, must be reengineered by younger Blacks as a way to alter attitudes and change expectations.

In discussing personal health issues among family members, more than half of the participants said that health issues were not discussed among the women in the family. Participants related similar stories of family members not talking about what were considered personal matters. An additional issue of family members not being proactive or practicing preventive health measures was also mentioned as it related to personal health behaviors. The generational norm of not discussing health or acting on health conditions has created a mental schema that centers on the concept of silence for the women in this study, according to Cultural Models Theory. This creates a substantial barrier for these women when it comes to their ability to not only recognize health issues in themselves, but to engaging in healthy behaviors.

Lucinda related this story:

When my father found out he had cancer by the time [my parents] told my sister and I they had already set the date for the surgery. They already had been through a lot of the process. So they kind of sat us down and said here is what's happening and here is what we are doing, and pretty much this is the plan. So we weren't involved in a lot of the initial stages, because my parents, when it comes to health, keep to themselves. I think it's part of that older generation.

Amber indicated she experienced the same unwillingness to discuss health with her parents. "My parents are very secretive. So they kind of wait until they've exhausted the issue. You know, work it out before they let me and my sister know." Zandra said "I

think it's just a generational thing where like you keep your private business private.

And so they just don't talk about it." Coleen said "I think they just keep it personal.

They don't want anybody to worry."

Gail described what happened when her mother had cancer.

We knew about it and she told us, but it wasn't anything that was harped on. It wasn't like something that we'd discuss all the time and she kind of did what she had to do. She would go to chemo and all of that, but beyond that it was just kind of like, it's a thing and we just don't talk about it.

Malaya's response indicated she was uncertain why health issues were not discussed in her family:

I guess it's more of a secret. My grandmother passed away from cancer and we have no idea what type of cancer she had. So, no one talks about it. I think in my grandmother's case, I think she did not want us to worry about her. But I guess I would do the same thing. I probably wouldn't tell if something was going on with me right away. I don't know why that is.

Liana gave this explanation why health issues were not discussed in her family:

I think some of it is just because they're not all maybe aware of what their health issues are. I think part of it is cultural and then I think in many ways, food and eating is sort of like bonding and so that doesn't always mix with discussing health concerns.... The tradition in our family is it's just not something that's discussed. I wouldn't go so far as to say it's taboo, because if someone did need to discuss something they wouldn't be shunned, but it's just not Sunday dinner conversation, if you will.

Karah also asserted that there was little discussion of health issues in her family.

We don't really get into things like that if we don't have to go to the doctor's so there really isn't much to discuss. You know, my sister may talk about, "well I had to go to my gynecologist" or something like that. But other than that, it's nothing really like a thorough conversation about it.

When asked why she thought the women in her family did not talk about their health issues, Amber gave this explanation:

I think that it just kind of, without sounding too crazy, I think it sounds like a Black family thing. Honestly, we don't really talk about it as much as we probably should. I'm kind of more of the biggest health nut in my family and

they always shut me down because I'll be in the grocery going "oh my God, don't buy that, don't eat that, don't eat that." I'm telling them what restaurants not to go to and they just don't want to hear it and so I'll let it go.

Rebecca said her cousin passed away from a pulmonary embolism last year, but "it's never really discussed as far as what may have caused it or whether it's generated genetically." Ranisha said health issues were discussed in her family, but the discussions were difficult.

It can be a little patchy with conversations with my sister. I never want to overstep boundaries and I know that she can be a little sensitive. She just started suffering from high blood pressure and when I ask her "are you checking your blood pressure?", "are you taking your medications?", she gets very, I don't want to say defensive, but just doesn't want to go and indulge into it. My mom is almost the same but if I ask her she will indulge and she'll answer but she doesn't talk to me about her doctor's appointment and things like that... I don't know why. Maybe it's fear of prejudgment or fear of reality.

Ranisha added these observations about discussions of health in the African American community:

Not only breast cancer but it goes from all aspects, from mental health to fibroids. I do think that it is a cultural thing and I think that's maybe why it [breast cancer] impacts us a little bit different than other cultures because we aren't open to saying "I'll go with you to the doctor" or "hey, how is your health doing?"

The lack of discussion becomes a health risk factor for younger Blacks because they do not have the benefit of obtaining health information or learning from family members about health conditions that may impact them in the future. Perhaps it is enough that these young women recognize the lack of open discussion among the family about health so that they will be able to change this cultural norm within their own family unit.

Those who said they did discuss health issues typically did so with their mother, grandmother, or siblings. Trissa said "I try to get my aunts to make sure they get mammograms since my mother was diagnosed [with breast cancer] so early." Jacy said "my grandma just told me yesterday that she has an appointment to have her heart

monitored because some lady at her job had a heart attack and now she's gonna go get checked."

As noted, several participants discussed the idea of not thinking about the long-term repercussions of health behaviors. "We prioritize things and so we don't invest in our health," said Camella. "Everything that is programmed towards African Americans on TV and in the media is materialistic and it doesn't have to do with being healthier or saving for retirement. Like that's not something that we are ever encouraged to do."

Camella added this:

[It's] cultural because a lot of times I feel like people should self-educate. I think it's something we are not exposed to.... We don't have people around us that are interested in health. Most people around us are interested in "let's go out to eat." We don't have people around us saying, "I'm going down to my gynecologist and get a checkup." It's almost like a taboo subject and people don't talk about it. So if there are no people around you or people in your family that are encouraging you to do these things, sometimes it's just ignorance.

Cassandra offered the following:

Some of us take care of ourselves. Some of us go to the doctor on a regular basis. Then there are a lot of us that don't go to the doctor. A lot of us don't have access to healthcare. A lot of those say "I'm okay, go lay down and this pain will go away." I think that goes back to early detection. A lot of these could be avoided if you caught it versus having Stage 4. You just kind of avoid it and a lot of African Americans are not aware you should be tested or examined for the trait. If you've had a history you have to ask those posing questions and lack of knowledge sometimes kind of hurts us as well.

Trissa said being proactive about health is not talked about.

The only time you hear people talk about it is if they know someone who has been affected by this. Even with my own family, we don't talk about it the way we should. I may bring it up, because my mom had breast cancer. People are like "yeah, I'm going to get checked," but they don't take it seriously.

Jillian said that the lack of discussion comes "from the family. I've been working for an insurance company and I'm sure there's a lot of African American women here, I can tell you a lot of them aren't going to the doctor for their annual."

Not being proactive about health is another form of secrecy practiced within Black families. Because of the cultural stereotype that Black women must remain strong, to admit illness means losing face within the Black community. Again, perhaps the mere recognition of secrecy will encourage the young Black women in this study to swim against the tide.

Participants were asked if they talked about their personal health issues with Black friends. Table 9 compares health discussions with Black family members versus friends of the participants. In a nearly equal number of participants, if health was discussed within the family, it was not discussed with friends, and vice versa. Four participants discussed health with both family and friends, and one participant did not discuss health with either. This indicates that there is still a level of secrecy and silence when it comes to discussing health matters even within the generation of women in this study.

Table 9

Health Discussions With Family and Friends

Health discussions with		Number of participants
Family	Friends	
Yes	Yes	4
Yes	No	8
No	Yes	9
No	No	1

It appears that the majority of participants typically discuss health with either family or friends, but not both. It is likely that the lack of discussion with one group is a reflection of the cultural norms practiced by that group.

Regarding the discussion of health with her friends, Violet responded with the following comments:

If any of us are dealing with some concern that we have about our health it's not uncommon for us to talk about "what should I do?" or "what have you heard?" or what information someone has about a certain topic in terms of exploring options out there. I think, generally speaking, I know that me and my friends are trying to be more proactive about our health than our family, our parents and previous generations have been and so a lot of that is related to that focus of value that we have in common.

In contrast, Chelsea said she did not talk about health issues with her friends and thinks it is because "I don't know if they really want to address it. I guess out of sight out of mind. Maybe if they don't talk about things like eating habits or lack of physical activity that means it's not a concern."

To further probe about health discussions in the family, participants were asked if they would tell their family and friends if they were diagnosed with breast cancer.

Participants indicated they would tell their family, but would wait to determine their treatment options before telling friends, and some would not want to disclose their illness at all. Amber said she would share the diagnosis

with my family, but I wouldn't immediately share it with my friends. Not until I would know what to do. I wouldn't immediately as soon as I was told go running around telling everybody. I would first want to figure out a treatment plan. I would probably get a second, third, fourth opinion to make sure before I actually sit down and tell everyone about it.

Chelsea said she might tell "maybe one or two friends. Probably not. I'm a very private person, so it would probably just be family." In contrast, Gail would tell her friends.

I'm pretty close to my friends, so I usually tell them everything about me. But I would definitely tell my family because I'd want them to know and I'm pretty close to my work family as well so I'd tell them.

Those participants who had a partner indicated they thought their partner would be supportive if they had breast cancer. Amber said this:

I'm sure it would probably be stressful. My husband is very interested in what's going on with me, so I know that it would be hurtful to him. He just lost his aunt from cancer and they were very, very close, so I know that would affect him negatively.

Lucinda thought "it would be tough. But probably we would be able to get through it. I don't think it is something that would end our relationship. I think it would hopefully bring us together." Juliet said this:

I don't think it would affect our relationship in a negative way on his end. For sure he would be supportive and try to be strong for me, but on my end, it could be a little difficult to deal with just thinking how I would feel in that type of situation. I'd probably have moments where I'm kind of distant or isolating.

Laquita was unsure:

I would like to say that if we were married then it would just be, "well I'm in this to see it through." But we are not married, so I'm sure there's that possibility that he'd say "I did not sign up for this so let me see how it plays out, and if it's too much for me."

It is interesting to note that the young women in this study would discuss a possible breast cancer diagnosis with a spouse whereas older Black women would be reluctant to openly discuss. This finding is in contrast to the researcher's initial assumption that is based on previous research. For instance, Bailey et al. (2000) found that if a diagnosis was shared with a significant other that it is believe the male would abandon the woman, particularly if the cancer was cervical or breast. This is an example of a cultural model handed down that the women in this study rejected, noting that a

diagnosis of breast cancer would not alienate their mate but would serve as a bond to strengthen their relationship.

The majority of participants said they were influenced by family when it comes to their health. Many who said they were influenced indicated that their mother played a key role in shaping their health behaviors. Ranisha said “My mom has always been very adamant about going to a gynecologist.... Preventive care is something that’s extremely important. I think just seeing my mom and even my dad doing it has been influential on my life.”

Monique said her mother shaped a lot of her eating habits. “My mother has always, even when I was younger, made it a point to make sure everything is very low cal. She doesn’t eat fried food, she doesn’t eat out.” Shaniqua reported this:

My mom is a little strict and making sure even I’m going to the doctor if you’re feeling something. So I think her being that way made me more aware of any changes or small things that I may notice in my body or my health.

Gail said “My mom, she was in the military, so she was very active. She is active to this day. She was always really conscious about the things she eats so I think she kind of instilled that in me.”

Knowing about the family health history was important to several participants. According to Jillian, “My grandmother on my mom’s side passed young, like 64, so for us, health is very important – seeing the doctor, getting you annuals done.” Zandra explained how she was influenced. “A lot of women in my family, especially the older women, have had conditions and illnesses that probably could have been prevented, being more health conscious about what they eat and exercise.” Chelsea made a similar

remark: “When I see the issues they go through I would like to avoid that if there’s something to prevent it, then I’ll do that.”

Liana said she was influenced by the women in her family when she was younger, but she also has taken control of her own health through her actions, thus exhibiting a high level of self-efficacy.

They were my example and the barometer by which I gauged what was healthy and what wasn’t until I became an adult.... Now I’m far more aware and I’ve taken ownership of my personal health and so now my personal health sense isn’t solely based on how they view theirs.

Those who said they were not influenced indicated they were not because they wanted to avoid their family’s health issues. Devon said “I have a family history of high blood pressure and diabetes and they’re not as proactive. They’re not as motivated to make some changes to reverse some of those things.”

Many participants said they try to influence the women in their family, an example of how the women in this study exhibit self-efficacy in their health behaviors, which is a key component in the RPA framework. According to Breyann, “They weren’t as active in doing some of the preventive visits until they found out what I was doing and I see them doing it more now.” Malaya said she has not been influenced due to the lack of discussion about health in her family. “We don’t really talk about it. No one says, make sure you go to the doctor every year for your annual. No one ever says anything like that. It’s just something you have to know how to do.”

Family health influences – which included practicing preventive health behaviors – were primarily seen between mother and daughter. This bodes well for the participants in this study as they will likely serve as role models for their children. Several women

showed a high level of self-efficacy in that they attempted to parlay their proactive health behaviors to the older members of the family.

The majority of participants said they felt influenced by the media, particularly social media, when taking care of their health. Of those that did not, Devon said “I primarily live my life according to actual social interaction or something I’ve read in a book.” Regarding social media, Ranisha expressed this thought: “There is definitely a conscious level that has changed where people are a lot more health informed and health driven.” Liana made this confession:

I don’t know a single day that I log onto any of those platforms and there isn’t some diet trend or some doctor sponsored article talking about some health topic or another or some supplement. I try to be aware of it all... but I may or may not try it.

Camella said she follows a lot of women on Instagram “that have lost weight, that have beat breast cancer or some other type of cancer, just strong and motivating women.”

Juliet admitted she pays more attention to people she knows on social media “because they’re sharing comments and there are actual discussions on them.”

Jillian noted that at her work there is a website “dedicated to activities, encouraging us to go to the gym or other incentive programs where if you take 10,000 steps a day for a hundred days you get t-shirts and other things if you do more.” Malaya said she sees a lot of health topics on Facebook “talking about all different types of health issues that could be going on. This could be happening to you. It gives you a lot to think about.”

Gail said the information that comes through the media on health influences her because “I’m getting new information that I haven’t had before. It all depends on what it

is. I'm not gullible but it is something that is actually believable I will listen.”

According to Shaniqua, media is

probably one of the biggest influences between all of the documentaries about the bad things that go into the food and how they can affect you, and how you have to really try and work at being more healthy. I think I have changed a lot because of the media.

Monique mentioned that what she hears in the media influences what she eats. “I hear about radiation and gluten and stuff like that. I used to be a McDonald’s fan until they changed their meat and they can’t even tell me what’s in the meat. What the heck am I eating?”

Media influences appeared to be positive for the most part. This may be due to the choices the women in the study made in what they followed in social media. For instance, several indicated they followed people who were health conscious and motivating.

The majority of participants did not feel their religious beliefs played a part in their health. Kelsey said she is more influenced by what her doctor says. Liana concluded by saying “I don’t know if the two marry. My religious beliefs are very important to me, but I don’t know if they necessarily influence my health.” Although Camella said she considers herself to be religious, “there is no religious practice that would make any decision that I make about my health.” Jillian also did not see religion affecting her health and remarked “I’m not really traditional that way.”

Those that did say their religious beliefs played a part in their health focused on taking care of their body, and Laquita said “my belief as a Christian affects all parts of me.... I believe that God wants me to take care of my body so I think it is very important.” Chelsea saw religion as providing a balance in life and said this:

You have to have spiritual, physical, and mental to have balance, you have to have all three. So being spiritual and religious, and going to church, and praying every day is very important to me, for my well-being, and for my family.

Ranisha related a story about attending a religious girlfriends' conference where the following was said about religion:

[It] ties into everything, whether with your belief and spirituality or how you eat. If you're not eating well how can your brain function properly? How can you feel good if you're not eating? Your body, mind, and your spirit need the proper food, whether it's brain food or actual food.

The lack of association by participants between religious beliefs and health is contrary to much of the research done with Black women and illness. Previous studies have shown that Black women have strong religious beliefs upon which they base decisions regarding health and illness (Gullatte, 2010). It is possible that because the women in this study are highly educated and self-efficacious that spiritual beliefs would not come into play in how they make decisions about their health. This is not to say that the women in this study did not have strong religious beliefs. There was simply no thought given to turning illness over to a higher power as opposed to relying on science and medicine to drive decisions.

Youth and culture play a key role in driving the health behaviors of the women in this study. Many believed that breast cancer was not a disease that young people needed to consider. This may be due to the fact that many had witnessed family members with conditions such as heart disease or diabetes and they were able to make an association between health behaviors and practices and the potential to develop a health condition. In addition to a youthful mindset, cultural influences were noted. Family norms of not talking about health or being proactive in taking care of health conditions were learned behaviors that the women in the study aspired to overcome. Family health influences

were positive for the most part, as were media influences due to the choices made by the women in the study. A youthful mindset and strongly ingrained cultural pressures likely impact a majority of young Black women like those in this study. Awareness of these obstacles by health educators is paramount when creating interventions and communication messages that encourage young Black women to enact preventive breast cancer measures.

Themes 5 and 6. Participants' media observations (Themes 1 and 2) are influenced by their own personal experiences and perceptions (Themes 3 and 4). When viewed through the lens of a theoretical foundation of the RPA framework and cultural models theory (Themes 5 and 6), participants create a cultural model of breast cancer that impacts perceptions of their own risk for breast cancer as well as any ensuing self-protective behaviors.

Theme 5: Low perceived risk and strong efficacy beliefs drive health behaviors.

According to the RPA framework, perceived risk is a motivator for change. In the case of the women in this study, although most participants perceived their risk to be low for breast cancer, they were motivated to act to try to prevent the disease. This sentiment carried through other health conditions discussed, such as watching sugar intake or exercising to prevent diabetes.

When asked how they would feel if they found out they had breast cancer the majority of participants indicated they would be fearful, overwhelmed, scared, and concerned. Several would turn to prayer, but a large majority said they would be ready to fight it, once again evoking the strong cultural model of strength. Laquita said she would have these thoughts: "How do I go through this long journey, and choosing what type of treatment to go through and if I want to go through it? What does God say?"

Devon said this:

There would be concern and fear initially, but I still have hope. I mean, there is so much advancement nowadays and again, prayer or maybe eating right or just doing certain things and being able to survive through it – that hope.

Gail said she would be “freaked out. I mean, because my mom had it and that was my reaction when she told me.” Jillian would be concerned about treatment. “I’d be worried and scared depending on what stage you are as well. So I would definitely be a little curious about what’s the plan.”

Lucinda was more pragmatic in her reaction when she said this:

Depending on how bad it is, I have actually told my mom that if I get it I’m am just going to cut it off. If that’s the stage it is I have no issues with just getting rid of it and then moving on.

Karah said she would feel “overwhelmed and just a little shocked, but I think overall I would be okay eventually and try to take the necessary steps to get rid of it as fast as possible.” Jacy related that she would be

devastated, but as bad as it sounds, the way technology is I wouldn’t be too worried unless it was at Stage 4 and I had just found out. But if I caught it in the beginning I would of course be devastated but I wouldn’t worry too much.

Zandra came to this conclusion:

I’d probably be very shocked, of course. And be a little fearful, to say the least, if I found out that I had it. But I know myself, I probably would, once I got over that initial shock, I would go full steam into what I can do to help me get rid of it or help me get through it if it’s a situation where it’s an end of life situation.

Nina said she would “be afraid, but I would have to pray about it and just go from there. I mean, if that’s what I have to go through, I’d see whatever treatments that I can go through with and fight it.” Ranisha had a similar reaction:

I would probably freak out knowing myself. I would just really try to find out what the best thing would be for me to do, the care I need. I wouldn’t hide it from anybody. I would try to be proactive about it and pray.

Learning about a diagnosis of breast cancer did not signify a death sentence to the women in this study. This may be due to their experience with other women who have survived the disease. They appeared to have a high level of self-efficacy when it came to their approach to a diagnosis – full speed ahead to treat it and get rid of it.

Participants were asked if they actively looked for health information or if they found out about health topics more in passing. Individuals engage with information through several means which fall along a continuum of passive acquisition, incidental exposure, information scanning, or information seeking. The women in this study exhibited information-seeking behaviors indicating high engagement in health. Most of the participants said they actively look for health information. Fewer than five were moderately active; two did not look for information; and one said she did not need to look for information because it was given to her at her workplace.

Monique said she looks up health information when it affects her.

When my friend told me she had breast cancer and ovarian cancer, those are the types of things that I look up.... when it affects people that are close to you, that's when I need to look stuff up, because I'm like, dang, that hit close to home, when it's your friends dying from it.

Gail said "Google is probably the most used app on my phone because I just like to know things. I just love having a wealth of knowledge about different things."

Camella said "I get a little obsessed sometimes when I'm researching something."

Conversely, Coleen said she doesn't do research because "I don't want to go searching for symptoms."

When it comes to getting information about health, most participants get theirs from family and friends and other people they talk to, followed by their doctor, the Internet, social media, community organizations, and work. Juliet said she will go to the

Internet “if something piques my interest where I feel I need to learn more about something then I’ll just search it and find a Website that is medical in nature.” Chelsea said this: “I share health tips with a couple of friends I work out with and then my doctor will also send me stuff about heart health, and eating, or not using salt and stuff like that.”

Kelsey said she uses multiple sources to get information on health.

I go to WebMD and other research sites and look up stuff or I even go to the library. I have maybe more resources than the average person that maybe doesn’t have as much education. If I have a question I’ll go online and look or email or call my doctor.

Lucinda reported that she finds articles on social media about diabetes and high blood pressure.

So if there is something I question I will Google it. There is one site I have that is primarily for African Americans called Black Doctors. It’s African American-based and I actually go in and do a quick read to get a better understanding and learning.

The active style of looking for information and studying a particular issue is a common behavior among the women in this study group. This is not surprising as nearly all have a college degree, with many having advanced degrees. The nature of the study group is such that they tend to seek knowledge to better themselves and exhibit high self-efficacy when it comes to reaching their ambitions.

Participants were split evenly when asked if their likelihood to get cancer was high, moderate, or low, with several participants saying they did not know. According to the RPA framework, the degree of risk perception determines the likelihood of an individual enacting self-protective behaviors.

Jacy said “I think my risk might be higher than others considering it ran in the family.” Kelsey, who also had multiple cases of cancer in her family, worried:

It's like I'm at risk to get any type of fucking cancer, sorry for my French. I really am. It's not like when I see a breast cancer commercial I'm getting scared, because I can get any type of cancer. My father died of bone cancer. My grandma died of colon cancer. My grandfather has prostate cancer. I could die of any cancer.

Lucinda also indicated she felt she had more risk.

I think that's probably one of the main reasons I go to get my yearly. As much as they tell you to look and feel for it, I always have a lump in my breast. I always feel that there is something hard in my breast so I can never know unless I go to the doctor.

Many participants echoed Lucinda's comments. For example, Amber said the following:

I feel like I'm at risk, but honestly no one has actually died in my family from breast cancer or of other types of cancer. But I feel I'm at risk just because first, I'm an African American woman and we are in an age where everything causes cancer nowadays. You look at everything that you see on TV – "oh don't eat that because it causes cancer, oh don't do that, it causes cancer." I feel like I'm at risk.

In contrast, Nina believed she was only at a slight risk

because my mom had cancer. She did not have breast cancer, but just because she had cancer period I do believe there is a percentage.... I think anybody that has an immediate family member that's been diagnosed, I think they should be a lot more aware.

Coleen, whose sister died from breast cancer, said "I don't know. I don't know if my sister ever got the genetic testing. I don't know if it's something in her genes, but we have the same parents. I don't know. I would say 50 – 50."

Gail, who also had a history of cancer in her family, asserted this:

I don't really know how much genetics plays into it, but I would say, if it did play a role, I would say, kind of likely. I mean, yes. I think about it all the time, but I'm not going to say I'm out of the woods, so I don't know.

In contrast, Breyann gave these reasons why she did not feel she was at risk:

It's not common in our family. I wouldn't think I'm at risk, but I could think maybe, because I don't know if it's more so that it's hereditary or if it comes from

lifestyle.... I have been so engaged in physical activity, I don't know if that reduces some of that either.

Table 10 illustrates participant responses when prompted about their breast cancer risk (interview question 37) versus when asked a general question about conditions they are concerned about in an unaided fashion (interview question 18).

Table 10

Family Health History of Breast Cancer With Unaided and Aided Response

Participant	Family history of breast cancer	Family member	Unaided response	Aided response
Cassandra	Yes	Grandmother, aunts	No	Thinks about it
Laquita	Yes	2 Grandmothers	No	50%
Kelsey	Yes	Sister, aunt	Yes	Any type of cancer
Gail	Yes	Mother	No	Yes, if genetics
Jillian	No	N/A	Yes	Possibly
Ranisha	No	N/A	Yes	A concern
Jacy	Yes	Mother, grandmother	Yes	Higher risk
Liana	Yes	Grandmother	Yes	Moderate risk

Risk perceptions were based on factors ranging from lack of knowledge of the causes and risks of cancer to having a family history of breast cancer. Due to lack of knowledge and understanding of how one acquires breast cancer the women in this study estimated that their risks were low.

The majority of participants did not feel there was anything they could do to prevent getting breast cancer, indicating a low level of self-efficacy. Amber concluded that “Honestly, I don’t know that there is outside of just making sure that you stay on top of your screenings.” Zandra said “as of right now I’m assuming it’s a genetic issue so there’s nothing you can do to prevent it.”

Because Breyann was unclear of what causes breast cancer, she affirmed: “If I understood more how it comes about maybe, but all I can do is continue to be physically active.” Karah agreed and said “if it’s meant to happen, it will happen. I mean I can only do my necessary precautions as far as I what I mainly do, but it if happens, it happens.”

Although Chelsea said she did not think she could prevent getting breast cancer, she added this description of what she could do: “I could definitely continue eating healthy, and no smoking, limit my alcohol intake, be more conscious of making sure I try to get some physical activity at least five times a week if not more.”

Due to a family history of several types of cancer, Kelsey did not think there was anything she should do to prevent cancer.

Not one thing, and that’s what’s discouraging about cancer, is that it’s not preventable and it’s pretty much based on if you can afford to go to the doctor. You have to have the resources to know when something is wrong with you.

A few participants did think they could do things to prevent getting breast cancer. For example, Devon said “I’m trying to be a little more aware of my health just because I am getting older, so I’m trying to prevent any type of health issue.” Valentina thought one way to prevent breast cancer was through “a healthy diet, healthy living, limited alcohol.”

All of the participants indicated they would get a screening mammogram, showing a high level of self-protective behavior in spite of their belief that they are at low

risk for breast cancer or that there was anything they could do to prevent getting breast cancer. Several had either already asked their doctor about mammograms or planned to ask in the future. According to Juliet, “It’s something that I haven’t inquired as much about but it’s something I’ll definitely bring up at my next appointment.” Breyann, who has asked her doctor, asserted this:

Normally what the doctors do now is ask you "do you have a history?" and I think if there’s a history they tend to allow you to get a mammogram earlier than normal. But if there’s no history, they keep you on the normal age, I guess.

Most participants felt they influenced their partner as opposed to their partner influencing them. Valentina said her partner “is a very typical eater in America, eats meat most of the time. So I think I’ve introduced a little bit more into his diet than he’s necessarily influenced me.” Ranisha made similar remarks: “He loves red meat, chips, gummy bears and I’ve actually been kind of waving him off of those things. I still love junk food but I think I am slowly influencing him and he’s accepting.”

Several participants said they stay on top of their health themselves. Karah said “I’m pretty proactive and if I’m in a relationship I make sure they are taking the necessary steps to stay on top of their health as well.” Shaniqua, who is in a relationship, said her partner influences her “a great deal. Especially as we started to talk about more focus on trying to incorporate our life together.” Juliet's partner helps her stay on track “as far as physical activity and that’s because he works out a lot and so it kind of motivates me to try and do something when I don’t feel like doing it.”

Although the women in this study felt they were at a low risk for breast cancer due primarily to a lack of knowledge of the causes of cancer, their self-protective behaviors were high when it came to undergoing breast cancer detection screening. Because they exhibit high self-protective behaviors in other areas of their health, such as

through diet and exercise, it is not surprising that they categorize mammograms as another way of taking care of their overall health and well-being.

Theme 6: Young Black women tend to take responsibility for their health. A high level of self-efficacy was exhibited by the women in this study. They were knowledgeable about healthy eating and exercise activities that could be undertaken to maintain and improve their health.

Participants were asked to describe what it means to be health conscious. Karah said eating healthy, which means “watching what you eat, eating things like fruit, vegetables, not eating too many processed foods or fast food.” Monique's view of healthy eating included “less fat, less carbohydrates, more protein, increased fiber. Just picking portions that aren't considered fattening and higher in calories.”

Participants indicated that being proactive about health means taking care of oneself. “I believe that is someone who just takes proactive care of their health,” Ranisha asserted. Kelsey declared this: “Trying to eat healthy, working out, getting proper sleep.” According to Kelsey, practicing preventive care involves someone who “knows their health history and goes to the doctor. They take heed of what the doctor tells them they might need to do.”

Several participants indicated awareness of what they put in their body as a key component of health consciousness, reinforcing the food-health concept previously mentioned. Someone who is health conscious is “aware of what they put in their body and how they treat their body,” said Nina. This awareness not only involves being cognizant of what someone puts into their body but “external factors that affect their body and how they feel. How much sleep they get, the environment around them,” acknowledged Liana.

When asked if they considered themselves to be health conscious, the majority of participants straddled the line when it came to being fully committed, but took responsibility for their actions. Ranisha said this: “I know what I should and shouldn’t eat, but that doesn’t mean I do it.” Nina echoed this sentiment: “I’m health aware. I won’t say health conscious. That’s because I know there’s a lot more I could do.”

Of those who considered themselves to be health conscious, eating well and exercising defined their self-assessment, a key indicator of self-efficacy. “I eat healthy and go to the gym 5 days a week” contended Chelsea. Valentina asserted this: “I make food decisions based on health and I make work-life balance decisions based on mental health. I make social outings, like consumption of alcohol, for example, based on health.”

A few participants did not believe they practiced health consciousness. Monique said the following :

Sometimes I am, don’t get me wrong, I don’t just eat fattening foods all the time, but there are times I want to feel good, and I want something that tastes good right now. And I don’t care. I don’t care if it’s health conscious or not.

Study participants exhibited a high level of understanding of preventive health behaviors and many actually practiced those behaviors. It is likely that this level of self-protective behavior is due to educational level and socioeconomic factors, but this is an area for study that should be explored to further understand the motivators for enacting preventive health strategies among young Black women.

To understand the level of proactivity in health behaviors, participants were asked if they had a primary care doctor and a gynecologist. They were also asked how often they saw each type of physician. All participants indicated they had both a primary care

doctor and a gynecologist and they received an annual physical exam from their primary care doctor and a well-woman exam from their gynecologist.

The majority of participants reported that they do not have any health conditions. Those conditions they did indicate included: high blood pressure (3), overweight (2), anemia (2), PCOS (2), hypoglycemia (1), rheumatoid arthritis (1), and mental health issues (1). Gail's comments were echoed by those who said they did not have a health condition: "I'm pretty healthy. I don't smoke or participate in behaviors that would make me concerned about my health."

Amber said she was concerned about her weight. "I want to lose a little bit of weight. That's the only thing I'm concerned about. I'm still working on it right now." Zandra, who said she is anemic, said "when it was really bad I would get really tired. I was often fatigued and not able to do a lot of strenuous activity."

Two participants said they have a condition called PCOS. Zandra stated this:

I have PCOS. I'm not sure if you know what that is or not. It's called Polycystic Ovarian Syndrome. So I have many cysts on my ovary. Well, I actually found out just the one set of ovaries on my left side. I have a lot of issues with weight gain, with insulin resistance, with facial hair. So it's definitely an issue that I'm concerned about.

Kelsey indicated she was not concerned about her physical health, but she also expressed the following thoughts:

I'm very mentally health conscious as well. I feel like it's a full circle, so it's not just your physical health. It's your mental health as well. Because working full-time as a Black person in corporate America I do experience some things that make me think, so I have to rely on both the physical and behavioral health component.

Few participants in this study had a health condition, and those who did were educated about their illness. Further demonstration of their proactivity and self-efficacy in taking care of their health could be seen through their annual doctor visits and well-

woman exams. As many women in the study had previously mentioned that they took their health cues from their mother, staying on top of preventive exams was to be expected.

When asked about eating habits, participant responses fell into one of four categories: (a) healthy eater, (b) healthy eater with a few bad habits, (c) working on eating healthy, and (d) don't eat healthy. The majority of participants reported that they were healthy eaters, demonstrating that they possessed a high degree of self-efficacy when it came to taking care of their health. The healthy eaters reported eating a variety of foods. Karah said this:

For the most part I definitely don't drink juices or sodas. I mainly drink water and tea on a daily basis. I do try to eat healthy as far as vegetables and fruits. I like eating leafy vegetables and I'll sometimes make a shake with kale, spinach, fruit, water, or almond milk. I do try to cook at least two to three times a week just to keep from eating out. When I do cook it's pretty much like the full courses with beef and vegetables. I might cook rice or mashed potatoes or sweet potato but I don't eat a lot of starch and try to stay away from bread.

Valentina and Cassandra talked about their food journeys – one as a vegan, and one with an 85-pound weight loss. Valentina said she has been a vegan for a little less than a year:

I haven't had any animal products in my diet since July of last year, so I eat a plant-based diet. I have been a mix of vegetarian and pescatarian, so a mix of plants and fish-based diet, for about 8 years. And I just felt my body was leaning more in the direction of not needing some of the animal-based protein. So I decided to make the switch. I definitely feel healthier. I feel like I'm the healthiest I've ever been. I have more energy throughout the day and friends comment on physical appearance, that I'm the healthiest they've seen me.

Cassandra described the past 2 1/2 years as "a weight loss journey."

I have to date lost 85 pounds. For the most part I think I have pretty good eating habits now. I can't say I was doing it that way three to four years ago.... I was on the verge of diabetes and I was definitely afraid of needles and the path I was taking. I was on the verge of probably going to have to take some type of insulin. So that in itself was a huge scare and I was like "I got to get it together." I work

for a healthcare company and I'm on the well-being team, so how can I tell someone about well-being when I'm not a good example.

Violet's response indicated she is an example of a basically healthy eater with a few bad habits.

Overall, I eat pretty well and try to stay away from things I know are bad, saturated fats and all that type of stuff. I do have a weakness for sweets. It it's anything that would be my downfall, I probably eat too much sugar, but I think I'm doing pretty good overall.

Working on eating healthy was a common response from some of the participants, such as Camella:

I have been trying to eat healthier, buy healthier foods, drink more water.... My problem is when I get busy I would say I can't stay on top of my healthy eating. I'm not a junk food person and I'm not a drive-through person and I really want to lose some of the weight I've gained in the past 5 years.

Zandra admitted that her eating habits are "bad."

I try to eat healthy. I try eating fruits at least once or twice a day but that usually doesn't happen. But I'm a very busy person which means I don't cook at home a lot like I should, so I'm usually getting fast food to go when I'm leaving work.

While most participants exhibited a high degree of self-efficacy in the area of healthy eating, they were less proactive when it came to exercise. The majority of participants said from a physical activity standpoint, they are not active or are active on an irregular basis. Seven of the 27 participants said they were very active, with eight indicating they were moderately active.

Violet said she doesn't exercise, but occasionally attends a rumba class. "We have a treadmill at our house, but that isn't consistent. So outside of that I'd say I'm pretty inactive."

Those who were moderately active exercised several times a week, primarily by walking.

The most active participants were engaged in several physical pursuits. Amber said the following:

I do workout quite a bit. I work out three to four times a week. I have a step class that I go to, like a hip hop class three times a week, and then I try to go to the gym at least once or twice a week.

Knowledge was high among this group of women when it came to being educated about healthy eating and physical activity to maintain health. About one-fourth of the group said they were physically active and regularly exercised on a weekly basis. There were several mentions of being overweight, which is a breast cancer risk factor, however this was not correlated to the disease by any of the women in the study.

In discussing family health conditions, the majority of participants had some type of cancer in their family, including cancers of the breast, ovaries, lung, prostate, colon, bone, and cervix. Two had a father with multiple myeloma. The next highest incidence of disease was diabetes, followed by high blood pressure, heart disease, high cholesterol, and Alzheimer's Disease. There was one mention each of COPD, lupus, kidney disease, and endometriosis.

Cassandra described multiple cases of breast cancer in her family:

My grandmother, she has had breast cancer, her sister had breast cancer, and then my mom, she has two sisters, so there's three of them, and both my mom's younger sisters. One is currently going through it now, and the other, she was diagnosed in 2012. She's finished her chemo.

Jacy said her mother was diagnosed with breast cancer in 2005 and said she was "kept out of the loop of everything so I did not really get to experience the chemo and the radiation she went through." Gail's mother also had breast cancer in 2013 when she was age 40. Gail described it this way:

From what she told me she was scratching under her arm one day and kind of felt the hardness there. She ended up going to the doctor because she always goes. When they discovered it they went into action. They caught it pretty early.

Devon related a story of her aunt's daughter who passed away from cancer a year ago. "It wasn't breast cancer but another form of cancer. They did not know she had it and it spread around through her whole body and she passed away."

While some participants indicated that some health issues were discussed and dealt with among family members, many said health issues were often not treated or talked about. Camella recalled this about her grandmother having cancer when Camella was growing up:

My grandma died from cancer and I'm not sure what it was, but it was when I was growing up. I was 13 when she died and for a long time all I would hear was feminine cancer or something like that and then it spread. She never got treatment and by the time she found out and they gave her an expiration date she decided not to follow and just deal with it on her own which I thought was very selfish and unfair.

Nina spoke of her grandmother who had diabetes but refused to get treatment.

My grandmother was diabetic and she said she was old and she would do what she wanted to. That did not work well for her. She ended up having to have one of her legs amputated just because she was stubborn.

When asked why she thought her grandmother refused treatment, Nina said this:

I think it's cultural. I don't think we as African Americans talk about it enough. It's always taboo. You don't talk about your health, you don't talk about anything personal. I just think it's cultural and that how we were, unfortunately, brought up.

Most participants were knowledgeable about their mother's health practices and indicated that she did receive annual well-woman exams and mammograms. However, four participants did not know if their mother saw a gynecologist and a few were not aware of their mother receiving mammograms.

Known family health issues were often not addressed, according to several women in the study. This goes to the cultural taboo previously discussed. In spite of this, the women in the study were responsible when it came to educating themselves about health conditions and practicing preventive health activities.

The majority of participants were aware of mammography screening and were able to articulate the purpose of the test. Comments ranged from “to see if anything’s irregular” (Cassandra) to “make a women more aware of breast cancer so she can be conscious of her breast health” (Rebecca) and “watch and make sure if there is something developing that you catch it early enough” (Amber). Only one participant (Valentina) was unclear of the purpose and said “that’s a good question. I don’t fully know. So I think just as a general check for women’s health, but I honestly am not fully clear what the mammogram process is.” Jillian was more specific when she said “the first one I would say is the signature base line and then after that to see if there’s any change.”

The majority of participants had never had a mammogram, although seven did report having had the screening. Rebecca said her doctor recommended a baseline at age 35 and then the start of a regular schedule at age 40. The other participants who had already had a mammogram before age 40 did so to examine a lump or due to family history of breast cancer. Those who had not had a mammogram said it was because their doctor either did not mention it or indicated that mammograms would start being performed at age 40. They were also asked if they did a monthly breast self-exam, and the majority of participants said they did check themselves every month.

Jillian indicated that she was concerned at age 35 that she had not yet had a mammogram. “I should’ve at least at 35. Things like that I should’ve already had at least

one. But I am concerned and I do look very often when I'm taking a shower." Because of her family history, Nina was also concerned that she had not had a mammogram yet.

I was always told 40 but I probably should have been getting it sooner just because my mom had cancer. But I was always told once you reach 40, it's when you start going for your mammograms. But I think if you're predisposed to any type of cancer, you should start getting them as soon as you're old enough to do it.

The women in this study were educated about their health and practiced preventive health measures, such as healthy eating and exercising. For the most part they were aware of family health conditions and took steps to prevent the onset of these illnesses. They often acted in contrast to familial behaviors and took responsibility for learning about health and integrating health behaviors into their daily life.

Chapter Summary

This study was designed as a way to capture young Black women's knowledge and perceptions about various facets of breast cancer and breast cancer detection methods. Through the 55 interview questions, participants expressed their concerns related to their lack of knowledge of the risks associated with breast cancer. Six themes emerged that provide an overarching view of the feelings and beliefs of participants regarding their experiences of breast cancer and the relevance of the disease to their own lives.

Through the narratives expressed by each participant one can gain a sense of the lived experiences of the women in this study. Their responses can be likened to storytelling, which calls to mind the rich history of storytelling found among Blacks (McQueen et al., 2011). Many such stories emerged from the data captured for this study such as the retelling of personal experiences of a mother, a sister, or an aunt who had

breast cancer. While a complete analysis of the impact of storytelling is beyond the scope of this study, further evaluation of this data could yield deeper meanings associated with the related experiences.

Chapter 5

Discussion and Recommendations

Introduction

The purpose of Chapter 5 is to discuss results, conclusions, implications, limitations, and recommendations of the current qualitative study exploring young Black women's perceptions of breast cancer messaging.

Discussion of Results

Six themes were identified through qualitative interviews with 27 Black women. The 27 women in this study were open and honest with their thoughts, not only regarding their personal and family health experiences, but in their feelings of what they observed in the media. In discussing statistics reported by the American Cancer Society as to the increased mortality of young Black women, the women in this study were surprised and shocked in some cases. In spite of known medical advances in identifying breast cancers that are specific to this population, few studies were found by this researcher with young Black women, particularly women under 40 who are at increased risk.

Identification of distinct breast cancer subtypes more than 10 years ago has shown crucial biological differences in the types of tumors most common in each racial group (Carey et al., 2006). Young Black women suffer from a higher incidence of basal-like breast cancers which are twice as prevalent in this group than in Whites. Epidemiologic research has identified key prevention strategies for reducing basal-like breast cancer such as increasing breastfeeding and reducing obesity (Millikan et al., 2008), yet vast knowledge gaps persist among young Black women. According to Allicock et al. (2013), "while scientific data accumulate to support basal-like breast cancer prevention, research

about what African American women know about breast cancer risk, basal-like breast cancer, and genomics is lacking” (p. 754).

Additionally, it is somewhat disheartening that many of the findings of the current study were reported in research conducted more than twenty years ago which indicates a lack of progress in addressing known issues.

For instance, data from a national study in 1994 (Costanza) revealed the following major barriers to early detection of breast cancer among older Black women that mirror many of the comments from the young Black women in the current study, including: (a) inaccurate knowledge of breast cancer and breast screening, (b) low awareness for early detection, (c) lack of encouragement from physicians to schedule a mammogram; (d) lack of early detection instruction, and; (e) cultural misconceptions about the causes and symptoms of cancer (Costanza, 1994).

Further, a study by Loehrer et al. (1991) found that lack of knowledge regarding the causes and treatments of cancer was associated with increasing age and decreasing level of formal education. It is particularly alarming that these misconceptions still exist among young, highly educated Black women today. The following discussion details the key themes and associated meanings elicited from the 27 interviews conducted for this study.

Theme 1: The absence of knowledge of risk and prevention factors limits breast cancer preventive measures. While young Black women are educated about health, practice preventive care, and for the most part, are healthy eaters and are active, they are primarily concerned about conditions they believe they can control, such as diabetes and high blood pressure, as opposed to the more predominant family condition, cancer, which they do not believe they can prevent.

Primary health concerns. According to the women in this study, primary health concerns included diabetes and high blood pressure. These conditions were prevalent within their families, and some participants had already been diagnosed with high blood pressure. The participants believed that these conditions are largely preventable or controllable through lifestyle choices. Diet and exercise were the most commonly mentioned methods of avoiding or controlling diabetes or high blood pressure.

Breast cancer concerns. Sixteen women in the study had a history of cancer in their family. Of the six study participants who said they had a family history of breast cancer, only half mentioned it as a health concern when asked in an open-ended fashion. When breast cancer was specifically mentioned as part of the interview question, the same three participants, who were not concerned during the unaided questioning, still did not consider themselves to be at a high risk for breast cancer. Table 11 details responses generated by aided versus unaided mentions of breast cancer as a condition of concern.

This finding is consistent with previous research that showed that women at increased risk underestimated their risk of breast cancer (Haas et al., 2005).

Conversely, two women from the study who did not have a history of breast cancer in their family indicated they were concerned about their risk. Again, this finding was revealed in previous research that showed that women at average risk who perceived they were at increased risk may suffer from unnecessary worry (Haas et al., 2005).

In further discussion, because participants did not know the causes of breast cancer, they indicated they did not know what types of preventive measures could be taken to prevent it, and in some cases, did not believe it could be prevented. The lack of knowledge regarding the causes of cancer was similarly found in previous research where participants attributed a wide range of potential causes, often responding in the form of a

question (e.g. “Smoking, right?” and “Pollution?) thus emphasizing their uncertainty (Allicock et al., 2008). Research by Barroso et al., 2000, found a similar lack knowledge about breast cancer which led to limited self-efficacy in Black women’s ability to do anything to prevent breast cancer.

Table 11

Family Health History of Breast Cancer: Unaided and Aided Response

Participant	Family history of breast cancer	Family member	Unaided response	Aided response
Cassandra	Yes	Grandmother, aunts	No	Thinks about it
Laquita	Yes	2 Grandmothers	No	50%
Kelsey	Yes	Sister, aunt	Yes	Any type of cancer
Gail	Yes	Mother	No	Yes, if genetics
Jillian	No	N/A	Yes	Possibly
Ranisha	No	N/A	Yes	A concern
Jacy	Yes	Mother, grandmother	Yes	Higher risk
Liana	Yes	Grandmother	Yes	Moderate risk

Throughout the discussions, participants linked food to the presence or absence of health conditions. For instance, they attributed unhealthy eating and weight gain to diabetes and heart conditions. The fact that the women in this study understood and practiced preventive behaviors for various health conditions indicates that were they fully educated about breast cancer causes. they may exhibit the same type of self-protective behaviors. Further research should examine messages that would encourage self-

protective behaviors if their risk was deemed to be relevant. Participants in the study also exhibited high information-seeking behaviors, therefore, health communication strategies that focus on educating young Black women fully about breast cancer could increase the relevance of these messages.

Theme 2: Lack of comprehensive media information contributes to higher mortality. The young Black women in this study believe that women of their race and age die more from breast cancer because the mainstream media does not paint a complete picture of the causes of breast cancer and who is at risk.

Breast cancer causes. The young Black women in this study mentioned a range of causes of breast cancer, including processed food/steroids in food, lifestyle, environment/pollution/pesticides, genetics, electronics, vaccines, hormonal imbalance, household products, deodorant, birth control, mammograms, products (smoking/drinking), and sugar. In contrast, according to the American Cancer Society, many factors known to increase the risk of breast cancer are not modifiable, such as age, family history, early menarche, and late menopause (ACS, 2015c). Modifiable factors include postmenopausal obesity, use of combined estrogen and progestin menopausal hormones, alcohol consumption, and breast feeding. In younger Black women, risk factors include younger at age of first full-term pregnancy and having more births, less likelihood of breast feeding, less but longer use of oral contraceptives, larger body size, higher waist/hip ratio, lower levels of education, less alcohol consumption, and less smoking (Hall et al., 2005). Factors that are not associated with breast cancer risk include abortion, hair dyes, antiperspirants, and breast implants (ACS, 2015c).

Talbert (2008) found a similar knowledge deficit among Black women regarding the causes of breast cancer. In her study on social marketing approaches she recommended focused messaging that would

address breast cancer prevention, and then conclude with factual data that illustrate why prevention can save lives. It is important to include some brief facts and figures; nothing overwhelming, but a message that provides women with enough information to understand the implications of this disease, the growing disparity, and more importantly, the prevention measures. (pp. 358)

Breast cancer diagnoses. In addition to a lack of awareness of the risk factors for breast cancer, study participants had a limited view of who is affected most by breast cancer. The women in this study indicated that, based on what they saw in the media, middle-aged White women were more likely to get breast cancer. Previous research participants categorized breast cancer as a “White disease” (Allicock et al., 2008, p. 756) coupled with “the lack of visual representation of African Americans in breast cancer information and activities [that] translated to lowered perceived relevance of the disease” (Allicock et al., 2008, p. 756).

Those with personal experience had a wider view of who could be diagnosed with breast cancer. Previous studies indicate similar findings from those who have experience with breast cancer. Although the media portrays cancer as primarily affecting White women, there is a general recognition and understanding that all populations can be diagnosed with cancer (Allicock et al., 2013).

Media images that portray positive stories or messages of strength and survival do not paint a full picture for young Black women of the realities of breast cancer. Media communications that use pink imagery and deliver messages such as “get checked” or “anybody can get it” are too general in nature, particularly when the women in this study primarily recall White women in advertising and communications. Health

communicators should take cues from diabetes education that is specific to Blacks in outlining the causes, risks, and preventive measures that can be taken to prevent the disease. While breast cancer awareness is high among the women in this study, the messages do not address topics that are crucial to reducing mortality in young Black women. Emotional approaches showing bald White women do not resonate with the women in this study when the majority of them haven no awareness of the facts and figures that contribute to the higher mortality rate for young Black women. Further research into messaging that compares factual versus emotional approaches should be undertaken to determine the most effective communication that encourages a new level of awareness among young Black women.

Theme 3: Personal experiences drive perceptions of who gets breast cancer.

Although the media portrays older White women as the primary target of breast cancer, the young Black women in this study form their perceptions of who is impacted by breast cancer based on personal experiences as opposed to being influenced by media images.

Previous research has shown that information relayed about breast cancer in the media focuses on a common set of themes (Barg & Grier, 2008). One such theme includes a woman fighting to beat the disease and winning (Davis, 2008; Wong & King, 2008). Additional research has shown that a common image portrayed in breast cancer communications is that of a young, professional White women who relates her story of developing and beating breast cancer (Wong & King, 2008). Analysis by Davis (2008) has also found that although communication content implies that breast cancer is not limited to one age or race, there is the implication that the primary victim of breast cancer is an educated, middle-class, married, White woman.

The fighting and winning theme was witnessed by several study participants who knew someone who had breast cancer. Gatison (2016) said the effect of the strong Black woman image is

a picture to the world that Black women are inherently strong and resilient, self-reliant, able to confront myriad challenges, and provide encouragement to self and others during times of adversity. These images foster the belief that Black women are courageous warriors. Any sign of vulnerability or weakness is tantamount to failing oneself, family, and community. (pp. 12-13)

According to Gatison (2016), this unrealistic expectation of strength in the face of adversity serves as a way to silence Black women as it relates to health matters.

Health communications that focus on themes of strength or of fighting the disease tell little of the story understood by women who have experienced breast cancer through a friend or family member. Their lived experiences tell a different story of Stage 4 breast cancer that the majority of young Black women who have not been exposed to breast cancer cannot fathom. Communication messages that are honest, such as those for smoking mentioned by the women in this study, will have a greater impact and be more memorable. Research should be conducted using storytelling as an approach relating the stories of young Black women who have suffered from breast cancer. The most valuable thing health communicators could do for young Black women is to provide factual information on the risks and preventive measures to avoid breast cancer.

Theme 4: Youth and culture are breast cancer risk factors for young Black women. Although the young Black women in this study appeared to be educated about the symptoms of breast cancer, a lack of knowledge of risk factors and how to prevent breast cancer, coupled with a youthful mindset and cultural influences, puts more young Black women in jeopardy of getting breast cancer.

Risk. Black women usually consider themselves to be at lower risk for developing breast cancer than do White women (Gerend & Pai, 2008). This can be seen even among Black women with a family history of breast cancer, as was demonstrated by two participants who had family members with breast cancer but did not consider themselves to be at high risk (Table 11). Low risk perceptions may translate into low perceived need for a mammogram or delays in seeking treatment for a breast abnormality (Gerend & Pai, 2008).

The lack of perceived risk for breast cancer at a young age was also noted in research conducted by Allicock et al. (2008), who found that there were three distinct views about how age relates to breast cancer risk: (a) risk increases with age; (b) when a woman is young age provides a period of protection, and (c) age doesn't relate to risk.

Prevention. Because the women in this study were unsure of the causes of breast cancer, they did not appear to be aware of preventive measures that could be undertaken. This is a theme that runs through nearly every facet of the current study.

All women can reduce their risk of breast cancer by avoiding weight gain and obesity, participating in physical activity, and reducing alcohol consumption. Combined estrogen and progestin hormone therapy and long-term heavy smoking before the first pregnancy have also been found to promote cancer (ACS, 2015c). According to the American Cancer Society, some studies indicate that Black women are more likely to be diagnosed with triple negative breast cancer due to their African ancestry. However, other studies have determined that the cause is related more to behavioral factors, such as reproductive patterns common in Black women that include giving birth to more than one child, early age at first pregnancy, and low rates of breast feeding (ACS, 2015c).

Youthful mindset. According to the Centers for Disease Control and Prevention (CDC, 2017), young Black women under the age of 35 have breast cancer rates that are two times higher than those of White women and are three times more likely to die than are White women of the same age. As was found with the participants in this study, there is a lack of awareness among young Black women regarding their risk for breast cancer which “is often a factor into why they have more harsh outcomes” (CDC, 2017). Furthermore, on a national level, 40% of young Black women with breast cancer had no idea they could get breast cancer prior to being diagnosed. Reasons cited for not getting a mammogram included fear and stigma (CDC, 2017).

This youthful mindset is held not only among young Black women, but often among health care professionals who ignore symptoms. This dismissive attitude by providers was mirrored in other research where a woman reported going to the doctor because of a small knot on her breast. Because the doctor could not feel the knot she was told that she was too young to be concerned about getting breast cancer and therefore the doctor would not order a mammogram (Allicock et al., 2008).

Cultural influences. Cultural issues loom large when it comes to matters of health among Black women. Study participants mentioned that there was a lack of discussion in their families about personal health, as well as a lack of proactivity when dealing with health issues.

Communication is an important aspect of the cultural issues. The lack of discussion in the family about generational health and increased risks for breast cancer often precludes women from enacting preventive measures (CDC, 2017). The cultural norm against discussing breast cancer that exists within the Black community contributes

to perceptions of invulnerability (Gerend & Pai, 2008). According to scholar Annette D. Madlock Gatison,

Black women with breast cancer are living within a cultural norm that favors silence about illness.... In the Black community it is not uncommon to be uninformed regarding any family history of chronic physical or mental illness. Family medical history is not discussed unless deemed absolutely necessary. (Gatison, 2016, p. 39)

Proactivity is another important aspect of cultural issues. An additional cultural norm identified through this study included the lack of proactivity in diagnosing and treating health conditions. Once symptoms are discovered, waiting to seek medical care has been attributed to poverty, culture, and social injustice (Gerend & Pai, 2008). Several participants indicated they had family members who resisted getting tested including one who related the story of her uncle, who refused to get tested in spite of having two brothers with prostate cancer.

The lack of discussion and proactivity in the family about cancer has been well-documented in previous research (Rimer & Bluman, 1997), (Lauver, 1004), (Guidry et al., 2002). Such silence has been related to the idea of not exploring the unknown and the belief that “what is not addressed will not happen or eventually will disappear” (Guidrey et al., 2002, p. 320).

Thomas (2004) found that family discussions about cancer “were either nonexistent or discussions were held in ‘hushed tones’ that, at times, may have conveyed inaccurate information” (Thomas, 2004, p. 299). Several studies have documented the reasons Blacks delay seeking medical care, including nonadherence to breast screening guidelines, fear, denial, reliance on alternative therapies, other priorities, low perceived risk, belief that the symptoms will go away, and religious, spiritual, and cancer fatalism beliefs (Gullatte, Brawley, Kinney, Powe, & Mooney, 2010).

Lack of knowledge of the risk factors for breast cancer coupled with the comment that “it’s not a young person’s disease,” and a familial code of silence in discussing health matters are exacting barriers that need to be overcome if one desires to impact the high mortality rate among young Black women. The fact that the young Black women in this study are highly self-efficacious and exhibit high information-seeking behaviors bodes well for health communicators. When the women in this study were informed of the risk factors and high mortality rate for young Black women with breast cancer they were “shocked.” Every individual in the study indicated that factual information would not only make them pay attention to messages about their risk for breast cancer, but that they would take action, either through preventive measures or by talking to their physician. This is an area for future communication research to determine messages that will evoke action and that will motivate young Black women to seek care if needed.

Theme 5: Low perceived risk and strong efficacy beliefs drive health behaviors.

In the absence of accurate information about the causes of breast cancer, young Black women tend to underestimate their risk of breast cancer. Because of general proactive health behaviors, however, they are more likely to practice screening behaviors.

The RPA framework provides insight into the degree to which health campaigns influence perceptions of breast cancer risk by examining health and self-protective behaviors as well as feelings of efficacy in undertaking breast cancer detection behaviors. According to this framework, “when risk and efficacy are made salient, people’s risk perception guides most of their subsequent actions” (Rimal & Real, 2003, p. 370).

The RPA framework classifies people into four groups based on their perceptions of risk and self-protective behavior: responsive (high risk, high efficacy), avoidance (high risk, low efficacy), proactive (low risk, high efficacy), and indifference (low risk, low

efficacy) (Rimal & Real, 2003). The majority of participants in this study did not consider themselves to be at a high risk, unless they had a family history of breast cancer, and even those women did not indicate that they were certain they were in a high risk category. Therefore, it is likely that this participant group can be categorized in the low risk category.

When it comes to self-efficacy and self-protective behaviors, all participants in this group indicated they felt a mammogram was important to their overall health for early detection of breast cancer. In fact, many were concerned that their doctor had not recommended a mammogram in light of the statistics of high mortality among young Black women under the age of 45.

The participants in this research study fall within the proactive attitudinal group because they revealed low risk perceptions but high efficacy beliefs. According to Rimal and Real (2003), “they are not motivated by their perceived risk status, but rather by their desire to remain disease free” (p. 372).

The primary application of the RPA framework is as an audience-targeting tool. Once audience members are categorized into a group, specific messages that resonate with their attitudes and behaviors can be developed to increase messaging effectiveness. In the case of this proactive group, their responses indicated they are very amenable to information that will help improve their health and well-being. For this group, messaging that stresses the ability of regular mammography to not only detect breast cancer early, but also act as a means to reduce breast cancer mortality in young Black women who tend to present at later stages, would be beneficial.

The RPA framework provides insight into the degree to which health campaigns influence participants’ perceptions of risk and feelings of efficacy. In spite of low risk

perceptions of this study group, public health campaigns that stimulate information-seeking behaviors could prove to be successful due to the high information-seeking behaviors of this study group. Research that investigates ways to communicate risk can strengthen health messages for the audience.

Theme 6: Young Black women take responsibility for their health. In spite of cultural beliefs and behaviors, such as the lack of discussion about personal health matters and the lack of proactivity by family members regarding health conditions, as well as confusing messages in the media, the young Black women in this research group actively practice preventive health measures.

Family influence. Those participants who indicated they followed the health practices of their family said they did so because of their mother's influence. Those who were not influenced said it was due to lack of self-care of family members with health conditions. In these cases, participants were more likely to influence family members with their preventive health behaviors.

Contrary to previous research with Black women regarding the importance of religious beliefs affecting the outcome of health conditions, the majority of the women in this group did not associate religion with their health. Mitchell, Lannin, Matthews, & Swanson (2002) found that belief in spiritual or religious intervention by a higher power versus medical treatment may explain why African American women delay getting medical care when breast lumps are found, thus contributing to advanced stage breast cancer at diagnosis. The majority of participants in this group did not see a relationship between religion or spirituality and health. Barroso et al. (2000) found that better educated women tended to have less belief in a higher power.

Conversely, according to Gatison (2016),

a growing body of literature has indicated the importance of spirituality and religious practice as contributing to improved health and quality of life for cancer survivors. Some have indicated that the lack of personal faith belief could be considered a risk factor to an individual's health. (p. 21)

An additional area found in previous research that did not manifest with this study group is the idea of individuals having a fatalistic view of cancer and believing a diagnosis is a death sentence. Across numerous studies, the majority of participants who held fatalistic views were Black, less educated, of lower socioeconomic status, and over the age of 50 (Gullatte et al., 2010). The women in this study believed those who had breast cancer had a good chance of surviving if caught early enough, or due to advances in medicine and technology.

While education was not a screening criteria, most participants had a bachelor's degree and nearly half also had advanced degrees (Table 7). Their advanced education, coupled with their status as working professionals, may explain the variances related to proactive self-care, spirituality, and fatalistic beliefs. The women in this study group were proactive in their health behaviors, researching health topics often and basing decisions on substantiated medical information and personal experience, versus relying on family traditions and beliefs.

Media influence. While participants were actively engaged in all forms of media, most were not heavily influenced by the media when it came to their health. They often took their cues on breast cancer from individuals who had suffered from breast cancer. Despite the media often portraying older White women as the primary victims of breast cancer, this group took away the image of women of all ages and races as being susceptible to breast cancer.

This lack of attention to media messages may be due in part to the lack of consistency in messages. Allicock et al. (2008) found that

information about race-related risk was counterbalanced by feedback that they need to be concerned due to youth or having no family history, or by media messages that further reinforced the sense of low personal relevance... These results also indicate gaps in health education and opportunities for better delivery of tailored messages. (pp. 761)

The young Black women in this study are highly health conscious information seekers. Health communication campaigns that key in on their mental linkages of food and health as it relates to breast cancer could prove to be motivating in a way that encourages self-protective behaviors as it relates to preventing breast cancer. Research may uncover salient risk factors that would encourage young Black women to enact self-protective behaviors.

Conclusions

The final element of the logic model (Figure 6) serves as the culmination of inputs, filters, and the theoretical lens, leading to a better understanding of what health behaviors may be derived from participants' perceptions about breast cancer as well as the influence the media may have on those behaviors.

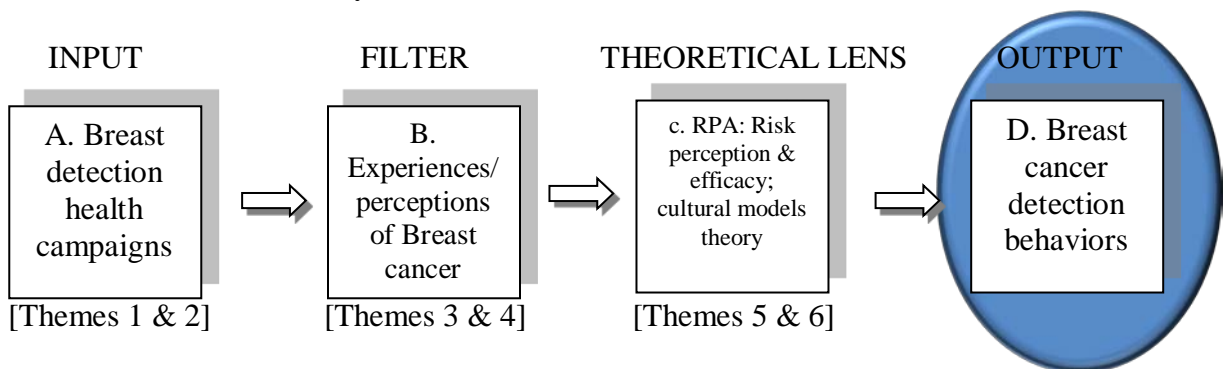


Figure 6. Logic model: Breast cancer detection behaviors.

Various studies have shown that differences in cancer knowledge and beliefs persist even when educational and socioeconomic measures are statistically controlled

(Consedine, Magai, & Neugut, 2004). The participants in this study group were highly educated and socioeconomically advantaged women. A strong undercurrent running through all the themes in the study was the lack of awareness and knowledge of causes of breast cancer, risk factors, and who is at risk. These elements are colored by cultural mores, such as a virtual family taboo about speaking of personal health, as well as a lack of desire to acknowledge the existence of health conditions.

Part of this research project was an endeavor to determine if the cultural models dimension had an impact on young Black women's perceptions of their risk for breast cancer. These perceptions could help define future health campaigns targeted to this population.

Previous research with 49 low-income Black women (Barg & Grier, 2008) found that they had a cultural model of breast cancer based on feelings of "difference." In the Barg & Grier study, 15 participants had been diagnosed with breast cancer and 34 had never been diagnosed. The women with breast cancer were more likely to be married and tended to be older (mean age 56 vs. 45) and have more education (12.9 years vs. 11.2 years).

In this cultural model, difference was expressed as stigmatizing and leading to withdrawal and social isolation. The participants indicated that breast cancer was a White woman's disease and didn't happen to Black women, that it was a stigmatizing condition for Black women, and that Black women cope with adversity by turning to religion. This shared cultural model, consisting of cultural beliefs and practices, informs Black women's perceptions of their risk for breast cancer (Barg & Grier, 2008).

The women who participated in the current study were younger, more educated, and mostly middle income professionals. Many were unaware that breast cancer could

happen to women their age; but based on their personal experiences, they believed that breast cancer was not limited to any one race or age. They expressed proactivity in their personal health habits and indicated that breast cancer could be survived if caught early through breast self-exams and mammograms.

Based upon the perceptions of 27 young Black women, the two research questions were addressed:

RQ1: What is the nature of insured young Black women's perceptions about breast cancer detection and its relevance to their lives?

Answer: Young Black women exist within a family norm that includes silence and secrecy. In spite of family culture, they are empowered in how they take care of their lives and their health. Breast cancer illness has been made real for them through their personal relationships with women with this disease who are fighting for their lives. Making it real for other young Black women means breaking cultural taboos and allowing young Black women to tell their stories so that others may learn from their experiences.

RQ2: How do insured young Black women experience mass media communications regarding prevention and detection?

Answer: The current cultural lens and pink ribbon society espoused by the media hold little relevance for young Black women. They see through the pink haze and hold no illusions. They are aware that breast cancer does in fact touch not only the lives of middle-class White women, but also those of Black women of every age and socioeconomic level. The breast cancer culture promulgated by the media, and by society, is in need of an overhaul. The young Black women in this study do not hold to the outdated images. Their proactive health behaviors and outspokenness may be what is

needed to begin to change the cultural dialogue for young Black women to one of self-care.

The concept of empowerment was echoed by Guidry et al. (2000) when they said “empowering African American women may overcome many of the psychosocial and cultural barriers and encourage their participation in their self-care” (p. 321).

Implications

This study was designed to address the disparate health outcomes of Black women with breast cancer compared to White women with breast cancer. Black women have the highest breast cancer rates of all ethnic/racial groups and a 41% higher rate of breast cancer deaths than do White women. More than 10% of Black women with breast cancer have been diagnosed before the age of 40 compared to 5% of White women (Johnson, 2002).

The aim of this study was to understand young Black women’s perceptions and experiences of breast cancer detection messaging in order to create relevant campaigns to counteract media generalizations of who is susceptible to being diagnosed with breast cancer. Understanding how members of different groups think about breast cancer can contribute to the creation of persuasive messages that effectively motivate people to undergo breast cancer screening or to seek medical care.

This study endeavored to examine the linkages between mass media campaigns and the impact such messaging has on the perceptions of young Black women. Based on the findings of this study, the following actionable campaigns could be informed by the results of this study:

- Communications that relate real-life stories of Black women—young and old—coupled with statistics of the disease.
- Efforts to fully inform young Black women of the causes of breast cancer, who is at risk, and how it can be prevented. Programs could be delivered to workplaces, churches, community organizations, or other locations common to young Black women.
- Detection campaigns that stray from the nationally recognized guidelines regarding breast cancer detection screening starting at age 40 to include younger Black women, who should be encouraged to talk to their doctors about their potential risks.
- Messaging used in educational interventions that supports the concept of empowerment exhibited by the women in this study.
- Ambassador programs using representative young Black women who have suffered from breast cancer who deliver their stories to Black communities including churches, Black sororities, or other community organizations.

Limitations of the Study

The current study was limited to 27 Black women. Although this study employed a small sample, the participants offered a unique perspective not found in previous studies based upon their high level of education, as well as their professional vocations. The following limiting factors defined the parameters of the research: (a) participants had to be between the ages of 30 and 40; (b) participants had to be employed full-time; (c) participants had to have private health insurance, and (d) participants had to never have been diagnosed or treated for breast cancer. Despite the limiting parameters, this study adds to the body of knowledge of Black women’s perspectives of breast cancer due to the

fact that participants in this study exhibited characteristics in contrast to previous studies. Prior research has primarily focused on older Black women from a lower socioeconomic strata whereas the women in this study were younger, employed in professional occupations, and had private health insurance which eliminated issues of access to care.

The study was conducted via telephone, which may have limited the researcher's ability to gauge participant responses and reactions. In spite of this, participant responses were descriptive and expressive. Additionally, the use of a semistructured questionnaire may have limited the researcher's ability to probe the participants' responses as thoroughly as needed. However, this approach enhanced data analysis by allowing response comparisons as well as identification of common responses and themes.

Recommendations for Future Study

The current research study examined the perceptions of young Black women regarding breast cancer messaging delivered through the media. Personal experiences with breast cancer and cultural influences played a role in the participants' perceptions. Following are eight approaches to extend the current study:

1. There have been a limited number of studies with young Black professional women regarding breast cancer; therefore it is recommended that additional studies with this population be undertaken to determine if the current study's findings are applicable to a larger group of this population segment.
2. In addition to expansion of the current study to a similar, but larger, population, the study instrument for this study should be used with a group of young Black women who are less educated and/or are employed in non-professional occupations to determine if these variables played a part in the results of this study.

3. Message content and delivery methods for breast cancer detection communication were key elements of this study. Additional studies should focus on testing specific messages and delivery modes with a similar population to create more effective health messaging around breast cancer that targets young Black women.
4. The concept of empowerment and its impact on young Black women should be evaluated as it relates to cancer control and prevention. This research could identify key factors that empower these women to participate in healthy behaviors and in breast cancer screening activities.
5. Interventions that target young Black women should be developed and tested among a diverse group that encompasses various educational and socioeconomic levels to determine the homogeneity or lack thereof of this population.
6. It is likely that the level of self-protective behavior exhibited by the women in this study is due to educational level and socioeconomic factors, but this is an area for study that should be explored to further understand the motivators for enacting preventive health strategies among young Black women.
7. Additional exploration of the concept of storytelling could extract relevant stories from Black women who have experienced breast cancer. These stories could inform health communication approaches that should be tested among young Black women.
8. The women in this study indicated that their physicians did not recommend breast cancer screening until the age of 40. Due to the high mortality rate among women under 40 studies with health care providers should probe for understanding of breast cancer risks for younger Black women as well as approaches to educate providers.

Summary

The primary purpose of this study was to address the high breast cancer mortality rate among young Black women, thus informing strategies to increase awareness of risk and encourage prevention activities. As such, the aim of this study was to determine how a group of young Black women make sense of the phenomenon of breast cancer detection health campaigns and how these campaigns inform their experiences and perspectives on breast cancer. The study represented an attempt to answer this question: What is the meaning, structure, and essence of the lived experience of this group of people?

The 27 young Black women in this study revealed familial and cultural influences in relation to health behaviors as well as their perspectives on how the media portrays breast cancer. Their open discussion allowed this researcher to identify shared meanings of breast cancer that could potentially be used in targeted campaigns designed to reduce the incidence and mortality of breast cancer in young Black women. According to Camella,

I think it would help women in general, especially African American women, to let the story out about the 22- and 25- and 28-year olds that do have breast cancer. I think the biggest misconception is still present in the fact that we keep thinking because your health insurance doesn't pay for your mammogram until you are 40 that you don't have to worry about breast cancer until you are 40. I think that's one of the biggest problems.

As health communicators, we have an opportunity—and an obligation—to change the dialogue of how breast cancer is depicted in the media. Health campaigns designed to educate and encourage women to engage in breast cancer detection screenings that are targeted to specific ethnic groups, such as Black women, not only raise awareness of the disease, but also act as a catalyst to influence behaviors of those targeted by these campaigns.

Appendix A. Pilot study questionnaire

FORM M. Data Collection Instrument

General Health Practices

1. Do you have a primary care physician? Why or why not?
2. If so, how often do you go to the doctor? Why?
3. Do you have an annual physical exam?
4. Do you have a gynecologist? Why or why not?
5. If so, do you have an annual exam? Why?
6. Do you have any concerns about your health? If so, explain.
7. Tell me about your eating habits.
8. Tell me about your physical activity habits.

Family Health History

9. Has anyone in your family ever had a health condition? Explain.
10. Does your mother, or other women in your family, have a gynecologist? If so, do they get regular exams? Have they had mammograms? At what age?
11. Do you discuss your health with other women in your family?

Health Knowledge

12. Are African Americans more likely to have certain health conditions, versus other ethnicities? Explain.
13. What health conditions do you feel you need to prevent?
14. What are the causes of general cancer? Of breast cancer?
15. Who do you think should get mammograms?
16. Have you ever had a mammogram? Why or why not?

17. Have other members of your family had mammograms? Why or why not?
18. At what age do you think women are most likely to get breast cancer? Why do you think this?

Breast Cancer Knowledge

19. What are the risk factors for breast cancer?
20. Do you believe that you are at risk for getting breast cancer? Why or why not?
21. Did you know that breast cancer occurs more frequently in African American women under the age of 40? Discuss your thoughts on this.
22. In light of this information, would you talk to your doctor about your risk?
23. Why do you think younger African American women tend to get breast cancer?

Breast Cancer Detection Awareness

24. Can you recall seeing information about breast cancer on TV or in magazines or newspapers? Explain.
25. If so, can you describe what you saw? If not, how do you learn about breast cancer?
26. Based on what you saw, who would you say is most likely to get breast cancer?
27. What were your thoughts as it relates to your health after seeing this information?
28. Are you familiar with events like the Race for the Cure and other breast cancer awareness events? Explain.
29. Discuss your thoughts on how information in the media and events impact your thoughts on the likelihood of you getting breast cancer.

Relevant Breast Cancer Messaging

30. What do you think would be important for young African American women to know about breast cancer?
31. How do you think those messages should be delivered?

32. Do you think the current messaging does a good job of letting African American women know about breast cancer? Why or why not?
33. How could we do a better job of informing African American women of their risks?
34. How could we encourage young African American women to get mammograms?

Appendix B. Final questionnaire
FORM M. Data Collection Instrument
Revised Draft

General Health Practices

1. When you say someone is health conscious, what does that mean?
2. Do you consider yourself to be health conscious? Why or why not?
3. Do you have a primary care physician? Why or why not?
4. If so, how often do you go to the doctor? Why?
5. Do you have an annual physical exam?
6. Do you have a gynecologist? Why or why not?
7. If so, do you have an annual exam? Why?
8. Do you have any general concerns about your health? If so, explain.
9. Tell me about your eating habits.
10. Tell me about your physical activity habits.

Culture (Physical and social environment, common beliefs, values, traditions, world view, similarities in lifestyle, attitude, perceptions, and behaviors.)

11. Do the women in your family talk about their personal health issues? Examples?
What about friends?
12. How important is what the women in your family say or do about their own health to you when it comes to taking care of your health? Examples?
13. Do you feel influenced from media, friends, family to take care of your health?
Where does most of the influence come from?
14. How important are your religious beliefs when it comes to your health?

15. What about relationships? If you have a partner, does your partner influence how you feel and what you do about your health? Why or why not?

Family Health History

16. Has anyone in your family ever had a health condition? Explain.

17. Does your mother, or other women in your family, have a gynecologist? If so, do they get regular exams?

18. Have they had mammograms? At what age? What have they said about it – how did they feel about it?

Health Knowledge

19. What health conditions do you think African Americans are more likely to get, i.e., diabetes, heart disease?

20. As an African American, what health conditions concern you or do you feel you need to prevent?

21. Are you likely to look for more information on these conditions? Why or why not?

22. Do you feel you might be at risk to get one of these conditions?

23. Is there anything you can do to prevent it?

Breast Cancer Knowledge

24. What are the causes of general cancer?

25. What do you think are the causes of breast cancer?

26. Where have you learned about breast cancer? Friends, family, media?

27. What are the symptoms/ what are the things that you might notice about your breasts that might mean you had breast cancer?

28. How would you feel if you found out you had breast cancer?

29. If you found out you had breast cancer, would you tell your family, friends, coworkers? Why or why not?
30. Would you tell your partner? How would it affect your relationship?
31. Do you know anyone who has had breast cancer? AA or other? How did they handle it?
32. At what age do you think women are most likely to get breast cancer? Why do you think this?
33. Based on what you know, do you believe that women who get breast cancer have a good chance of surviving? Why or why not?
34. When you think of the image of a person with breast cancer, what does it look like – who is it?
35. More White women are diagnosed with breast cancer, but more African American women die. Among African American women, more women under age 40 die from breast cancer. Why do you think more young women die?

Mammography

36. What is the purpose of getting a mammogram? How does it help women? Is it effective in finding cancer?
37. Who do you think should get mammograms? What age?
38. Have you ever had a mammogram? Why or why not? Describe the experience.

Breast Cancer Detection Awareness

39. Tell me about information you've seen about breast cancer on TV, in magazines or newspapers, or the Internet? What is it about (detection, treatment, etc)?
40. How did it make you feel?

41. Did it make you want to do anything about your health, i.e. get a mammogram? If you haven't seen any information, how did you learn about breast cancer?
42. Based on what you saw, who would you say is most likely to get breast cancer?
43. What were your thoughts as it relates to your health after seeing this information?
44. Based on what you saw, do you think you can prevent breast cancer? What could you do? Why do you think that?

Health Messaging to African Americans: Advertising and the Media

45. Where do you get your information about health? **Media:** Newspaper, magazines, internet, TV, radio, social media? **People:** family, friends, coworkers, medical professionals?
46. What types of health issues do you see information on?
47. When you see information in the media on health, is it relevant to you – do you relate to it?

Relevant Breast Cancer Messaging

48. Do you think the current messaging does a good job of letting African American women know about breast cancer and what their risk might be? Why or why not?
49. What do you think would be important for young African American women to know about breast cancer?
50. How do you think those messages should be delivered?

RPA – Information-Seeking Behaviors

51. When it comes to finding out information about health, would you say you actively look for information or do you find out information as you are watching the news or in conversation with people?

52. Based on what you know and your impressions of what you see about breast cancer, how likely is it that you feel you might be at risk to get breast cancer? Why?

53. Do you believe that there is anything you can do to prevent getting breast cancer? Are you likely to do those things? Why or why not?

54. What about getting a screening mammogram? Based on what you know about breast cancer and see in the media, do you feel like that is something you would/could do? If your doctor recommended it would you be more likely to get one? Why or why not?

Closing Thoughts

55. Any final thoughts on what we've discussed?

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Director of Marketing and Promotion, WDRB-TV/Fox 41

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Vice President, Account Group Manager, Sheehy & Associates Advertising

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CORE COMPETENCIES

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