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Full Title: Integrating Client and Clinician Perspectives on Psychotropic Medication Decisions: Developing a Communication-Centered Epistemic Model of Shared Decision Making for Mental Health Contexts

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Running Head: Epistemic Model of Shared Decision Making

Abstract: Shared decision making (SDM) interventions aim to improve client autonomy, information sharing and collaborative decision making, yet implementation of these interventions has been variably perceived. Using interviews and focus groups with clients and clinicians from mental health clinics, we explored experiences with and perceptions about decision support strategies aimed to promote SDM around psychotropic medication treatment. Using thematic analysis, we identified themes regarding beliefs about participant involvement, information management and participants' broader understanding of their epistemic expertise. Clients and clinicians highly valued client-centered priorities such as autonomy and empowerment when making decisions. However, two frequently discussed themes revealed complex beliefs about what that involvement should look like in practice: 1) the role of communication and information exchange and 2) the value and stability of clinician and client epistemic expertise. Complex beliefs regarding these two themes suggested a dynamic and reflexive approach to information management. Situating these findings within the Theory of Motivated Information Management, we discuss implications for conceptualizing SDM in mental health services and adapt Siminoff and Step's Communication Model of Shared Decision Making (CMSDM) to propose a Communication-centered Epistemic Model of Shared Decision Making (CEM-SDM).

The quality of mental health care has been argued to be largely dependent on the quality of client-clinician communication (Priebe & McCabe, 2008), which is critical for accomplishing clinical tasks and improving health outcomes (Alegría et al., 2008; Wissow et al., 2008). The model of *shared decision making* (SDM) reconceptualizes client-clinician communication (Patel, Bakken & Ruland, 2008) by redefining the terms by which participants come together to make treatment decisions (Drake, Deegan & Rapp, 2010). In a SDM frame, neither clinicians (paternalistic model) nor clients (informed choice model) are singularly responsible for making decisions (Makoul & Clayman, 2006). Instead, decision making is characterized by the exchange of unbiased information (Drake et al., 2010), collaboration (Charles, Gafni & Whelan, 1999) and mutual respect for differing expertise (Deegan & Drake, 2006). Given the centrality of communication in mental health care, we believe the assumptions underlying SDM warrant critical examination.

For instance, despite widespread support for SDM, its principles are not uniformly perceived or advocated. Not all clients desire high levels of autonomy (Levinson, Kao, Kuby & Thisted, 2005; Say, Murtagh & Thompson, 2006), and psychiatrists have been found to both value and criticize elements of SDM including the exchange of unbiased information (Seale, Chaplin, Lelliott & Quirk, 2006). To elucidate these discrepancies, we elicited perspectives from clients and mental health clinicians about their experiences making and facilitating medication decisions and about strategies that might support client-clinician communication, improve client informed choice, and promote safe and appropriate antipsychotic medication treatment. Participants frequently addressed how they manage information, which included perceptions about transparent

communication and unbiased information exchange as well as how they value client and clinician knowledge. We thus highlight how participant responses reflect the importance of information management as well as client and clinician perceived *epistemic expertise* – that is, the logics used to make sense of knowledge structures as they relate to participation within the mental health system. In considering these perspectives we extend the theoretical foundations of the Theory of Motivated Information Management (TMIM; Afifi & Weiner, 2004), particularly TMIM’s conceptualization of *efficacy* in making mental health related medication decisions.

Bringing together both client and clinician perspectives on epistemic expertise, we build upon Siminoff and Step’s Communication Model of Shared Decision Making (2005; CMSDM) to develop a provisional model of SDM for mental health contexts. We believe this model to be valuable for three reasons: First, a model of SDM has yet to be conceptualized specifically for decisions related to mental health care. Second, emphasizing the dynamic influence of participants’ perceptions of epistemic expertise on decision making contributes to understanding the fluidity and transactional process of information management, which have been under-conceptualized (Afifi & Weiner, 2004). Third, situating these findings within TMIM, we highlight the critical role of the clinician as contributing to this transactional process: respondents emphasized the importance of clinicians’ assessments of clients making decisions as well as clients’ assessments of clinicians (‘targets’ in Afifi & Weiner, 2004) and clinicians’ effectiveness (‘efficacy’ in Afifi & Weiner, 2004) in sharing information and assisting decision making. These features, as they are informed by TMIM, are fundamental to developing a grounded model of SDM in mental health that can inform interventions to support it.

Conceptualizing Shared Decision Making

SDM has seen a surge of support in many health fields because of its potential to support client-centered medicine (Barry & Edgman-Levitan, 2012) by upholding four conditions: (1) decisions involve both the client and clinician; (2) the exchange of personal and medical information flow in both directions between client and clinician; (3) options and outcomes are openly discussed and weighed; (4) decisions are joint efforts requiring collaboration and balanced participation (Charles et al., 1999). In mental health contexts, although SDM interventions have been argued to be effective methods for information sharing, some have criticized them as strategies “to increase clients’ behavioral conformity to a practitioner’s view of optimal treatment” rather than treat the client and clinician both as experts who “must share their respective knowledge and determine collaboratively” what is optimal (Deegan & Drake, 2006, p. 1636). Nevertheless, because SDM has the potential to improve client-clinician collaboration and provide clarity for clients making complex decisions (Drake et al., 2010), many perceive SDM to be an ethical imperative (Drake & Deegan, 2009).

Recent models of decision making acknowledge that the decision process is not accomplished individually but in interaction with others (e.g., Charles et al., 1999; Afifi et al., 2006). Siminoff and Step (2005), for instance, developed a Communication Model of Shared Decision-Making (CMSDM) in the context of cancer treatment decisions to “[identify] the communication process as the vehicle for decision making, [embed] it within the doctor-patient relationship, and [acknowledge] it as a social process” (S99; see Figure 1 from Siminoff & Step, 2005, p. S102). Like TMIM, their model highlights the transactional process of decision making. We find the CMSDM model particularly

appropriate to our study because, like cancer treatment, mental illness treatment can pose relational and communicative burdens due to the range of treatment options, uncertainty about prognosis and the variability of client responses to treatment (Siminoff, Ravdin, Colabianchi & Saunders Sturm, 2000).

[FIGURE 1 ABOUT HERE]

CMSDM postulates that *patient-physician communication antecedents* such as sociodemographic characteristics interact with the *communication climate* (e.g., decision preferences) to lead to a treatment decision (see also Street, 1992). Such models suggest that participants' epistemic expertise precede the clinic consultation but may change as a consequence of the communication that occurs within it. Exploring how client and clinician epistemic expertise and involvement are valued is crucial for elucidating connections between clinic communication, information exchange and decision making as well as identifying target areas to guide adaptations of SDM interventions.

Theory of Motivated Information Management

Concerns about SDM implementation often hinge on what information is valued and how it might be interpreted: should information be unbiased and limitless or should it be selectively transmitted to meet specific objectives? Several theories of information management purport that individuals seek information in an effort to reduce uncertainty; however, accessing more information has the potential to both decrease and increase uncertainty, and subsequent research has shown that uncertainty can be adaptive (Brashers, 2001). The Theory of Motivated Information Management (TMIM) argues that individuals seek information not to manage uncertainty but to reduce anxiety (Afifi et al., 2006), leaving room for individuals to selectively seek out *and* avoid information.

Several factors are proposed to be involved in this selection-avoidance process. TMIM highlights the role of an individual's "efficacy," described by Basu and Dutta (2008) as a "perceived ability to seek out health information" (p. 71) that requires both information availability and a perceived capacity to master the information. TMIM details different types of efficacy: *communication efficacy* or "individuals' perception that they can successfully enact a particular information-seeking strategy" (Afifi et al., 2006, p. 192); *coping efficacy* or individuals' confidence in the resources (e.g., network support) they have to manage expected outcomes; *target efficacy* which includes *target ability* or whether the information source – the clinician in this case – "has access to the sought-after information" and *target honesty*: whether the clinician is inclined "to provide all the information about the issue that is at his/her disposal" (Afifi et al., 2006, p. 192). Considering the role of efficacy in information seeking and avoidance strategies, we expand Siminoff and Step's CMSDM (see Figure 2) and further explicate the iterative nature of communication and its relationship to participants' perceived epistemic expertise and desire for information.

Methods

As part of a larger study exploring strategies to promote SDM around medication decisions in mental health services, we conducted 60-minute semi-structured interviews with two administrators and three team leaders, 90-minute focus groups (n=3) with 25 clinicians and 90-minute focus groups (n=3) with 14¹ clients and six family members in two publicly-funded mental health clinics in Southern California. Both clinics serve adults and transition-aged youth diagnosed with serious mental illness (SMI) (i.e.,

¹ Two respondents did not report their client/family member status on the survey: the total number of client/family participants was 22.

psychotic and mood disorders). Interviews and focus groups (Morgan, 1998) aimed to explore whether clients and clinicians believe clients have difficulty making medication decisions, and if so, under what circumstances. They also examined clients' and clinicians' perspectives on decision aid supports including peer providers (Chinman, 2014), psychiatric medication decision aids (SAMHSA, 2012), or other strategies.

Focus group questions included: Do clients have difficulty making medication decisions, and if so, what kinds of clients and decisions? What role could decision aids play in supporting SDM? What other kinds of support could be important for clients to assist with decision making? Moderators also explored participants' experiences with medication decisions and the potential usefulness of a preliminary draft of a decision support tool that included symptom and side effect information as well as decision making exercises for clients considering psychotropic medications.

Participants were recruited from two publicly-funded health clinics serving predominantly individuals without private health insurance or veteran benefits. All participating clinicians occupied the role of case manager and were responsible for treating individuals diagnosed with SMI for >70% of their time. Clients were in treatment at the clinic site and most received medications from a prescribing psychiatrist located on site. Clients and clinicians were invited to participate through verbal invitation during a clinic team meeting and a flier distributed at the clinic. None of the treating psychiatrists chose to participate in data collection. Demographic information is shown in Table 1.

[INSERT TABLE 1 HERE]

Clinicians' mean age was 37.7 years (SD=10.9); 12% (n=3) were male. Clients'² all had a primary diagnosis of either a psychotic or mood disorder; their mean age was 45.3 years (SD=12.1); 57.1% were male.

Data Analysis

We adopted an inductive approach to thematic analysis (Joffe & Yardley, 2004; Ryan & Bernard, 2003) to capture the range of perspectives regarding medication decision making. After interviews and focus groups were transcribed, the first author read through them in their entirety. This reading revealed recurring issues discussed as central to decision making. First, clients and clinicians expressed support for client involvement in the decision process, empowering clients and respecting client choice, that is, participants valued client priorities (theme 1: client-centered priorities). Second, participants frequently expressed perceptions about communicating honestly and sharing complete information about the decision at hand (theme 2: communication and information exchange). Third, they discussed the value of the domains of knowledge and expertise held by each participant involved in the decision making process (theme 3: epistemic expertise).

Unlike the overwhelming support expressed for theme 1, both clients and clinicians valued and criticized themes 2 and 3. These contrasting perspectives were of note because communicating openly and balancing the inclusion of medical evidence with experiential knowledge are often considered essential for SDM. Based on this first reading, the first author drafted an analytical protocol for the research team that

² Two participants declined to report their demographic information and are not included in the summary statistics. Tests of neurocognition and symptom severity were not collected so functional status may vary among client participants.

explicated these three identified themes and provided textual examples including both valuing and critical responses for themes 2 and 3.

During this step, because contrasting perspectives may arise in focus groups as a result of the interaction between participants (Hyden & Bulow, 2003; Parker & Tritter, 2006), the first author also aimed to systematically examine contrasting perspectives within the context of the focus group discussions: Were contrasting perspectives voiced as direct rebuttals to other participants' responses or did they emerge independently? This phase of data analysis revealed that dichotomous responses did not arise because of direct disagreement between participants; rather, they emerged at different points in the discussion and in response to new topics.

After the refinement of the analytical protocol, the research team discussed the identified themes. Team discussions confirmed that the first theme, client-centered priorities, elicited overwhelming support from both clients and clinicians, demonstrating very few dichotomous responses. We understood theme 2 – communication and information exchange – and theme 3 – epistemic expertise – to be addressing perceptions about the nature of participant involvement: what information participants should share and how participants' knowledge and expertise should be valued and utilized. Following team discussions, the first author revised the analytical protocol to refine theme boundaries. A second team member then applied this analytical protocol to a subset (roughly 25%) of the data to determine usability and researcher agreement. Level of agreement was good ($\kappa = 0.74$) and discrepancies were discussed until resolutions were reached. The first author used Atlas.ti (version 6) software to conduct a final round of theme identification of the entire data set.

Results

Theme 1: Client-Centered Priorities

Clients and clinicians overwhelmingly agreed on the value of client-centered constructs such as autonomy and empowerment. Participants demonstrated a shared belief that client involvement is vital and that empowering the client and prioritizing client wants/needs during the decision-making process are essential for SDM. For instance, clients supported the use of the decision support tool because they believed it would enhance their involvement:

(Ex 1)

C1: I feel like this [the decision support tool] would tip the scales more toward you having a say in your treatment.

C2: Yeah, I do too.

C3: I think I do. I feel the same way.

C4: It's definitely a step in the direction of being proactive in your treatment.

Clinicians also expressed that clients should have a “voice” and “choice” in their treatment.

(Ex 2) You work with so many developmentally disabled people and people really had all these rights protected for them, that we are, it's ingrained in us that they should have, everybody should have a say in their care.

(Ex 3) I think every client should have more of a voice in the process. I absolutely believe that.

Several clinicians criticized coercive strategies, at times noting that the decision to not adhere to treatment recommendations is a legitimate one:

(Ex 4) I would say without a doubt that everyone knows that there is no forcing.

There is no effort to ever pressure anyone to do something they don't want to.

In general, clients and clinicians recognized the importance of client involvement in making medication decisions regardless of what decisions are made.

Although participants agreed on the importance of client involvement in decision making, they revealed challenges determining what that involvement should look like in practice. Clients and clinicians identified two themes important for grounding SDM in practice. Theme 2 centered on *Communication and Information Exchange* and included beliefs about the role(s) of communication in the clinic and the desired amount and types of information that should be exchanged between clients and clinicians.

Theme 2: Communication and Information Exchange

Participants expressed support for transparent communication and also voiced concerns about the consequences and practicality of sharing unfiltered information.

Clinician Support. Clinicians highlighted the need for clients to be open and reliable communicators, for clients' to "do their part," "speak up" and keep clinicians well-informed. As one clinician remarked, "[clients] need to be good communicators, and it's their responsibility to let the doctor know what their symptoms are, and then when they are prescribed medications, how are those medications working for them" While clinicians most frequently highlighted client responsibility, they also acknowledged their own role in helping clients communicate clearly:

(Ex 5) ... so really encouraging, supporting them to talk during the initial evaluation with the psychiatrist or a follow up session about their concerns, questions, side effects, alternatives to medication, so kind of being a support for them to talk to medical personnel.

Clinicians also discussed their responsibility in fostering a culture of truthfulness:

(Ex 6) When [clients] come in here and get services from us, sometimes it's the first time they've ever been in a functional environment. And, where they can hear the truth, and they're not- no head games are being played with them.

Clinicians indicated that clients are entitled to honest information, which is not always provided. One clinician commented, "a lot of [patients] have been on this medication for years, and no one has really actually explained it really in depth, you know. They wonder 'oh why am I overweight? Why am I this and that?'" Another clinician highlighted the importance of clients having access to many information sources:

(Ex 7) ...you have clients [who] are saying 'this is what I did and this is what worked and its helpful,' then you have others that say 'no don't take anything, it's not helpful.' And it optimally, you know, it's still the client's decision, but I want them to have- I want them to hear all that kind of feedback. It's just part of making a decision."

This comment suggests that information should not be filtered for clients and also that clients are a valuable source of information (see Theme 3).

Client Support. Clients discussed information gathering as a way to remain present in the treatment plan, as important for understanding one's medication and symptoms and as a path to empowerment:

(Ex 8)

01 C1: Education. You know, learning about what meds are and what the side
02 effects are, and you can find that out at the library or on the internet or by
03 asking questions and things like that.

04 C2: If it could help you be more informed, yeah.

05 C3: It's so empowering and so helpful. I agree.

Clients also valued bi-directional communication or when clinicians made a notable effort to both explain and elicit information:

(Ex 9) He would explain the side effects and the benefits, and you know, he would be open to, you know, any notifications of anything wrong happening, like—and we just worked on it.

Clinician Concerns. Clinicians equally voiced concerns about unfiltered information:

(Ex 10)

P1: I mean and a kid, going through puberty in high school? Could you imagine? It's bad enough gaining weight as an adult.

P2: Of course we're not going to say that to the parents of the children who are taking these medications.

P1: No!

P3: No but we're in a focus group right here so it's –

P2: No but what I'm saying is that I would never say that to a parent or a child. "Oh my god you're sixteen, you're going to gain weight! You shouldn't take this medicine!"

This exchange highlights clinicians' desire to provide clients with the information they believe will result in the best clinical outcome and vividly contrasts with comments

discouraging deception or “game-playing.” One clinician outlined how deception can be beneficial for clients:

(Ex 11) In some cases we don't want to give a lot of the side effects to a client because they'll have everything that's on the list and that's a... a doctor will say “I kept this a little quiet.” They have the right to look it up obviously for themselves. And this is why there are some clients we don't even give their diagnosis to because it could be harmful to the client ... [diagnosis] changes a lot in mental health, as we get to know the client, so sometimes it's damaging.

Such commentary suggests that withholding information may, at times, be perceived as a therapeutic obligation.

Many comments underscored concerns that too much information may confuse clients (Ex 12) or lead clients to communicate experiences in ways that are not clinically meaningful (Ex 13):

(Ex 12) [discussing uses of the decision support tool]

P1: But I think we would, we would run a risk with some of our clients giving out this much information. Because we would be reading –

P2: They get overwhelmed.

P3: They're gonna want to see [the tool] and it'll just confuse them.

(Ex 13) Try to get a client to tell you their symptoms: “Well I'm depressed, I'm anxious.” Well what does that mean; can you tell me what that looks like?

They're not good at it, and if you give them a longer list [of symptoms] they'll say yes to everything.

Client Concerns. Like clinicians, clients were concerned about their capacity to effectively utilize unscaffolded information. The following client remarks that, if given

the raw data provided in the decision support tool, clients may focus exclusively on the negatives:

(Ex 14) I don't know where the balance is, and you guys probably don't either.

Because sometimes people in their condition, if they start reading [the medication] is gonna do this to me, they won't look at any of the benefits because they're seeing all the side effects.

Clients expressed concerns that mental illness can compromise their ability to find information. One client remarked, "I get too scattered. I have a few, quite a few, disorders. And I get too scattered to even get on the internet to find help."

Clients also described transparency as unrealistic, noting clinician authority (Ex 15) and other practical constraints (Ex 16) as barriers to clients' cooperativeness and open communication.

(Ex 15) ... So basically I led him [psychiatrist] to believe I was still taking it because I was afraid to tell him, you know? Because I thought—I didn't want him getting mad at me, you know?

(Ex 16) I don't discuss my medication with her [psychiatrist] because she's got a zillion people, and she's not going to remember any of that anyway.

Such comments point to underlying attitudes about desires to comply with clinicians and understandings of clinician burden.

Theme 3: Epistemic Expertise

Participants often addressed how knowledge domains are defined and valued, both questioning and privileging at different times client and clinician expertise and understandings of mental illness. Participants expressed desires to assert their own expertise while realizing that their expertise may be faulty and/or require reliance on

others' domains of knowledge. To capture the dynamic interplay between perceptions of knowledge domains, we present clients' and clinicians' reflections together.

Client epistemic expertise. Clients and clinicians believed client epistemic expertise to be especially relevant for accomplishing clinical tasks such as symptom monitoring and medication management. The following client, in questioning the foundation of clinical knowledge, notes the value of eliciting clients' understandings of symptoms.

(Ex 17) ...when it comes to symptoms, you can't just look at someone and decide what their symptoms are. You have to listen to them.

Clinicians' comments often echoed client beliefs that privileging client knowledge can enhance clinician effectiveness. One clinic administrator, for example, discussed how she facilitates clinicians' access to client domains:

(Ex 18) I ask my staff to be part of the member activities, so if they have a gathering to be part of that and you know get to learn a little bit more about what helps and what doesn't help, so integrating that way.

She suggests that blurring the boundaries of traditional epistemic expertise is important for disseminating information across the clinical hierarchy. Clinicians also discussed how valuing client domains positively impacts the client-clinician relationship:

(Ex 19) The fact that I put value on what [clients] have to say, I think gives- kind of sets the stage for them to trust me, because I'm putting value on what they have to say, their opinions and their family beliefs and what they think, because really they know best about their family.

Clients also expressed value for their epistemic expertise when recounting times they felt clinicians did not adequately appreciate their experiences. The following participant, for example, describes how psychiatrists' attachment to a medication can conflict with clients' understandings:

(Ex 20) ... usually [clinicians] have their own medications that they push and that are working for them, and they try to say 'Well, okay, sir. We don't like this. You're taking too much of this. I see it in your chart, so we're going to try and put you on this one.' And it's like, 'But dude, this works for me. This already works, and I have already got this established, like for my anxiety, my panic attacks. ... The Ativan helps me in the ER. The Ativan helps me at home.' 'So we're going to put you on Xanax.' It's like, 'no no ...'

Both groups also questioned client expertise, particularly clients, who questioned what they know, should know and are capable of knowing, often formulated as doubts about their capacity to make decisions:

(Ex 21) There are times when I am in my right mind, and I am able to make those decisions, but there are times when I am not ...

(Ex 22) You can't leave the decision up to the person, and this is only my opinion, you can't leave it up to them to make that decision.

Clients' concerns about their epistemic expertise were particularly pronounced when symptomatic or "in crisis," although occasionally clients described concerns that arose when they were stable. The following respondent, for instance, suggests that clients' understandings of "normal" may have negative consequences:

(Ex 23) As a mental health patient, you cannot do that, you cannot decide for yourself. ... When you are stable, you feel like, we feel like we're normal, we can do things without all our medication, stop taking everything without the doctor knowing, that's bad.

The following client similarly notes that clients' understandings about medication may be faulty:

(Ex 24) [Clinicians] encourage [medication] all the time, but you will refuse it because they're saying I'm not man enough to manage my own behavior or my own functions, I gotta rely on something you give me. Half of the citizens of the world don't need it. Then you kind of think back, you think well, I'm the selective one of this diagnosis, maybe I need a little more encouraging, a little more fasting [sic] to take this pill or whatever shot.

Likewise, clinicians raised concerns about how to value clients' expertise regarding prognosis, medication and decision making. The following comment describes clients' understanding of the decision-making process as inferior to "all of us" who would know to do things differently.

(Ex 25) ... some of them just don't realize that they have a choice, and I know that all of us, if we were going to be put on some kind of a medication or considering medication, we would, I know I would be looking things up and asking specific questions, and I don't even think that they know how to do that often.

In general, clients and clinicians supported client *involvement*; however, given concerns about client expertise and understandings, they were cautious about supporting client *autonomy* when making decisions.

Clinician epistemic expertise. Both groups raised concerns that *beliefs about* clinicians' expertise and authority can limit client involvement:

(Ex 26, clinician) What I'm finding with clients is they think that because someone is a doctor that they know everything, and they don't.

(Ex 27, client) For me, it's that I have, you know, starting at childhood and all the way through now, afraid to question authority because authority was like – you listen to authority, period, you know? So your doctor says this, and this is what you do. You don't question it.

The client's comment, indicating a stifled desire to “question authority,” may also suggest that clients treat clinicians' knowledge as superior but not necessarily perceive it as such.

Indeed, the legitimacy of clinical expertise was questioned by both clients and clinicians. Clinicians addressed the limits of their epistemic authority, most often by explicitly remarking on what they do not know:

(Ex 28) ...we were able to outreach... and help a very challenging person, and the peer advocate had the answer. Yeah, we don't know everything believe it or not.

Clients, however, often conveyed confusion about clinicians' formalized domains of knowledge and expressed frustration with how this knowledge translated to epistemic authority. The following client indicates that even if clinicians' knowledge is recognized, there may still be reasons to distrust it:

(Ex 29) ...my current doctor knows a lot about meds, but I'm very suspicious, and if he recommends something, I'll go, 'okay,' and then I'll go home, have my husband look it up on the internet, and then if the internet says it's okay and that the side effects are minimum or something, then I'll take maybe a quarter ...

This comment illustrates what kind of knowledge is considered reliable, suggesting that it may not always be clinical or 'expert' knowledge.

Clients also expressed frustrations with the process of knowing in psychiatry more generally, often describing treatment as a system of trial and error. The following client notes the mysteriousness of prescribing medications, which was perceived to lack a strong clinical rationale:

(Ex 30) 'Cause it's just, you try you try you try, and it's, 'Okay that doesn't work so try this one. Okay that one works but it needs a mood stabilizer to go with it so let's put this one together.' It's all very, it's all very touch and go. And it's kind of like, you know, Nancy Drew and the Hardy Boys out in the middle of the woods, [*others laugh*] trying to find out what the mystery is with things like that.

At the same time, clients expressed beliefs that clinicians' domains of knowledge reflected professional understandings important for services to be rendered effectively. Clients thus described clinicians' epistemic expertise as both suspicious and trustworthy, a mixed sentiment expressed in the following comment:

(Ex 31) In reality, you need to find out from your doctor, you know, that's who we depend on. ... and to me, sometimes all they do is like give me, "Here you go, here you go." Every visit, "Here you go," something new. And I don't know if it's right for me or not.

Although this client notes the importance of relying on the doctor's expertise, he indicates that this may be complicated by an uncertainty about how to trust that expertise.

Other clients discussed how clinical knowledge contributed to a trusting relationship, better health outcomes and fostered feelings of safety and security.

(Ex 32) I like Dr. [name]. He's really, really educated, and very informative and sometimes just says things straight out to you like, "Look if you're going to do this, you're going to have this, this, you know, you can't do this, or this medication won't work like this."

(Ex 33) ... it was good that I was in the hospital because they can monitor you and the doctor was at least trying different things and asking me how I felt on them.

Example (32) notes that clinicians' knowledge, including the directness with which it is expressed, enhances trust in clinical expertise. Example (33) suggests that clinicians' expertise makes their observations especially valuable while also noting that clinicians' expertise is partially dependent on the client and their willingness or ability to communicate their experiences.

Clinicians similarly discussed their epistemic expertise as crucial for client well-being. The following comment describes clinicians' understandings as essential for sound decision-making, even if clients may not be immediately aware of the value:

(Ex 34) I actually had a client thanking me for doing a [Child and Family Services] report -- and her going to go and losing her kids, because she was under the influence and abusing her medication. And then she actually thanked me for it.

Clinicians discussed how their epistemic expertise allowed them to assist clients in locating information and determining its significance (Ex 35) and to scaffold complicated technical information for clients who may become overwhelmed (Ex 36):

(Ex 35) ... And really, teaching them to go on the internet and do some of their own research and formulate their own questions because it's – it may not be what's necessarily right for that family.

(Ex 36) I can see that some of our clients would have difficulty reading this [the decision support tool] maybe and understanding what it said, but if we went through it with them, we could explain it to them, you know, on their level too.

Discussion

Role of Epistemic Expertise in Managing Information

Clients and clinicians agreed that clients should maintain an active role in making medication decisions. However, despite overwhelming support for client involvement and autonomy (Theme 1), both groups revealed complexities regarding how that involvement should be established in practice (Themes 2 and 3). Theme 2 focuses on communication and information exchange, while Theme 3 underscores the perceived value of participants' epistemic expertise. Regarding Theme 2, clinicians valued truthfulness with clients but also expressed that concealing information can be therapeutically useful. Clients echoed similar beliefs that they wanted to be fully informed but also that access to large amounts or certain types of information can be harmful. Regarding Theme 3, clients' epistemic expertise was recognized as important for client well-being and clinical outcomes and was also perceived, at times, to be insufficient. Clinicians' specialized epistemic expertise was valued for client recovery

and also recognized to have salient limits, especially when it did not incorporate client expertise and understandings.

In line with TMIM, participants' perceptions of information management thus highlighted the value of information seeking and avoidance practices. While honest information exchange was perceived as valuable for building a therapeutic relationship and facilitating client participation, avoiding and concealing information were also noted to be useful strategies for facilitating decisions more likely to realize health outcomes. Such seeking and avoidance strategies often hinged on participants' perceptions about their own and others' knowledge domains and expertise. At times, comments about epistemic expertise reflected client's *communication efficacy* – or one's perceived ability to engage in an information management strategy (Afifi & Weiner, 2004): For instance, participants' perceptions of the decision support tool as a way to manage medication information often depended on perceptions of clients' ability to process the amount and kind of information presented. Other times, comments about epistemic expertise reflected the role of clinician or *target efficacy* – the clinician's access to and willingness to provide the desired information (Afifi & Weiner, 2004). For instance, clients discussed the importance of whether clinicians' understandings were grounded in systematic clinical rationales (access) or whether the clinician had time and availability to both receive and provide information (willingness).³ Additionally, clinicians' perceptions of clients' communication efficacy were often associated with clinicians' expressed willingness to provide information, suggesting a dynamic relationship between communication efficacy and target efficacy that may warrant further exploration.

³ Coping efficacy was not discussed as a factor impacting information management strategies. This may have been so because focus group questions did not explicitly ask about the role of “non-clinical” resources such as family and social support.

One interpretation of the dichotomous views that emerged may relate to the gap that often exists between policy and practice and the challenges with putting rhetorical ideals of SDM (Barnes & Bowl, 2001) into action. Deegan and Drake (2006) discuss the importance of adopting new language (e.g., working alliance, informed choice) to replace more antiquated terms (e.g., medical authority, compliance) (p. 1638). While shifting the rhetoric surrounding a discipline may help reconceptualize it, it may not be sufficient to change beliefs grounded in everyday practice. Participants in our study rallied around the concepts of “empowerment,” and “choice” but also expressed views complicating how they should be implemented. Although this policy-practice gap may have explanatory value, we believe our data also reflect participants’ subjugated understandings of the nature of communication, epistemic expertise and engagement in mental health services as well as their understandings of treatment expectations. These perspectives may point to challenges with the adoption of a simple linear model of decision-making and information exchange (see Hanson, 2008; Moreau et al., 2011). Moreover, such perspectives were not only expressed by clinicians but by clients as well, which is an important finding given that rhetoric often frames SDM as a transformation of practice that is unquestionably in favor of clients.

Conceptualizing Participant Involvement in SDM

Variable attitudes toward the role of communication in mental health settings foregrounded aims to both inform and persuade (see Roscoe, Tullis, Reich & McCaffrey, 2013). In line with TMIM’s claim that information seeking and avoidance are ways to reduce anxiety and are embedded in a relational and fluid process, communication and expertise were not perceived as static. Rather, they were perceived to shift according to

changing client and clinician needs and understandings. This dynamicity often had implications for how to conceptualize participant involvement in making decisions.

Although respondents supported clients in being active decision makers, they also revealed beliefs that clinicians should, in the interest of the client, be intimately involved in how information is disseminated and decisions are made. Participants' understandings about the necessity of clinician involvement were often tied to beliefs about the diminished competence of individuals with mental illness and illustrated a dynamic relationship between clinician authority and client autonomy whereby one may not necessarily be perceived to diametrically oppose the other, especially when they are both understood to be in the service of an individual in treatment. Beliefs about participant involvement thus seem to center on one's perceived epistemic status, which vary by domain and change over time.

The role of communication to both inform and persuade became evident when participants discussed case managers' responsibilities as primarily involving two tasks: 1) serving as a bridge between clients and the psychiatrist (e.g., translating technical information) was discussed as an informational or educational task, and 2) shaping client behavior and perceptions to achieve a successful clinical outcome (e.g., encouraging medication adherence) was often discussed as a persuasive task. Whereas the informational task may be perceived as client-centered and thus consonant with the values of SDM, the persuasive task may seem contrary to such ideals. Several studies have found clinicians' perceptions of client-centeredness to conflict with their perceived need for coercion. In mental health contexts, diverse factors may encourage some degree of coercion including that clinicians often work in underresourced contexts where ideal

treatment is not available and work with individuals for whom risk-taking can result in serious consequences including homelessness or rehospitalization (Bromley, Mikesell, Armstrong & Young, 2014). While we also found such discordance between the need for both client-centeredness and coercion, it did not merely stem from beliefs that clinicians' knowledge is superior but appeared to equally arise from beliefs about clinicians' roles (cf. Moreau et al., 2011), namely, to encourage both patient autonomy *and* treatment adherence.

Although these provider responsibilities and the values underlying them can be easily perceived as incompatible, both are frequently supported. For instance, some of the literature criticizes communication practices that do not support client-centered ideals (see Goossensen, Zijlstra & Koopmanschap, 2007), and yet models of health communication and evidence-based medicine (EBM) purport that one function of communication should be to promote behavior that will benefit disease management and treatment adherence (Tuckett, Boulton, Olson & Williams, 1985; cf. Pickering, 1993; see Barratt, 2008; Fulford, 2011). de Haes and Bensing (2009), for example, argue that one reason for prioritizing information sharing (a client-centered value) is to persuade clients who might not cooperate with medical advice (a treatment adherence value) (p. 289). Additionally, and as was suggested in our data, client engagement and empowerment have also been promoted as a means to improve treatment adherence (Alegría et al., 2008) and reduce psychotic symptoms (Joosten et al., 2009).

Recognizing both values of patient autonomy and treatment adherence means that they are likely to be envisioned as part of a dynamic, fluid process (Siminoff & Step, 2005). Our findings suggest that SDM models specifying fixed functions of

communication or perceiving participants' roles and epistemic expertise as static are unlikely to capture the relationships between communicative functions and expectations of participant responsibilities (see Moreau et al., 2011). Clinicians and clients might value several functions of information sharing and avoidance and perceive the communication practices employed to fulfill these functions as dependent on a number of factors (cf. Young et al., 2008) including shifts in epistemic expertise.

A Communication-Centered Epistemic Model of SDM

We consider these findings to contribute to Siminoff and Step's existing model of SDM (CMSDM, Figure 1), suggesting preliminary modifications for mental health contexts to develop a Communication-centered Epistemic Model of SDM (CEM-SDM). This provisional model explicates the nature of communicative processes that are shaped by and shape participants' epistemic expertise. The model highlights the dynamicity of this epistemic expertise and the fluidity of information sharing practices that participants described (Figure 2) and also represents participants' epistemic expertise and communication practices as mutually influential.

We retain from Siminoff and Step's (2005) CMSDM (Figure 1) the role of participant antecedents such as sociodemographic characteristics and of the communication climate. We specify in CEM-SDM features of the communication climate that seem especially relevant for mental health contexts. For instance, 'disease severity' in Siminoff and Step's model may include clients' mental status and cognitive capacity, and 'role expectations' may include the clinician's discipline (e.g., case manager), which may change clients' expectations about what kinds of information and communication to expect. We also highlight the transactional processes within the information exchange event as stipulated, for example, by Street (1992) and Afifi et al.

(2004, 2006). These transactional processes help define the nature of the relationship and include communication practices such as clinicians' elicitation of client preferences and client requests for clarification.

[FIGURE 2 HERE]

The model addresses the evolving role of information exchange and epistemic involvement in decision-making, highlighting it as dynamic and iteratively shaped by 'internal' domains and individual processes (e.g., personal characteristics and individual understandings), by 'external' domains and interactional processes (e.g., possible decision-making facilitators and communication practices) and by how these internal/external domains and individual/interactional processes may influence each other. The model also incorporates the potential impact of possible facilitators (e.g., decision support tools) on communication, information seeking and sharing strategies, and participant expertise.

Conceptualizing epistemic involvement in treatment decisions as dynamic also supports Makoul and Clayman's (2006) conclusion that responsibility in decision-making is unlikely to be equally shared and may be best envisioned along a continuum "with physicians leading the discussion and making decisions at one end" and "patients leading the discussion and making decisions at the other..." (p. 307). They propose that there are essential elements (e.g., explain problem, present options, discuss pros/cons) and ideal elements (e.g., provide unbiased information, define roles/desires for involvement, present evidence) of SDM where ideal elements "may enhance the process of SDM but are more applicable to some encounters than others" (p. 306). Situating our findings in TMIM provides insights about when these "ideal" elements may add benefit, which centers on how participants perceive their own and others' epistemic expertise and efficacy. Client-

clinician communication may benefit from open and ongoing discussions about these perceptions. Such discussions may direct the way SDM is translated during and across clinic visits without neglecting the basic principles of SDM, such as increased client involvement, mutual understanding and exchange of information.

Limitations

The CEM-SDM model is provisional because the data were localized to a particular geographic region and focused exclusively on psychotropic medication decisions. The perspectives of the medication prescriber were also not included. Although psychiatrists were invited to participate in the focus groups, only case managers responded to the study announcement. While we recognize the importance of documenting psychiatrists' perspectives, the homogeneity of the clinician focus groups may have been beneficial: clinicians' shared role and expertise may have helped create an environment in which they felt comfortable discussing the strengths and limitations of their knowledge domains and information management practices. Such openness may not have surfaced in discussions between clinicians with differing professional status. Further research should expand the breadth of diversity of clients served and types of clinicians as well as include other geographic locations to explore the impact of clinic and organizational factors on treatment decisions.

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Table 1: Demographic Characteristics of Participants

Characteristic	Clinician (n=25)	Client (n=14)	Family (n=6)^a
	Mean (SD)	Mean (SD)	Mean (SD)
Age	37.7 (10.9)	45.3 (12.1)	49.7 (17)
	N (%)	N (%)	N (%)
Gender			
Male	3 (12)	8 (57)	2 (33)
Female	22 (88)	6 (43)	4 (67)
Race/Ethnicity			
White	16 (64)	4 (29)	6 (100)
African American	4 (16)	4 (29)	0
Asian	2 (8)	0	0
Hispanic	1 (4)	4 (29)	0
Other	2 (8)	2 (14)	0
Education ^b			
BA	9 (36)		
MSW/MA	6 (24)		
RN	1 (4)		
Declined	9 (36)		
Unemployed		11 (79)	

a Demographic information missing for two participants.

b Education only asked of clinicians.

Figure 1: Siminoff and Step's CMSDM (reproduced from Siminoff & Step, 2005, p. S102)

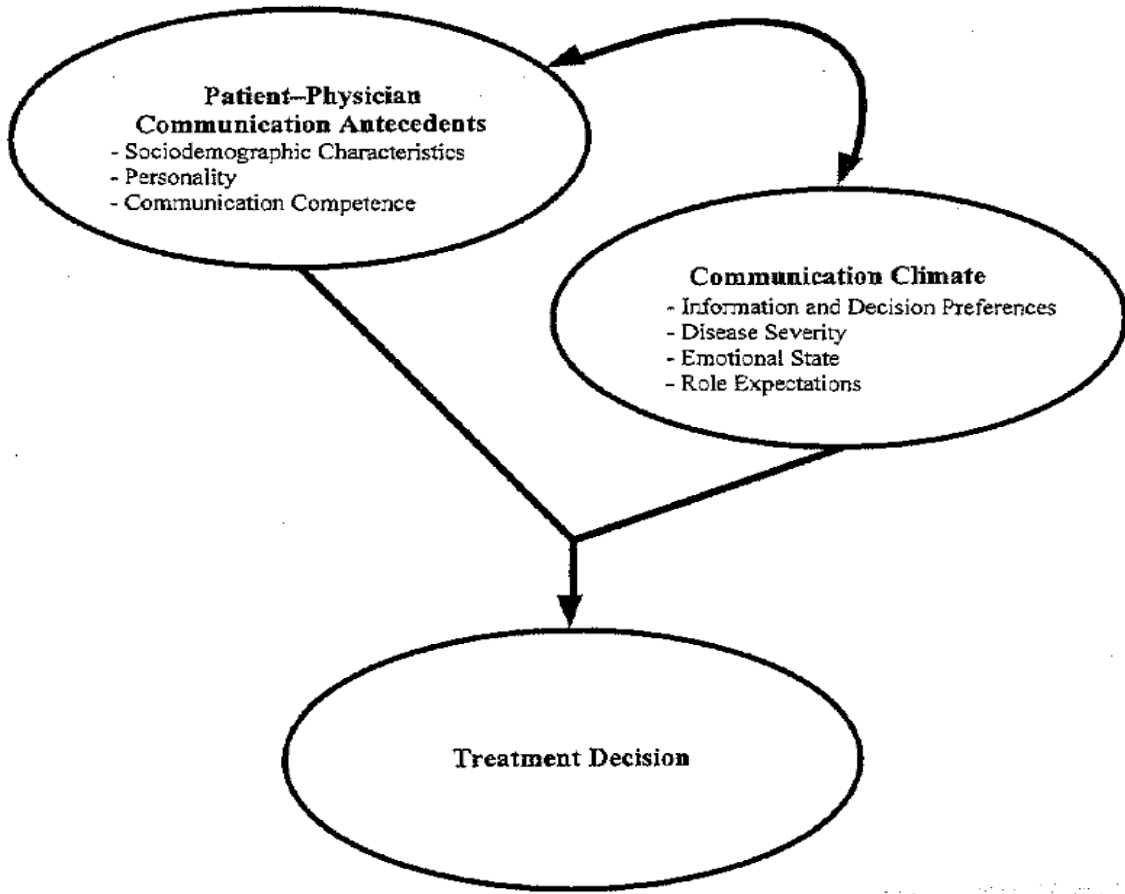
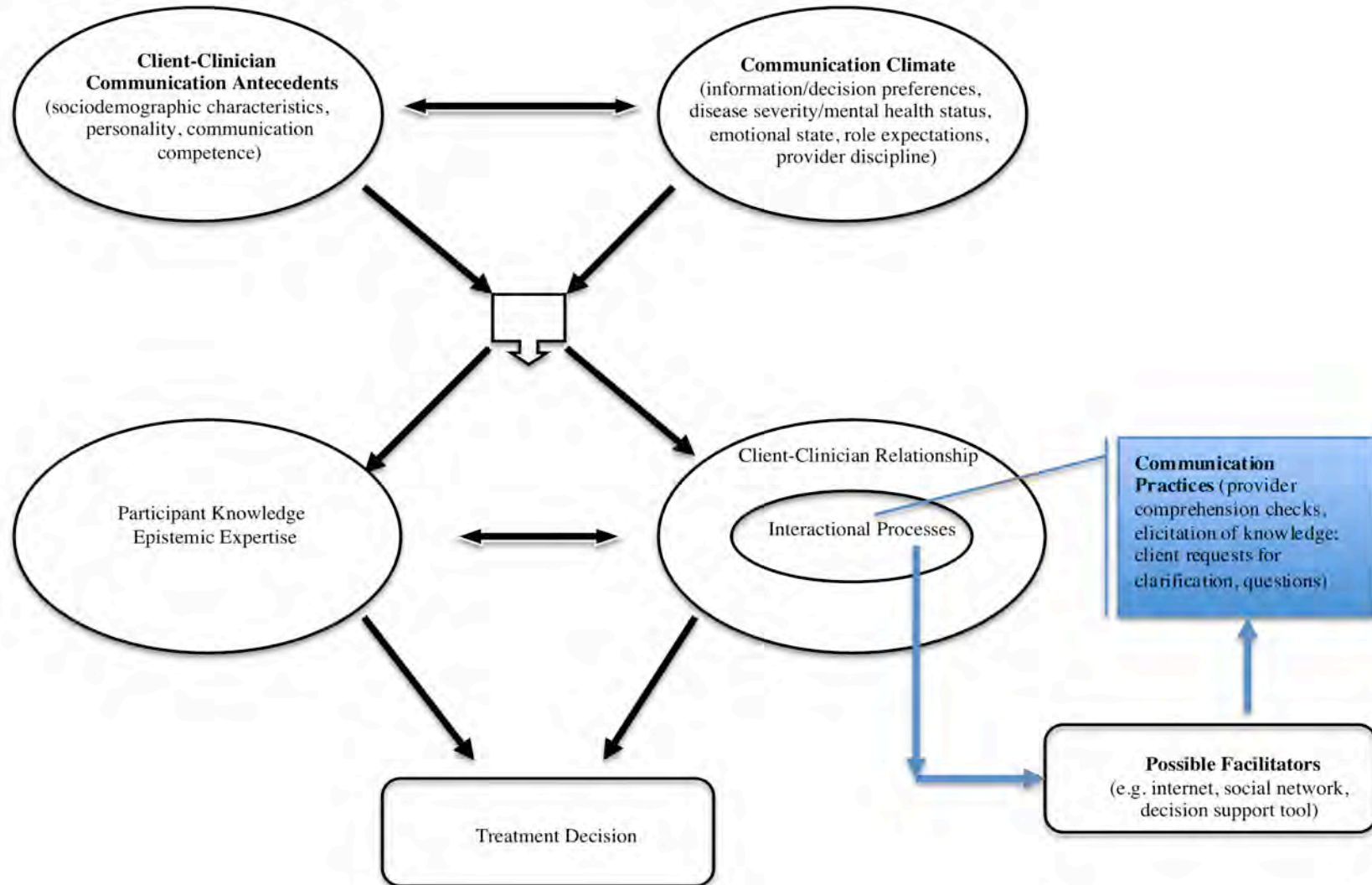


Figure 2: Communication-centered Epistemic Model of Shared Decision Making (CEM-SDM)



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