

Patients' understanding of shared decision-making in a mental health setting: The importance of the patient-provider relationship

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Abstract

Shared decision making is a fundamental component of patient-centered care and has been linked to positive health outcomes. Increasingly, researchers are turning their attention to shared decision making in mental health; however, few studies have explored decision making in these settings from patients' perspectives. We examined patients' accounts and understanding of shared decision making. We analyzed interviews from 54 veterans receiving outpatient mental health care at a Department of Veterans Affairs Medical Center in the United States. Although patients' understanding of shared decision making was consistent with accounts published in the literature, participants reported that shared decision making goes well beyond these components. They identified the patient-provider relationship as the bedrock of shared decision making and highlighted several factors that interfere with shared decision making. Our findings highlight the importance of the patient-provider relationship as a fundamental element of shared decision making and point to areas for potential improvement.

Keywords

communication; decision making; mental health and illness; relationships, health care; research, qualitative

Ethicists and patient advocates have long supported shared decision making on ethical grounds, arguing for the autonomy and involvement of patients in their own care (Ashcroft, Hope, & Parker, 2001; Deegan & Drake, 2006; Freedom Commission, 2003; Institute of Medicine, 2001). Recent studies documenting positive health outcomes associated with shared decision making, such as decreased hospitalization, improved satisfaction with treatment, and increased medication adherence strengthen efforts to improve health communication (Davey, Lim, Buttow, Barratt, & Redman, 2004; Joosten, DeFuentes-Merillas, de Wert, Sensky, van der Staak, & de John, 2008a; Loh, Simon, & Wills, 2007; Wennberg, O'Connor, Collins, & Weinstein, 2007). Moreover, institutions such as the U.S. Veterans Health Administration have incorporated shared decision making in their health policies with the goals of implementing patient-centered care and improving individuals' health (Anderson, 1997; Saha et al., 2008).

Despite significant research on shared decision making and reports that patients with mental illness are interested in participating in treatment decisions (Adams, Drake, & Wolford, 2007; Mahone et al., 2011; Matthias, Salyers, Rollins, & Frankel, 2012; Woltmann & Whitley, 2010), the process of shared decision making in psychiatric settings remains largely unexplored (Adams & Drake, 2006; Hamann, Leucht, & Kissing, 2003; Hamann, Cohen, Leucht, Busch, & Kissling, 2007; Mahone et al., 2011). Most psychiatric illnesses are chronic conditions that require ongoing treatment decisions about medication management, psychosocial support, and physical health care needs. These decisions are sensitive to patient-provider collaboration and influence the quality of psychiatric care services and, ultimately, patients' mental health. Thus far, research studies on how patients receiving mental health care make treatment decisions are scarce (Mahone et al., 2011; Matthias, et al., 2012).

We also have limited understanding of patients' views of shared decision making in mental health and the factors that facilitate or impede their participation in this process. In addition, few studies have explored how patients with mental illness describe their ideal decision making process, and how it might vary from current research models of shared decision making. If shared decision making is to be truly patient-centered, then it is critical to understand what patients value when making treatment decisions.

This lack of knowledge is complicated by varied definitions of shared decision making among researchers. In fact, 2 literature reviews on this subject revealed that there is no consensus on the definition and measures of shared decision making (Makoul & Clayman, 2006; Momjid, Gafni, Brémond, & Carrère, 2007). These reviews indicated that published journal articles on shared decision making often do not provide a clear definition, or they use the term inconsistently. Such inconsistencies obscure research efforts, undermine processes of implementation, and might lead to confusion for patients and physicians who would like to use this approach (Charles, Whelan, Gafni, Willan, & Farrell, 2003; Makoul & Clayman, 2006; Momjid, Gafni, Brémond, & Carrère, 2007).

One of the most commonly cited frameworks of shared decision making in the literature is that of Charles, Gafni and Whelan (1997). They described shared decision making as an interactive process in which patients and providers participate in all stages of the decision making process. In this framework, providers and patients work collaboratively to set goals, explore health concerns and treatment preferences, discuss treatment options, and decide together on a course of action.

The purpose of this study was to investigate how patients understand the concept of shared decision making. We examined patients' descriptions of shared decision making and

narratives of treatment decisions with their providers. We focused on patients with mental illness and examined routine outpatient medication management visits with providers in a psychiatric clinic. The context of routine outpatient medication management visits provided opportunities to assess how patients made treatment decisions with their providers as well as health communication in everyday clinical practice (Shaligram, Nestelbaum, Pearlmutter, & Brown, 2011).

Methods

Study Design

This article is based on the qualitative component of a larger study of patient-provider communication in mental health (Matthias et al., in press). The parent research project was a mixed-methods study, in which we examined processes of shared decision making in routine mental health visits in a psychiatric outpatient clinic at a Veterans Affairs medical center in the United States. It included analyses of audio-recorded interactions between mental health providers (1 psychiatrist and 2 nurse practitioners) and patients. We used the Shared Decision Making Scale (Salyers et al., 2012), an adaptation of the Braddock Informed Decision Making rating scale (Braddock, Fihn, Levinson, Jonsen, & Pearlman, 1997) to assess shared decision making.

We also administered questionnaires to patients to evaluate patient activation, illness management, medication adherence, and patient-provider working alliance. In addition, we conducted interviews with patients after their scheduled medication-check visits, which were explicitly designed with the goal of examining patients' understanding of the concept of shared decision making. The focus on patients' perspectives facilitated a greater understanding of their

views, attitudes, and meanings associated with shared decision making, as well as what matters the most to them in their interactions with providers.

Participants

The parent study included 79 participants who were recruited using a convenience sampling method. This involved approaching patients of participating providers while they waited for their visits and asking them to participate in the study. Of these participants, 54 (68%), agreed to complete a one-time interview immediately after their medication management visits. The main reason given for non-participation was time constraints. Written, signed consent forms were obtained from all participants prior to the interviews. Research procedures were approved by the local institutional review board and medical center research and development committee.

The majority of patients were White (75%), men (90%), and between the ages of 40 to 65 (68%). All patients were veterans receiving psychiatric care for a broad range of psychiatric conditions such as mood disorders, PTSD, and schizophrenia. Participants had varied lengths of relationship with their providers, ranging from 3 months to 8 years. Two thirds of the participants had worked with the same provider for 1 to 3 years. The diagnostic diversity of this sample closely mirrors the diversity of patients in psychiatric clinics, where providers are likely to treat patients with a wide variety of diagnoses, co-morbid disorders, and considerable variation in relationship duration.

Interviews

Participants completed semi-structured interviews that lasted approximately 60 minutes. The interviews consisted of open-ended questions that focused on patients' views of shared decision making, medication and treatment decisions, illness management, and relationship with their providers. Questions about medication assessed patients' knowledge about their medication,

medication treatment decisions, and history of medication adherence. In the interviews, we asked participants about their history of involving providers, relatives, and friends in their treatment decision making. Some questions focused specifically on their understanding of shared decision making e.g., “What does shared decision making mean to you?” It is important to underscore that participants were never given a definition of shared decision making; rather, they were asked an open-ended question and were allowed to take the question in any direction they wanted.

We also queried participants about their relationship with their providers, including experiences of disagreement. Finally, the interview protocol included questions about the participants’ management of their illness and factors that could help improve their mental health. The questions were formulated to facilitate participants’ descriptions of their own experiences, while exploring in-depth issues related to patient-provider communication and treatment decision making (Clandinin & Connelly, 2000). All interviews were audio-recorded, transcribed verbatim, de-identified, checked for accuracy by comparing transcribed text to the original audio recordings, and imported into Atlas.ti computer program (2010), a qualitative data analysis tool.

Data Analysis

We utilized a thematic analysis approach to identify patients’ understanding of shared decision making. We analyzed the data by first reading independently sets of transcripts to identify key themes and to gain a general understanding of the data. Then, we met to compare emergent themes and develop initial coding structures. We conducted open coding by dividing portions of the text into meaningful units of analysis or codes and common themes that emerged across the transcripts. We discussed this list of preliminary codes identified during this initial open coding procedure and sorted them into categories that reflected important ideas and themes (axial

coding) (Auerbach & Silverstein, 2003; DeSantis & Ugarriza, 2000; Glaser, 1978; Guest, MacQueen, & Namey, 2012; Saldaña, 2009).

We noted and discussed repeated themes that emerged across multiple participants as well as deviations from common opinions and counter-examples. We refined the coding categories by generating sub-themes, making connections between the themes, and linking them to key questions and broad content areas. Any discrepancies in the coding process were resolved by discussion during regular data analysis meetings. After we finalized the list of codes, we applied the codes to all transcripts, including the transcripts that were used for generating the initial coding categories, using Atlas-ti.

Throughout data analysis, we continually returned to the data to answer questions and review the coding and themes using an iterative process for category reliability (Birks & Mills, 2011). In reviewing the transcripts, we also focused attention on discerning how participants described shared decision making in their own terms and how such understandings varied. We examined the saliency and consistency of key themes across participants. We determined saturation in the sample once we could not identify new information or variations of a given theme in the data, and based on evidence of multiple repeated coding within the same core category (Suter, 2012).

Results

Participants' Understanding of Shared Decision Making

The participants defined shared decision making as a process that requires active participation and collaboration of patient and provider, with the goal of making a mutually agreed-upon decision that will benefit the patient. Most participants, even those who were unfamiliar with the concept, were able to draw from their personal, lived experiences to describe shared decision

making. Their descriptions underscored 3 key components that paralleled definitions of the concept in the literature: information sharing between patient and provider, general discussion about treatment options, and a final decision that is mutually agreed upon by provider and the patient. To illustrate, one participant stated:

Shared decision making is gathering all the facts and sitting down with the parties involved. In my case, it would be my wife, myself, and my caregiver, and looking at those facts and coming up with a consensus between all of us on the route we take for my recovery.

Even though most participants had a general understanding of shared decision making, a small number of participants struggled to provide a definition or deviated from the essence of the concept, which involves collaborative partnership. A few participants described shared decision making as having someone else making treatment decisions for them. One participant stated: “Either I figure it out myself or somebody tells me what to do.” Another one defined it as follows: “Someone else wants to make the decision.”

These participants were more likely to report deferring mental health treatment decisions to their providers. For example, one of the participants quoted above also noted that he “gladly left [treatment decision] up to the doctor.” He described how his doctor made treatment recommendations and decisions for him and he agreed with her decisions without much discussion or input. Notably, these participants were not characteristically different from the rest of the sample. They shared similar diagnoses, demographics, and providers with other participants in the study, which suggest that other personal and experiential factors might account for their varied understandings of shared decision making.

Situating the Patient-Provider Relationship at the Center of Shared Decision Making

As participants articulated their views of shared decision making, they repeatedly mentioned that a strong, trusting patient-provider relationship is integral to the process of sharing treatment decisions. They noted that the kind of patient-provider relationship involved in shared decision making parallels many features of marriage. They ascribed several key characteristics to the relationship in order for it to be effective and to lead to successful shared decision making. These were equality and partnership, mutual agreement, trust and honesty, care and empathy. In this section, we examined these characteristics by exploring how they are expressed in contexts of mental health treatment decision making. We concluded by analyzing the power dynamics involved in framing the patient-provider relationship as a marriage and situating it at the center of shared decision making.

In defining shared decision making, many participants used the schema of a successful, egalitarian marriage to describe the complexities and dynamics, as well as the benefits, of making shared decisions in a meaningful relationship. For example, one person gave the following definition: “Agreeing with somebody else. . . . Well, like me and my wife. We talk something over before we do something or buy something. That's a shared decision.” Participants also compared marriage to a relationship with one’s doctor insofar as it requires shared decision making to be successful. One participant articulated this point by attributing the success of his 44 years of marriage to shared decision making. He emphasized the importance of communication and prolonged, open discussions to make it work in a marriage as in a patient-provider relationship:

[Shared decision making] means discussion on both sides. It's me giving my ideas to somebody or discussing what I feel and letting that person discuss, come back with their

thoughts of what I am doing. . . . I found that marriage is the same way, as with your doctor. You've got to discuss with the person. That's what has helped me be for forty-four years married to the same woman.

As these examples illustrate, using marriage to describe the patient-provider relationship reconfigures the traditional roles of patients and providers, and assigns new meanings to their relationship. In this new configuration, patients are no longer submissive recipients of care, but active participants and equal partners who complement their counterparts. Moreover, participants identified several characteristics they deemed essential for a strong patient-provider relationship and successful shared decision making. They discussed the importance of being heard and having mutual respect to help foster a strong relationship. Only with such a foundation in place would they be able to truly participate in shared decision making – be able to collaborate, negotiate, and compromise on treatment decisions with their providers. As an example, a participant described shared decision as follows: “Equal input. Sounds like compromise. Sounds like a partnership, fifty/fifty. . . . A total agreement with both parties; [Having] equal opinions.”

The importance of equality and respect is also reflected in participants’ discussions about having mutual agreement in shared decision making. For the participants, mutual agreement implied recognizing that patients and providers are “at the same level,” respecting each other’s input, and engaging in a discussion or a “two-way conversation” that would lead to an agreement. A participant outlined this point in his definition: “Shared decision making? Well, it's something you agree on. I mean, it's not something that's pushed down your throat.” A different participant added:

[Shared decision making] means both parties give input and come up with agreement. I mean, she gives me input and I also give input, and then we come to an agreement, with her input and my input all on the same level.

In these examples, participants contrasted the process of shared decision making with the traditional, paternalistic decision making model where providers are the sole decision makers who impose their ideas on patients. The traditional model positions patients as subordinates rather than active and engaged participants in the decision making process. These excerpts also speak to the power struggle that often exists in patient-provider relationships. One participant quoted above explicitly referred to the ways providers' decisions are sometimes "pushed down [patients'] throats," leaving them disempowered and with few choices. He asserted that in shared decision making both parties, patients and providers, are viewed as experts and their contributions to the treatment decision are equally valued. Discussions about mutual respect and equality relate to the core principles of shared decision making, which seek to empower patients, to become collaborative partners in their treatment.

Participants also listed personal attributes of their providers that they believed facilitated interpersonal connections. Although many noted that time helped to strengthen their relationships with their providers, they also argued that providers' personal characteristics were influential in fostering their relationship. They believed their providers genuinely care for them not just as patients, but as human beings with dignity and agency. Both new and established patients identified similar provider characteristics that contributed to the development of their relationships and shared decision making.

For example, participants shared experiences in which their providers inquired about their personal lives and expressed interests in them. One participant noted that his provider visited him while he was hospitalized. Another talked about how he and his provider share a common interest in dogs and often spent time exchanging stories about their pets. These exchanges facilitated a human connection, leading to the development of a genuine relationship. One participant, shared: “[Our relationship] is strictly professional but in a friendly manner. . . . We've even hugged each other on occasion. We've both cried. I mean, not so much her. . . . I can tell she's sincere. She's been good.” Another participant noted:

I like her because she actually does care about me being her patient instead of just a number, next, next one in line. The other ones just see how fast they can get me out of their office. . . . She's really curious and she's suggesting things that will help me instead of just running me through the mill.

In these excerpts as in other examples, participants pointed to how their providers inquired about their personal lives and connected with them on a personal level. They also acknowledged the time pressure that both patients and providers face during clinical encounters, and that despite these barriers, patients value and seek personal connections with their providers. These relationships become the bedrock for shared decision making and facilitate the ongoing development and application of the various components of the process, particularly open discussion about difficult mental health subjects such as addictions and maladaptive behaviors.

Participants were keenly aware of their role and contributions in the patient-provider relationship. They identified the need for patients to be active partners in the marriage and to embrace the same qualities that they expect from the providers, particularly honesty. They

reported that they need to be honest with their providers and open to their feedback and recommendations to make informed decisions and to ensure progress in their recovery. Several participants explicitly stated that shared decision making is more than just “being friendly,” reinforcing that a deeper level of connection is needed to facilitate open discussion and collaborative partnership in treatment decisions.

Participants reported that they valued providers’ honest opinions, straightforwardness and directness. Many noted that they appreciated their providers’ ability to hold them accountable, to keep them honest, and to have high expectations of them in their own care. Doing so indicated to them that the providers respect them and genuinely care for their well-being. In fact, several participants reflected that the turning points or significant moments in their relationships with their providers involved being challenged by them. As in marriage, having a solid relationship with their providers enabled the participants to have open, productive discussions that could lead to behavioral change, trust, and better health. One participant explained the importance of honesty in his relationship with his provider in the following excerpt:

[We have a] very good [relationship]. It's not really just a matter of liking one another. It's just that I think she's very professional, knowledgeable, and trustworthy. She doesn't just say things to be sounding good or to say them because it sounds like something I would want to hear. I think it's very honest.

Although participants valued honesty, they were not always receptive to providers’ feedback and directness. The context of the provider’s feedback and the quality of the patient-provider relationship influenced participants’ interpretations of and receptiveness to providers’ recommendations. For some patients, a solid relationship embedded in trust and mutual respect

facilitated openness to constructive criticisms. It also fostered resiliency – the ability to overcome ruptures or difficult impasses in the relationship. In the absence of such a foundation, providers' directness could be construed negatively or viewed as assaults on the patient's dignity and sense of self.

To illustrate, one participant discussed how he responded to 2 different providers' feedback about his alcohol use. This participant described contrasting views of his relationships and interactions with 2 different providers. In the first excerpt, he painted a scenario in which key components of shared decision making, as outlined above by the participants, were absent. In contrast, in the second excerpt, the participant detailed a more collaborative process that welcomed the participant's input and facilitated his engagement in treatment.

When I first started to come up here, they gave me a man [as a provider] and to be honest, I think he had issues. He fixated on drinking. "Well, you drink." I said, yeah, you asked me if I drank. "Well, that seems to be a whole lot of your problem." How did he know that? He's only met me once. How can he tell me what my problem is? I'm trying to tell you what I think my problem is. . . . He had a very pompous attitude, like I didn't know what I was talking about. I'm not a dumb person. I had enough sense to come up here to seek help, so I'm not real stupid. Part of my problem is being made to feel inadequate based on the depression, anxiety and stuff.

From the beginning, she let me talk. She didn't baby me. She told me my mistakes too. But she didn't fixate just on alcohol. Yes, alcohol can be a problem depending on how you react to it. She said that. To over-use alcohol is wrong. She made that clear. [However], she realized that wasn't my only problem. . . . We have worked on the

problems that I've brought to her. I feel comfortable enough with her that I can open up. I can open up to her about my drinking if I feel like it's too much.

The participants' description of the provider as pompous in the first excerpt reflects what he perceived to be the unequal status of their positions during the clinical encounter. He interpreted the provider's comments as moral judgments against his behavior and an incomplete, narrow analysis of his problems. The provider's perceived premature attempt to inform the patient of his problem, rather than offering help, created further distance between them. In the second excerpt, the provider listened to and tried to understand the patient, not just his presenting problems. She first developed a working alliance that helped him to be forthcoming and receptive to his providers' recommendations.

In sum, participants situated the patient-provider relationship at the center of the development and implementation of collaborative treatment decision making in mental health. They viewed patients as having equal rights, responsibilities, and contributions to the decision making process. However, participants' emphasis on equality does not completely disavow the reality of the intrinsic power dynamics in the patient-provider relationship. Participants called attention to the value of equality and mutual respect to facilitate open discussions and shared decision making, but also pointed to tensions and difficulties that might arise in such relationship because of power dynamics. For example, one participant explicitly stated that, as in his relationship with his ex-wife, he had to agree to disagree sometimes with his provider. Others acknowledged the expertise of their providers and the need to rely on or defer to their providers at times, as they continue to be involved in the decision making process.

Indeed, as with in many marriages, the power dynamics are inherent and fluid, and mediated by gender, cultural identities, and values. Although both parties might bring valuable contributions to the partnership, they possess different skills, knowledge, and strengths that are manifested and exploited at different times. In similar ways, patients' views of their relationships with their providers espouse cultural values and take into account practicalities such as complexities of one's condition. Moreover, the patient-provider relationship goes beyond a typical working partnership. While it involves trust, struggles, and success like in any other relationships, to be truly successful, it also requires strong emotional connections, open discussions, and opportunities for growth by challenging patients to face their struggles and take ownership in their treatment.

Challenges to the Patient-Provider Relationship and Shared Decision Making

Participants also discussed challenges to the relationship that could ultimately impede shared decision making. They outlined several barriers, such as gender and ethnicity that reflect the social contexts in which shared decision making is embedded. Gender differences posed difficulties for some patients in their efforts to connect and communicate with their providers. The majority of participants were middle-aged White men, and all the providers were women. Some noted that it is difficult at times to talk openly about their illness experiences, particularly sexual symptoms. Some questioned whether their providers would understand or be able to relate to them. However, they also noted that their provider's ability to engage with them facilitated discussion about their sexual concerns.

In the excerpts below, the participants talked about how they were able to overcome their embarrassment to discuss sexual problems with their female provider. They noted that their provider's communication skills – many of the same skills required for shared decision making –

helped them to open up and seek the care they needed. They also emphasized that a strong patient-provider relationship could help overcome potential gender and other barriers in the shared decision making process.

I do not feel embarrassed as I would with other females, like with the back condition and with the ankle. Sometimes when you're placed in that position, it causes you problems in your sexual area as well. I had a big hernia. I felt comfortable to let her know it was doing that. But at first I wasn't. I was red in the face, but then, she laughed and got it out of me. It's been good ever since. And she does know how to communicate really good.

I wonder if everybody else can open up to their doctor like I can with [provider], without her judging me. She made me feel free to talk to her about everything. I mean, you would not believe some of the stuff I say to this woman, I mean, as far as what's going on with me. I surprise myself. That's how comfortable she has made me feel.

For a few participants, ethnicity was a barrier. They discussed their experiences of shutting down during their visits with providers who were from the Middle East; both relationships eventually ended. They explained that having a Middle Eastern clinician provoked negative emotions from their experiences of military deployment in the region. One participant shared that a previous mental health provider had a heavy accent and he could not run the risk of being misunderstood by a mental health provider who has the power to assign psychiatric diagnoses that would remain in his medical records.

He believed that the consequences of being misunderstood by a mental health provider were far greater than being misunderstood by his primary care provider, who is also non-white

and speaks with an accent. For him, an incorrect mental health diagnosis has serious long-term implications, such as stigma, that could jeopardize his social standing and future. A few others also noted the role of gender in communicating and developing a relationship with mental health providers. Some participants preferred female providers because they perceived them as more engaging and empathic. One noted: “I have a good rapport with her 'cause I've had some [whispers] [expletive] in here, especially males. . . . The female doctors seem to care a little bit more than the males.”

Although only a few participants raised the issues of ethnicity and gender, their concerns point to how individual characteristics and social contexts might challenge the process of shared decision making. They also reinforce participants' assertions that the patient-provider relationship is central to the shared decision making process. Consequently, factors that undermine the relationship will also have adverse impacts on patients' participation in treatment decisions.

Discussion

Patients with mental illness understood the concept of shared decision making and desired to be engaged at some level in this model of treatment decision making. Their descriptions of shared decision making closely parallel Charles et al.'s (1997) model of the concept by outlining key characteristics, such as shared information, general discussion about treatment options, and mutual agreement on a final decision. Of these components, participants strongly emphasized mutual agreement as a core element of shared decision making. This emphasis reflects the value that participants placed on collaboration with their providers and having an input in their treatment decisions.

However, participants also saw dimensions to shared decision making that Charles et al. (1997) did not discuss. Participants viewed the patient-provider relationship not simply as a prerequisite for shared decision making, but as a necessary component that frames the context in which shared decision making occurs. This relationship also facilitates implementation of all elements of shared decision making – information sharing, discussion of treatment options, and decision on the final course of action. Participants indicated that without this foundation, shared decision making might not be possible. In the absence of a strong relationship, other elements of shared decision making highlighted in the literature, such as the presentation of options and discussion of pros and cons of treatment options, become less meaningful, or might not even occur.

In the medical literature, shared decision making is often presented as a method or a model of decision making that is applied formulaically to treatment discussions to facilitate treatment decisions between patients and providers. As such, decision aids and measures developed to assess and facilitate shared decision making rely on items that do not always capture the dynamics, nuances, and values that are integral to the development and process of shared decision making. Although shared decision making is based on the principle of collaborative partnership between patient and provider, it is often discussed without consideration of the quality of the relationship. Indeed, discussions about the patient-provider relationship remain at the periphery of the process.

In contrast, participants in this study situated the patient-provider relationship at the center of shared decision making and maintained that it is essential for the process of treatment decisions. This finding adds an important dimension to theoretical constructions of shared decision making and provides impetus for additional research into the impact of the patient-

provider relationship on shared decision-making. Moreover, participants' definitions of shared decision making, especially the emphasis on the patient-provider relationship, have many parallels to the construct of working alliance.

Conceptualizations of working alliance have evolved over time and its definition varies (Ardito & Rabellino, 2011). Bordin's conceptualization of working alliance is, however, applicable across therapeutic approaches and is widely cited (Ardito & Rabellino, 2011; Bordin, 1979; Horvath & Luborsky, 1993). According to Bordin, working alliance refers to the collaborative relationship between patient and provider with the common goal to overcome patients' suffering. It consists of 3 essential elements that are similar to components of shared decision making: the development of a personal bond, agreement on the goals of treatment, and agreement on treatment tasks or methods. Collaboration and personal attachment between therapists and patients are key aspects of working alliance that correlate with patients' health outcomes (Horvath & Luborsky 1993). These aspects also relate to shared decision making (Fische, 2006; Joosten, de Weert, Sensky, van der Staak, & de Jong, 2014b).

Although limited, emerging studies have indicated that shared decision making might moderate the quality of the patient-provider relationship. In a randomized controlled trial with patients with fibromyalgia, Bieber et al. (2006, 2008) found that patients and providers reported improved patient-provider relationship and interactions after they participated in a shared decision making communication training. In a study with substance-dependent patients in inpatient settings, Joosten et al. (2008b) found that a shared decision making intervention increased clinicians' but not patients' perceptions of therapeutic alliance. These findings suggest that shared decision making might lead to improved patient-provider relationships, particularly

with regard to working and therapeutic alliances. These authors called for more research to better understand the relationship between shared decision making and working alliance.

In contrast to working alliance, measures of shared decision making do not generally assess the presence and quality of the patient –provider relationship. Rather, they emphasize the process of communication between patients and providers in the clinical encounter. Indeed, multiple interventions frame shared decision making as a treatment strategy that promotes better communication and decision making across disciplines (Corser, Holmes-Rovner, Lein, & Gossain, 2007; Hamann et al., 2006; Jones, Bruce, Shah, Taylor, & Stewart, 2011; Mott, Stantley, Street, Grady, & Teng, 2014; van der Krieke et al., 2014).

Participants' focus on the patient-provider relationship suggests that, while still professional, the relationship remains an intimate, meaningful partnership that goes beyond many other professional relationships. In particular, the marriage schema provides a specific set of meanings through which many patients perceived and interpreted their relationship. Providers do not simply deliver treatment, but build relationships that invite patients' engagement. Building a trusting partnership is a process that takes time and requires ongoing effort and attention. Participants' discussions underscore the importance of this evolving process and their desire to maintain a positive relationship with their providers.

Even though the marriage schema provides a powerful metaphor to describe the patient-provider relationship, it is entrenched in specific cultural values and meanings. For these participants, a marriage is an egalitarian partnership in which both partners have equal rights and make decisions together. Others might have different views of marriage that might contradict the basic principles of collaboration and shared input in the model of shared decision making. Moreover, participants identified their relationship with their provider as critical to shared

decision making, corroborating the notion that, to fully understand, teach, encourage, and assess shared decision making, researchers must capture the context of the clinical encounter. They must also connect communication behaviors to the patient-provider relationship, and understand elements of larger conversations between patients and providers over time (Beach, Inui, & The Relationship-Centered Care Research Network, 2005; Matthias et al., 2013; Frankel, 2004).

This study's findings are consistent with the argument that shared decision making is much more than a process that happens when a decision is made, but is shaped by the entire clinical encounter, and notably, the entire patient-provider relationship (Matthias, Salyers, & Frankel, 2013). Indeed, when shared decision making is conceptualized only as the point when a decision is made, it can lead to an incomplete and de-contextualized picture of shared decision making. Participants' definitions of shared decision making also suggest that a formulaic application of the concept and its varied components fall short of providing person-centered care, and call for a greater investment in true partnerships between patients and providers.

Limitations

Participants in this study were all veterans, and mostly White men between the ages of 40 and 65 who received psychiatric care at one outpatient clinic in a U.S. Veterans Affairs medical center. Given the characteristics of the sample, especially the unique experiences of veterans, the findings might not be applicable to all patients in other psychiatric settings. Moreover, the results might reflect generational and cohort effects. The participants might have different perceptions of shared decision making and attitudes toward patient-provider interactions than members of other age groups. Additionally, most participants described positive relationships with their providers and endorsed aspects of relationships that are generally valued as desirable. It is

possible that both patients and providers who were in positive patient-provider relationships were more likely to agree to participate in this study.

Future studies should seek to include a more diverse patient sample, and assess how different socio-demographic factors, as well as a wider range of patient-provider relationships could impact shared decision making. However, despite these limitations, in this article, we provided valuable data from the patients' perspectives that support theoretical arguments about health communication, and underscored the fundamental role of the patient-provider relationship in the development and implementation of shared decision making. In particular, we noted the centrality of the patient-provider in shared decision making.

Implications for Mental Health Practice

This is among the first studies to examine patients' perceptions of shared decision making in mental health care. As such, it provides valuable insights into how patients understand this decision making model and its feasibility in psychiatric outpatient settings. Participants understood the fundamental principles of shared decision making and wanted to be involved in the decision making process with their providers. However, even those who did not want to be actively involved in generating treatment decisions and making active choices in their care preferred to be informed of their providers' treatment decision and have the choice to accept or reject the treatment option.

In efforts to provide patient-centered care, providers should assess and match patients' preferences for degree of involvement in shared decision making. Additionally, even if patients appear passive in the decision making process, this does not preclude implementation of the core elements of shared decision making. In particular, clear communication about treatment options,

eliciting patients' perspectives and opinions—and continuing to foster a trusting patient-provider relationship—are all critical to deliver patient-centered care.

Finally, in this article, we highlighted the critical role of the patient-provider relationship and sociocultural contexts in the process of shared decision making. We expanded on existing studies by suggesting the need to rethink how providers view their roles and interactions with patients. In particular, providers should pay close attention to the notion that patients situate qualities such as genuine caring, equality, and trust at the center of the process of shared decision making. This critical aspect of shared decision making is often omitted or marginalized in the literature on shared decision making. In addition, providers should focus on cultural competence in practice, as awareness and sensitivity to the sociocultural factors highlighted in this article, such as gender and ethnicity, are important building blocks for open communication, the development of meaningful patient-provider relationships, and person-centered care.

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