led to long appointment wait times at our center, reaching a maximum of eight months. Group education has been recently utilized as a means of providing more efficient cancer genetic counseling. We report our experience using group counseling for HBOC. METHODS: Lower-risk patients (*BRCA*Pro probability of *BRCA*1/2 mutation <10%) were offered group genetic counseling (GGC) during either a morning or evening bi-monthly session. After GGC, patients had the option to return for a shorter individual session with a genetic counselor and physician to expand family history, discuss concerns, develop an individualized plan, provide consent, and have blood drawn for testing. RESULTS: Introducing GGC dramatically decreased all clinic patients' wait time and allowed higher-risk patients to be offered appointments within 1–2 weeks. To date, 441 patients have attended 30 group sessions (average 15 per class). 95% returned for the abbreviated individual counseling session. 82% of patients completed an evaluation form and all agreed that the session was "well-organized and information was presented well." A majority (97%) indicated that the amount of information presented was appropriate and that the audiovisuals were helpful. 89% were satisfied with the convenience of the class time. 91% indicated that the session provided sufficient information to decide whether or not to pursue genetic testing; 9% checked "unsure" or "disagree" with reasons including having decided about testing prior to the session, individuals' physicians having recommended this testing, or the desire to check insurance coverage before testing. CONCLUSION: GGC is successful and has significantly reduced our appointment wait time while maintaining patient satisfaction. Future expansion of GGC may include satellite clinics, higher-risk HBOC patients and/or patients referred for evaluation of other cancer predisposition syndromes.

IV. COMMUNICATION

Patient Preferences for an Appropriate Time for Cancer Genetic Counseling and *BRCA* Testing for Women Diagnosed with Breast Cancer

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The point at which genetic counseling and testing is offered following a woman's diagnosis of breast cancer may be of importance to her surgical decision-making. Whether she receives counseling between diagnosis and treatment or after treatment may be important with respect to her emotional well-being and may influence treatment decision-making options. Few studies have focused on patient attitudes toward the timing of their counseling sessions and receipt of test results or how the timing may influence any surgical decisions. The purposes of this study were to determine if women diagnosed with breast cancer have a preference about when they should receive genetic counseling and testing for hereditary breast cancer risk assessment and to gain a better understanding of whether genetic counseling and testing influence surgical decision-making. We recruited 60 women from Women and Infants' Hospital in Providence, RI, and the Facing Our Risk of Cancer Empowered online support group, who were diagnosed with breast cancer and received genetic counseling between September 2006 thru 2008, to participate in an online anonymous survey. The survey consisted of 31 multiple-choice and open-ended questions addressing demographics, personal and family cancer history and preferences for timing of genetic counseling. Most women (56%) preferred genetic counseling and testing prior to surgery. None of our participants preferred counseling later than when they actually received it. Almost 80% of our sample who received counseling and testing prior to surgery (n=13) felt their counseling and genetic test result influenced their surgical decision. Only 15% of our sample felt psychologically overwhelmed by the information received during counseling regardless of whether they received counseling before or after surgery. Our results provide evidence to support the practice of referring women diagnosed with breast cancer to genetic counseling for *BRCA* testing prior to surgical treatment.

Identifying Different Patterns of Patient-Provider Communication During the Disclosure of Susceptibility Test Results for Alzheimer's Disease

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Introduction: Communicating genetics test results involves complex social interactions. Previous studies examining patient-provider communication in genetic counseling considered pre-testing sessions only, not test result disclosure sessions - often the last opportunity to ensure patients' successful comprehension of complicated information. This study identified patterns of communication during test result disclosure sessions and the associated participant character-

istics. Hypothesis: Clinically distinct communication patterns in genetic test result disclosure sessions could be identified, with pattern variation associated with patient (e.g., race, gender) and provider characteristics. Methods: 262 genetic counseling sessions conducted by five genetic counselors and four physicians were observed during the REVEAL II randomized controlled trial assessing the impact of providing genetic risk based on *APOE* genotyping to unaffected adult children of AD patients. Most subjects were women (71%), 21% were African–American, and the mean age was 58. Audio recordings of sessions were coded using the Roter Interactional Analysis System (RIAS), a well-validated communication analysis scheme whereby all patient-provider interactions are categorized into domains addressing content, affect and function of verbal exchanges. A hierarchical cluster analysis was performed to identify the interaction patterns. Chi square and ANOVA analyses were used to test associations between interaction patterns and participant characteristics. Results: Four patterns were identified: patient-centered, (i.e., less biomedical talk, more patient psychosocial talk) patient-centered leaning, traditional biomedical (i.e., most provider biomedical talk, least patient psychosocial talk), and biomedical leaning. Patient race, provider type and session length were associated with pattern differences ($p<0.05$); patient age, gender, and *APOE* status were not. Conclusions: While each disclosure of test results is a unique case, the interaction largely conforms to a small number of discrete patterns, which vary according to patient race and the provider orientation. This classification allows future research to examine whether different communication styles predict patient response and adjustment to genetic test information.

"What Would You Do if You were Me?" Effects of Counselor Self- Disclosure Versus Non-Disclosure in a Hypothetical Genetic Counseling Session

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Self-disclosure is a controversial genetic counselor behavior. Prior research suggests the most prevalent reason genetic counselors disclose is because clients ask them to do so (Peters et al., 2004; Thomas et al., 2006), asking for instance, "What would you do if you were me?" Empirical data describing the effects of counselor disclosure on genetic counseling processes and outcomes are lacking. To begin to address this issue, we recruited 151 students (94 undergraduates, 57 graduates) at a major Midwestern university. They completed one of three randomly assigned versions of an anonymous survey. Respondents were asked to imagine themselves as the client at risk for FAP in a hypothetical cancer genetic counseling scenario and to read a dialogue between the client and genetic counselor. The client was considering whether to pursue testing or surveillance procedures. The dialogue was identical in all survey versions except for the final interchange: The client asks "What would you do if you were me?" In the Personal Disclosure Survey the counselor reveals what she would do. In the Impersonal Disclosure Survey she reveals what prior clients have done. In the No-Disclosure Survey she reflects the client's feelings. Respondents were asked to: write a response to the counselor; indicate their perceptions of her expertness, trustworthiness, and attractiveness (warmth, likeability) using the Counselor Rating Form-S (Corrigan and Dell, 1980); and rate their satisfaction with the counselor. Multivariate analysis of variance and post-hoc tests revealed both undergraduates and graduate students rated the No Disclosure counselor significantly lower in attractiveness than the other two counselors and significantly less satisfying than the Impersonal Disclosure counselor. Content analysis of written responses yielded four themes: Information Seeking, Decision Making, No Decision, Patient Psychological State. Additional findings (e.g., thematic differences in responses across disclosure conditions), practice implications, and research recommendations are provided.

Improving the Process of Breaking Bad News: A Study of Family Experiences

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"Breaking bad news" is an integral part of clinical genetics practice. Despite published suggestions for minimizing this trauma, many families still report dissatisfaction in receiving a genetic diagnosis. Our study aimed to garner information on negative and positive statements made, or actions taken, by healthcare providers during the diagnostic process. Email invitations were sent to 1700 members of the Williams Syndrome Association (WSA) inviting them to complete an anonymous online 13 question mixed-method survey. The questionnaire, developed specifically for this study, contained multiple choice and open-ended items. Significance was calculated using a chi-squared test of association. Responses were received from 600 families nationally (exact participation rate not calculable due to barriers of mass-emailings). Individuals with Williams syndrome ranged from <1 year to 55 years ($M=14.31$, $SD=11.27$), and in 75% the diagnosis was established before age 3. Factors associated with families