

WHO HOLDS THE POWER: FACTORS ASSOCIATED WITH SHARED DECISION
MAKING REGARDING PSYCHOTROPIC MEDICATION

by

Tiffani A. Elliott, B.S

A thesis submitted to the Graduate Council of
Texas State University in partial fulfillment
of the requirements for the degree of
Master of Arts
with a Major in Sociology
May 2021

Committee Members:

Toni T. Watt, Chair

Patti Giuffre

Natalie Ceballos

COPYRIGHT

by

Tiffani A. Elliott

2021

FAIR USE AND AUTHOR'S PERMISSION STATEMENT

Fair Use

This work is protected by the Copyright Laws of the United States (Public Law 94-553, section 107). Consistent with fair use as defined in the Copyright Laws, brief quotations from this material are allowed with proper acknowledgement. Use of this material for financial gain without the author's express written permission is not allowed.

Duplication Permission

As the copyright holder of this work I, Tiffani A. Elliott, authorize duplication of this work, in whole or in part, for educational or scholarly purposes only.

ACKNOWLEDGEMENTS

I would like to express deep gratitude for my committee, especially my thesis chair, Dr. Watt. Without their unwavering support this research would not have been possible. I am grateful for all the lives of those who inspired me to do this research in the first place and for respondents who were willing to be vulnerable in their participation. Thank you to my family, friends, and cohort whose support means more than they know.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	iv
LIST OF TABLES	vii
ABSTRACT	viii
CHAPTER	
I. INTRODUCTION	1
II. LITERATURE REVIEW	3
Current Paradigm of Mental Health Treatment	3
Attitudes Towards the use of Psychotropic Medications	4
Mental Health Care Experiences	5
III. THEORETICAL FRAMEWORK	7
Models of Consumer-Provider Relationships	7
Person-Centered Care and Shared Decision Making	7
Shared Decision Making in Current Paradigm of Mental Healthcare	8
Medicalization of Mental Health	10
Gaps in Literature	12
IV. METHODS	14
Recruitment and Sample	14
Measures	15
Demographic Characteristics	15
Mental Health Characteristics	15
Attitudes Toward Etiology of Mental Health Problems and Treatments ..	15
Shared Decision Making Measures	16
Experiences with Providers	16
The Control Preferences Scale	16
Decision Self-Efficacy Scale	17

V. STATISTICAL ANALYSES AND RESULTS	18
Descriptive Statistics.....	18
Demographic Characteristics	18
Mental Health Characteristics	19
Attitudes Toward Etiology of Mental Health Problems and Treatments ..	20
Experiences with Providers.....	21
Factors Associated with Shared Decision Making	22
Bivariate Analyses	22
Multivariate Analyses	24
VI. DISCUSSION.....	26
Limitations of Study	28
Areas of Future Research.....	29
Shared Decision Making in Action.....	29
APPENDIX SECTION.....	32
REFERENCES	37

LIST OF TABLES

Table	Page
1. Demographic and Mental Health Characteristics	19
2. Attitudes Toward Etiology of Mental Health Problems and Treatments	20
3. Experiences with Providers and Shared Decision Making Variables.....	21
4. Bivariate Statistics on Demographic Factors and Shared Decision Making	23
5. Linear Regression Predicting Control Preferences and Self Efficacy Score	24

ABSTRACT

Shared decision making between consumers and providers is associated with improved health outcomes. However, we know very little about shared decision making with regard to outpatient mental health treatment, particularly with regard to the use of psychotropic medication. Using quantitative survey methods, this research seeks to understand attitudes about the use of medication for mental healthcare amongst Texas State University students; it then examines factors associated with the likelihood of engaging in shared decision making with providers. Many endorse the efficacy of medication but also have concerns and prefer that medication be used after other treatment modalities and on a short-term basis. People who had concerns about medication took them despite their uncertainty indicating a lack of shared decision making with their provider. Socioeconomic status and age were found to be significant predictors of one's confidence to engage in shared decision making. Implications of these findings are discussed.

I. INTRODUCTION

Psychotropic medication is the most common approach to mental health treatment (APA 2012; Smith 2014). However, research on the consumer-provider relationship indicates that current mental healthcare systems are paternalistic and lack shared decision making regarding the use of medication (Barnett et al. 2019). Consumers of mental health care specifically report feeling disempowered about treatment decisions related to medication (Morant, Kaminskiy, and Ramon 2015).

Most research on factors associated with shared decision making and psychotropic medication in mental healthcare have been examined within the context of institutionalized settings (i.e., psychiatric hospitals) and with populations who are considered seriously mentally ill (O’Neal et al. 2008). The purpose of this research is two-fold. Using quantitative research methods, I will first seek to better understand current attitudes about the use of medication for mental treatment amongst Texas State University students. Second, I will examine decision making preferences and who is more likely to engage in shared decision making with their mental healthcare providers.

For the context of this research, the term “consumer” will be used to describe those receiving mental healthcare treatment. This term derives from the consumer/recovery movement – a mental health empowerment movement largely consisting of people who have been treated with medication against their will in the past. Through their fight for social justice, they advocate for mental health policies and practices that respect the rights and autonomy of people with mental health conditions (Everett 1994; Drake, Deegan, and Rapp 2010). The title of “consumer” is preferred rather than patient, because it reduces the asymmetry in power between physicians and

people receiving care (Van Tosh, Ralph, and Campbell 2000). The term “provider” will be uniformly used throughout this thesis and include those with the authority to prescribe psychotropic medication (e.g., psychiatrists, doctors, nurse practitioners).

II. LITERATURE REVIEW

Current Paradigm of Mental Health Treatment

Mental health is a predominately medicalized field. The emergence of psychotropic drugs in the 1980's and the establishment of the DSM-III, a classification system for diagnosing mental health issues, has resulted in a medication-based model of treatment (Conrad 1992; Smith 2014; Whooley 2014). Psychotropic medications are now top sellers for the pharmaceutical industry; one in five adults take at least one psychotropic medication (APA 2012) and antipsychotics alone produce \$18 billion a year in revenue (Frances 2013).

In fact, the use of medication extends beyond severe mental distress and is used to treat a wide range of social conditions including ADHD, anxiety and depression (Conrad and Slodan 2013). Medication is commonly used to address behavioral concerns in vulnerable populations including children in foster care (Park, Okpych, and Courtney 2019), the intellectually and developmentally disabled (Perry et al. 2018), elderly persons in nursing homes (Galik and Resnik 2013) and those with traumatic brain injuries (Farinde 2014).

A shift in prescribing practices has contributed to an increase in the accessibility and use of psychotropic medication. Most people taking psychotropic medication are never seen by a mental health professional because the majority of prescriptions are now written by non-psychiatrists such as doctors and nurse practitioners (APA 2012). In fact, an official mental health diagnosis is not required for an initial prescription; patients did not have a diagnosis in 60.4% (n=8,618) of doctor's visits where a new psychotropic medication was prescribed (Rhee and Rosenheck 2019). Once initially prescribed, the use

of medication is often long-term. Prescribing guidelines indicate short-term use, but one-third of benzodiazepine users receive prescriptions long-term (Ashton 1994; Van Hulten et al. 2003) and 70% report taking psychotropic medications for over 9 years (Ostrow et al. 2017).

Although psychotropic medications are commonly used, their adverse side effects and questionable long-term efficacy have provoked debate (Whitaker 2004; Morant et al. 2018; Gupta and Cahill 2016). Even though they provide short-term psychological relief, research suggests that medication may be doing more harm than good overtime and some consumers fare better when never taking medication (Whitaker 2004; Whitaker 2010). Long-term psychotropic users often complain of adverse side effects such as weight gain, sexual dysfunction, and mental clouding. Other long-term, and sometimes irreversible, side effects include kidney failure and tardive dyskinesia, a motor control issue that manifests in involuntary movements (Morant et al. 2018; Gupta and Cahill 2016).

Attitudes Towards the use of Psychotropic Medications

There is well documented research on public attitudes towards the efficacy and willingness to use psychotropic medication. A common finding is that people endorse the efficacy of medication but are less willing to take them (Martin and Pescosolido 2005), consider them to be harmful (Kaparounaki et al. 2019), and believe the use of medication should depend on the severity of the illness (McLeod et al. 2004). Beliefs about the etiology of illness are often linked with attitudes about treatment; those who believe mental illness is rooted in brain abnormalities are more likely to use or suggest medication to others (Abid et al. 2018).

Sociodemographic factors are found to be significant indicators of attitudes about

medication for mental health treatment. College educated people are more likely to agree with a biomedical model of mental health care (Schnittker 2003). On average, older white adults are more trusting of physicians, have a positive outlook on medication, and are more willing to depend on them (Martin and Pescosolido 2005). Older adults also have a stronger desire for involvement in medical decision making (O’Neal et al. 2008).

Racial minority groups, especially those who have distrust in providers, are less willing to use psychotropic medication and more likely to be skeptical of side effects (Martin and Pescosolido 2005; Schnittker 2003). In one study, African American families in inner city communities were more hesitant to give their children medication for ADHD because they acknowledge negative side effects and had concerns that prescription medication use could lead to other drug use; however, in the same study, parents became more trusting of the efficacy of ADHD medication when the recommendation came from a provider (DosReis et al. 2006).

Cultural differences are also found to influence attitudes towards medication use, specifically in Latino cultures (Adams et al. 2015) and for those who believe in an Eastern approach to medicine where medications are believed to be addicting and less effective than homeopathic remedies (Economou et al. 2016).

Mental Health Care Experiences

Research on user experiences show that many consumers who followed their provider’s recommendation of taking psychotropic medication choose to discontinue medication because of adverse side effects (Ostrow et al. 2017). When reflecting on their healthcare experience, they report feelings of disempowerment in their initial treatment decision because they were not fully informed about the risks involved or given other

treatment options (Morant et al. 2018; Ostrow et al. 2017). Current findings on sociodemographic differences on attitudes towards mental health treatment and healthcare experiences that lack informed choice lend to the importance of discussing consumer-provider relations in mental health treatment.

III. THEORETICAL FRAMEWORK

Models of Consumer-Provider Relationships

Models of Consumer-Provider (i.e., doctor-patient) relationships have been thoroughly studied and characterize consumer-provider interactions based on the roles each person plays in healthcare interactions. Models of this relationship operate on a continuum of care that ranges from paternalism to patient autonomy (Emmanuel and Emmanuel 1992; Szasz and Hollender 1955). On one end of the continuum, being completely paternalistic is characterized as the provider having complete control in medical decision making and most often occurs in medical emergencies; on the other end, complete autonomy gives the consumer complete choice and control over medical care (Emmanuel and Emmanuel 1992). It is important to note that these models of interactions are fluid in nature and do not typically operate entirely on one end or the other. The theoretical basis for this research is derived from a shared decision making model of care which falls in the middle of the continuum.

Person-Centered Care and Shared Decision Making

Person-centered care is highly advocated for long-term health issues that require regular consumer-provider interactions (Mead and Bower 2002). There is no standard definition of person-centered care, because it has been defined in various theoretical contexts; however, the basic premise involves a therapeutic consumer-provider alliance that values autonomy, encourages active participation in one's treatment, and shares power in decision making (Mead and Bower 2002; Barnett et al. 2019).

Shared decision making is a pertinent aspect of person-centered care and is perhaps most relevant to discuss in the context of the current analysis. Shared decision

making has been most advocated for amongst consumers of mental health care who feel disempowered and lack choice in treatment decisions (Drake, Deegan, and Rapp 2010). It involves bi-directional interactions where doctors provide complete and unbiased information about treatment options and consumers are granted self-determination, support, and autonomy in making their own choices (Hamann, Leucht, and Kissling 2003). Person-centered care and shared decision making have been researched and implemented in general medical practice but are less developed in mental health care (Morant et al. 2018; Morant et al. 2015).

In general medical practice there is a relationship between the nature of consumer-provider interactions and subsequent health outcomes; a shared decision making style of communication increases patient involvement which is found to play a significant role in consumer self-care; this has led to better hypertension outcomes and improved overall health (Kaplan et al. 1989; Naik et al. 2008). Similarly, research on shared decision making and mental health outcomes show that consumer involvement results in a person-centered treatment plan that leads to treatment adherence and more noticeable improvements in mental health (Clever et al. 2006).

Shared Decision Making in Current Paradigm of Mental Healthcare

Although research indicates improved mental health outcomes when shared decision making is the center of consumer-provider relationships, research indicates a lack of shared decision making and exposes modern day paternalism in mental healthcare. Although there has been mental healthcare reform and the use of medication appears to be a less punitive form of treatment compared to coercive treatments of the past (i.e., bloodletting, lobotomies, and electric shock treatment), the lack of involvement

in decision making is paternalistic (Whitaker 2002).

Research on decision making in mental healthcare is predominately studied in the context of institutionalized settings. The focus of these studies is expected because institutionalized settings are most critiqued for coercive practices; the use of involuntary commitment and forced medication are used for those who pose a threat to themselves or others (Lim 2016). It is within these institutions that consumers advocate the most for egalitarian approaches to treatment and urge psychiatric authorities to consider their requests for how medication is incorporated (Rissemiller and Rissemiller 2006).

Many consumers feel pressured to take medication (Norvoll and Pederson 2015) and mental health professionals admit to using coercive treatment strategies to encourage medication adherence (Schori et al. 2018; Szmukler and Appelbaum 2008; Valenti et al. 2015). Practitioners acknowledge the need for less paternalism in mental healthcare, yet feel it is effective and unavoidable in hospitalized settings where taking medication is considered essential for patient recovery (Valenti et al. 2015). However, consumers who voluntarily commit themselves and are not under legal sanctions also describe being left out of treatment decisions indicating that coercion is more widespread (Prebble et al. 2015).

Although less documented, researchers acknowledge that a lack of shared decision making in consumer-provider interactions extend beyond hospitalized settings. Attitudes towards psychiatric care and provider interactions were measured from the perspective of youth in foster care. Most acknowledged that medication was intended to control their behavior, reported not knowing information about their medication, and doubted the efficacy of it (Barnett et al. 2019). These findings are all indicative of mental

healthcare system that devalues shared decision making and lacks a person-centered approach to treatment.

Medicalization of Mental Health

It is important to consider the sociological perspective as it relates to the medicalized nature of mental health treatment; although this is not the primary theoretical framework for the current analysis, it does shape the motivation for this research and how I interpret the implications of my findings. Sociologists of mental health express concerns about the consequences of medicalizing social behavior and mental distress.

Pathologizing human behavior dictates what society views as normal and abnormal (Conrad and Slodden 2013). This process of socially constructing illness shapes how one views themselves and their mental distress as well as how others perceive the appropriate treatment for them (Conrad and Barker 2010).

The medicalization of mental health has created power imbalances in the consumer-provider relationship because interactions about mental health primarily consist of the negotiation of medical knowledge where consumers hold subordinate positions (May 2007). Shared decision making is essentially a negotiation of knowledge that occurs between consumers and providers; how this transfer of power is negotiated affects how patients socially construct and make meaning of their illness (Conrad and Barker 2010). This along with coercive treatment pressures largely determine how consumers perceive their prescribed illnesses and suitable treatment (Conrad and Barker 2010) and to what extent they are able to engage in shared decision making (Van Hulst et al. 2003).

Perhaps the most prominent concern is that the medicalization of mental health

decontextualizes mental distress and largely discounts social structures that contribute to mental health issues (Whooley 2014). Our current mental health system is reduced to a biomedical model of care that largely ignores social factors critical to understanding mental health problems. It takes the role of context out of diagnostic procedures and treatment which has created a system of care unsuitable for mental distress that is social in nature (e.g., trauma related mental health disorders) (Watt 2017).

However, structural factors such as inequality are root causes of mental health problems. Poverty and extreme social change are associated with a higher likelihood of mental health problems (Abid et al. 2018). People of Color, especially Blacks experience racism and discrimination as a chronic stressor which is associated with higher levels of anxiety and depression (Pieterse et al. 2012). There is also a consistent association between adverse family experiences/childhood adversity and higher risks of mental health issues (Alcala, Horino, and Delva 2018).

Having mental health problems, even if they are a result of inequality, increases the chances of receiving mental health treatment and the possibility of needing to make treatment decisions regarding medication. Therefore, it is important to consider factors that make shared decision making less likely for certain groups. Children in the foster care system are prone to poor communication and insufficient monitoring of medication (Barnet et al. 2019). Shared decision making is especially complicated for these children because they cannot consent to treatment and have several people caring for them (Barnet et al. 2019).

Communication issues between consumers and providers are exacerbated when they do not share the same sociocultural background (i.e., differences in class, status, and

religious beliefs) (Herselman 1996); men in general and African American men especially are less likely to engage in shared decision making (Herselman 1996). These are all factors that influence perceptions of medicine and illness etiologies which are known to influence treatment preferences (Martin and Pescosolido 2005; Schnittker 2003; Adams et al. 2015; Economou et al. 2016). These sociological findings establish a need for a paradigm shift in mental health treatment and supports the need to further examine consumer-provider relationships.

Gaps in Literature

Most research on consumer-provider relationships involving psychotropic medication have been examined within the context of institutionalized settings. These findings have indicated a lack of shared decision making regarding the use of medication for treatment. Although important, such research neglects the fact that the majority of mental health treatment and prescribing of medication takes place in outpatient settings and involves non-psychiatrists (Rhee and Rosenheck 2019). The current direction of mental healthcare is reduced to a biomedical model of diagnostic systems and treatment (Whooley 2014). Therefore, it is appropriate to assume that the use of psychotropic medications will remain a predominant form of mental health treatment making this topic relevant and important.

A preliminary step to supporting consumers of mental healthcare is to examine consumer-provider relationships in non-institutionalized settings. The present study will aim to better understand current attitudes towards the use of psychotropic medications for mental health treatment amongst Texas State University students. Secondly, it will examine decision making preferences and sociodemographic factors related to the

likelihood of engaging in shared decision making with mental health providers.

The first area of inquiry is necessary to fully understand aspects of shared decision making as they relate to medication use. For instance, one who believes in the efficacy of medication may be less inclined to engage in shared decision making because they agree with proposed treatments (Abid et al. 2018). For the context of this research, shared decision making will be based on definitions set forth by Hamann et al. (2003), which involves bi-directional interactions where doctors provide complete and unbiased information about treatment options and consumers are granted self-determination, support, and autonomy in making their own choices.

IV. METHODS

Recruitment and Sample

Eligibility criteria for participation in this study included that the respondent be a current Texas State University undergraduate or graduate student and be at least 18 years old. Participants were found using non-probability convenience sampling and were primarily recruited using the Texas State Department of Psychology SONA system, an online platform for undergraduate students enrolled in introductory psychology courses to access and engage in research for course participation credits. The survey was also advertised to other classes within the Psychology and Sociology departments; depending on the course, extra credit was offered for participating in the survey. Lastly, the survey was advertised by word of mouth amongst graduate students. The research advertisement stated that the purpose of the study is to examine shared decision making between students and providers (i.e., doctors, nurse practitioners, psychiatrists) about mental health treatment.

Participants took a self-administered online survey via the survey software Qualtrics. Consent was obtained and then participants were redirected to another webpage to begin the survey. The confidentiality of respondents was protected by limiting identifiable information on the survey and prohibiting the collection of IP addresses. At the end of the survey, a mental health resources page was provided for participants and included local and State mental health agencies, phone numbers, and websites. Texas State University IRB approval for this project was obtained on March 2, 2021.

Measures

Demographic Characteristics

The survey captured sociodemographic characteristics including race/ethnicity, gender identity, age, student classification, and mother's educational attainment.

Participants reported mother's educational attainment by choosing their mother's highest level of education. Since the sample was comprised of college students, mother's educational attainment was used as an indicator of socioeconomic status.

Mental Health Characteristics

Information on mental health characteristics including mental health status and diagnoses was collected. Mental health status was based on self-perception and ranged from very poor to excellent.

Attitudes Toward Etiology of Mental Health Problems and Treatments

Survey questions were constructed based on existing research and were used to capture beliefs about the causes of mental health problems, attitudes towards the use of medication for mental health treatment and beliefs about the efficacy of other treatments (Martin and Pescosolido 2005; McLeod et al. 2004; Abid et al. 2018; Schnittker 2003; Ostrow et al. 2017; Abid et al. 2018).

Participants ranked the following causes of mental health issues from most to least important: biological (e.g., chemical imbalances in the brain, genetic/inherited), psychological (e.g., disordered thought processes), and social/environmental (e.g., family influences, trauma, stressful circumstances). They also selected which options they felt were effective mental health treatments (e.g., counseling, holistic methods, medication, talking with family/friends).

Shared Decision Making Measures

Experiences with Providers

Participants whose doctors had previously recommended medication for mental health treatment reported how they felt about the recommendation and whether they ended up taking medication.

The Control Preferences Scale

The Control Preferences Scale (CPS) was designed by Degner, Sloan, and Venkatesh (1997) to measure the degree of control one desires to have when decisions are being made about their medical treatment. The scale consists of five options that are characterized as ranging from an active role where the patient makes the treatment decision, a collaborative role where a decision is jointly made, or a passive role where the provider makes the decision. The CPS is a valid and reliable measure that has been used to study a variety of populations including those with chronic illnesses and emotional disorders (Cronbach's alpha = 0.72) (Degner et al. 1997; Negarandeh et al. 2020; De las Cuevas et al. 2016).

O'Neal et al. 2008 used an expanded version of the CPS that included specific scenarios related to mental health treatment (i.e., a change in medication dosage, hospital admissions) to study age related differences in decision making preferences for people with serious mental illness. The CPS has also been used to teach shared decision making skills in clinical settings (O'Neal et al. 2008).

For the context of this research, the CPS measured decision making preferences regarding mental health treatment. Participants were asked to choose the option that best describes their preferences regarding decision making with their provider about their

mental health treatment. The scale presented on the survey was derived directly from the CPS. However, the wording was adapted to include the phrase “mental health treatment” to specify decision making related to mental health treatment.

Decision Self-Efficacy Scale

The Decision Self-Efficacy Scale (DSES) is an instrument used to measure how confident someone is in engaging in decision making with their doctor. The scale was developed based on the concept of self-efficacy, the idea that one feels they can adequately and efficiently handle a situation (Bunn and O’Connor 1996; Degner et al. 1997). DSES consists of 11 items and participants rate their level of confidence with each statement on a 5-point response category ranging from 0 (not all confident) to 4 (very confident). Items include statements such as “I feel confident that I can get facts about the medication choices available to me, ask questions without feeling dumb, and let my provider know what is best for me”.

Self-efficacy scores were calculated for each participant based on instructions in the DSES user manual. Numerical scores on all 11-items were summed, divided by 11, and multiplied by 25, resulting in a self-efficacy score ranging from 0 (not at all confident) to 100 (very confident) (O’Connor 1995). A score of 0 indicates low self-efficacy and a score of 100 indicates high self-efficacy in engaging in medical decision making. The DSES has been found to be valid and reliable in psychiatric and mental health studies (Cronbach’s $\alpha = 0.84$) as well as in other medical contexts (Bunn and O’Connor 1996; Negarandeh et al. 2020; O’Neal et al. 2008). An entire list of survey questions used for the current analysis can be found in appendix A.

V. STATISTICAL ANALYSES AND RESULTS

SPSS (Statistical Package for the Social Sciences) was used for all statistical analyses. Descriptive statistics were examined on all variables and were used to identify common attitudes and beliefs about mental health problems and treatments. Bivariate analyses were used as a preliminary test to examine relationships between demographic characteristics and shared decision making (control preferences and self-efficacy scores). A series of linear regressions were used to further explore the nature of these relationships.

Descriptive Statistics

Demographic Characteristics

The following Tables (1-3) provide descriptive statistics of all variables for the sample of 237 students who participated in the survey. The sample was predominately female (74%, n=174) with an age range of 18 to 54 years old, a mean age of 21.58 years \pm 5.39 years. Approximately 41% (n=97) were non-Hispanic white and the remainder of the sample was classified as other. The size of each racial group was not sufficient to analyze independently. Student classification amongst participants was diverse with most students being freshman (36.3%, n=86) and graduate students being the least represented (5.1%, n=12). The majority of the sample (65.5%, n=154) had mothers with less than a college degree indicating a lower socioeconomic status compared to the rest of the sample (34.5%, n=81).

Table 1. Demographic and Mental Health Characteristics

Demographic Characteristics		Mental Health Characteristics	
Variable	<i>M (SD)</i>	Variable	<i>f (%)</i>
Age; years	21.58 (\pm 5.39)	Mental Health Rating	
Classification	<i>f (%)</i>	Very Poor	3 (1.3)
Freshman	86 (36.3)	Poor	59 (25)
Sophomore	51 (21.5)	Average	96 (40.7)
Junior	44 (18.6)	Good	61 (25.8)
Senior	44 (18.6)	Excellent	17 (7.2)
Graduate Student	12 (5.1)	Mental Health Diagnosis	
Gender		ADHD/ADD	23 (9.7)
Male	53 (22.6)	Bipolar Disorder	4 (1.7)
Female	174 (74)	Depression	69 (29.1)
Other	8 (3.4)	Anxiety	76 (32.1)
Race/Ethnicity		Schizophrenia	1 (.4)
Non-Hispanic White	97 (41.8)	Obsessive Compulsive	6 (2.5)
Other	140 (59.1)	Other – self-reported	14 (5.9)
Mother’s Highest Education			
Less than High School	22 (9.3)		
High School or GED	61 (25.7)		
Some college	48 (20.3)		
2-year degree	23 (9.7)		
4-year degree	50 (21.1)		
Graduate degree	31 (13.1)		
Unknown	2 (.8)		

Mental Health Characteristics

Sixty five percent (n=97) of participants had previously received a mental health diagnosis from a provider. The most common diagnoses were depression 29.1% (n=69) and anxiety 32.1% (n=76). A provider had previously prescribed or recommended medication for mental health treatment to 32.1% (n=76) of the sample.

Attitudes Toward Etiology of Mental Health Problems and Treatments

Table 2 provides summary statistics for variables related to attitudes towards mental health and treatment.

Table 2. Attitudes Toward Etiology of Mental Health Problems and Treatments

Attitudes about mental health and medication	
Variable	<i>f (%)</i>
Etiology of Mental Health Problems	
Social/Environmental	102 (58.6)
Biological	48 (27.6)
Psychological	24 (10.1)
Attitudes about Medication	
Meds help with symptoms	163 (69)
Have negative side effects	169 (71.6)
Overprescribed	89 (50.4)
Other treatments first	173 (73.3)
Attitudes about Effective Treatment	
Counseling	205 (86.5)
Holistic methods	168 (70.9)
Talking with family/friends	165 (69.6)
Prescription medication	147 (62)

Based on descriptive statistics, attitudes about effective treatments coincide with attitudes about the etiology of mental health problems. Most people believed the leading cause of mental health problems to be social/environmental (58.6%, n=102) and counseling was selected as an effective treatment the most (86.5%, n=205) while prescription medication was selected the least (62%, n=147). Most people agreed that medication helps with mental health symptoms (69%, n=163), but around the same agreed that medications have negative side-effects (71%, n=169). Most people also agree that medication for mental health treatment is overprescribed (50.4%, n=89) and that other mental health treatments should be tried before medication (73.3%, n=173).

Experiences with Providers

Table 3 provides a summary of statistics regarding experiences with providers and shared decision making variables.

Table 3. Experiences with Providers and Shared Decision Making Variables

Experiences with Providers	
Variable	<i>f (%)</i>
Prescribed/Recommended Meds	
Yes	76 (32.8)
No	156 (67.2)
Feelings about Recommendation	
Wanted to take meds	41 (51.9)
Unsure about taking them	21 (26.6)
Concerned about taking them	7 (8.9)
Did not want to take	10 (12.7)
Medication Outcome	173 (73.3)
No meds due to concerns	12 (15.2)
Took meds with concerns	23 (29.1)
Took meds & was concerned over time	18 (22.8)
Took meds with no concerns	26 (32.9)
Wanted to take meds	41 (51.9)
Shared Decision Making	
Variable	<i>f (%)</i>
Control Preferences	
Prefers to make own decision	41 (17.4)
Prefers to make final decision after considering provider's opinion	115 (48.7)
Prefers a shared responsibility in making a decision	62 (26.3)
Prefers provider makes final decision after considering their opinion	16 (6.8)
Prefers provider makes all decisions	2 (.8)
Variable	<i>M (SD)</i>
Self-Efficacy Score	71.58 (\pm 19.93)

A provider had previously prescribed or recommended medication for mental health treatment for 32.8% (n=76) of the sample. Of those people, about half wanted to take the medication (51.9%, n=41), 26.6% (n=21) were unsure about taking medication, 8.9% (n=7) were concerned about taking medication and 12.7% (n=10) did *not* want to take medication for their mental health treatment. However, of the people who had concerns about taking medication (48.2%, n=38), more than half of them took medication despite their uncertainty and concerns (60.5%, n=23).

This subsample of people was not large enough to use in more complex statistical analyses. However, existing research on the relationship between causes of mental health problems and appropriate treatments suggest that those who believe mental health problems are rooted in brain abnormalities are more willing to take medication (Abid et al. 2018). This makes the current finding even more puzzling; if most people ranked biological etiologies last, prescription medication was ranked last in terms of perceived effectiveness, and there was a strong consensus that other treatments should be tried first, why are so many people taking medication despite their concerns and uncertainty?

The remaining areas of exploration and findings will focus on how demographic factors relate to shared decision making in mental healthcare by examining the relationships between demographic factors, control preferences, and self-efficacy scores. This will serve as a first step in exploring the discrepancies between people's attitudes about taking medication and medication use.

Factors Associated with Shared Decision Making

Bivariate Analyses

Table 4 provides a summary of all bivariate statistics that examine the relationship

between demographic factors and shared decision making variables.

Table 4. Bivariate Statistics on Demographic Factors and Shared Decision Making

Independent Samples T-Test				
Control Preference			Self-Efficacy Score	
	Mean	Sig. (2-tailed)	Mean	Sig. (2-tailed)
Race/Ethnicity		.111		.860
Non-Hispanic White	2.14		71.3068	
Other	2.32		71.7803	
Age		.316		.079
<25 years old	2.26		71.2883	
>25 years old	2.08		78.4545	
Mother's Education				*.020
College Degree	2.14		75.9740	
No College Degree	2.32		69.4783	
ANOVA				
Control Preference			Self-Efficacy Score	
	Mean	Sig. (2-tailed)	Mean	Sig. (2-tailed)
Gender Identity		.379		.528
Female	2.28		71.99	
Male	2.13		71.34	
Other	2.50		63.31	

* $\leq .05$, ** $\leq .01$, *** $\leq .001$

To make mother's education a nominal dichotomy, responses were coded as 1=less than a college degree (less than high school, high school or GED, some college, 2-year degree) and 2=college degree or graduate degree. An Independent Samples T-test showed a statistically significant relationship between mother's education and self-efficacy score ($p=.02$). The mean self-efficacy score for those with college educated mothers was 75.97 compared to those whose mothers had less than a college degree (69.48). This corresponds to a 6.49 difference in self-efficacy scores and suggests that those belonging to higher socioeconomic groups have a higher self-efficacy score on average. There was however no significant relationship between mother's education and control preference.

Additional Independent T-tests were done to test the relationships between race/ethnicity and age with control preference and self-efficacy score. Age was recoded

into a nominal dichotomy where responses were coded as 1 if younger than 25 years of age and 2 if 25 and older. There were no significant relationships found for race/ethnicity or age. An ANOVA test was done to test the relationship between gender identity (1=male, 2=female, 3=other) with control preference and self-efficacy score; no significant relationship was found.

Multivariate Analyses

Regression analyses (Table 5) were conducted to predict the dependent variables with all demographic variables included in the models (e.g., age, gender, race/ethnicity, and mother's education).

Table 5. Linear Regression Predicting Control Preferences and Self Efficacy Score

Control Preferences					
Sociodemographic Characteristics	B	S.E.	Stand. Co. B	T	Sig.
Constant	2.582	.213		12.095	.000
Race/Ethnicity	-.090	.115	-.054	-.784	.434
Mother's Education	-.184	.119	-.106	-1.553	.122
Age	-.180	.180	-.068	-1.000	.319
Female-(reference category)	----	----	----	----	----
Male (dummy variable)	-.158	.136	-.078	-1.157	.248
Other gender (dummy variable)	-.142	.319	-.030	-.445	.657
Self-Efficacy Score					
Constant	60.416	4.944		12.219	.000
Race/Ethnicity	-4.026	2.680	-.103	-1.502	.135
Mother's Education	7.441	2.788	.184	2.669	** .008
Age	9.348	4.154	.154	2.250	* .025
Female (reference category)	----	----	----	----	----
Male (dummy variable)	2.117	3.193	.045	.663	.508
Other gender (dummy variable)	3.633	7.915	.031	.459	.647

* $\leq .05$, ** $\leq .01$, *** $\leq .001$

Based on the linear regression analyses, controlling for all other variables, mother's educational attainment is a significant predictor of self-efficacy scores; having a college educated mother is associated with a 7.441 increase in self-efficacy score ($\beta=7.441$, $p=.008$). This suggests that those with a higher socioeconomic status are more likely to *feel* confident in their ability to advocate for themselves about taking medication for mental health treatment compared to those in lower socioeconomic statuses. It is important to note that this scale does not reveal whether the person will actually advocate for themselves; it only reveals that they feel confident that they could.

Independent of all other demographic variables, age is also found to be a significant predictor of self-efficacy scores; being 25 years or older is associated with a 9.348 increase in self-efficacy scores ($\beta=9.348$, $p=.025$). This indicates that the older someone is the more confident they feel in advocating for themselves and engaging in medical decision making regarding mental health treatment. Race/ethnicity and gender identity were not found to be significant predictors of self-efficacy scores. Another linear regression found that none of the demographic variables (race/ethnicity, gender identity, mother's education, age) were significant predictors of control preferences.

VI. DISSCUSSION

The descriptive statistics in this study suggest that people have concerns about medication and prefer that medication be used after other treatment modalities and on a short-term basis. However, results also reveal that people are following their provider's recommendations even if they have concerns, prefer other treatment options, and doubt the efficacy of medication for their mental health treatment.

Most research on the topic of treatment compliance captures provider perspectives and focuses on problems associated with consumers being non-compliant with their provider's treatment plan (Gupta and Cahill 2016); some providers assume non-compliance is due to loss of insight caused by mental health problems and suggest the solution is the development of interventions intended to improve compliance (Byerly et al. 2007; Mitchell 2007). However, research on consumer perspectives reveal that in many cases choosing to take medication has more to do with attitudes about medication, health beliefs and the type of interactions they have with their provider (Mitchell 2007).

The additional analyses were the first step in exploring possible factors related to the discrepancies between people's attitudes about taking medication and medication use. Additional research should be done to specifically focus on the subsample of the population who have had experiences with providers regarding mental health treatment. A larger sample size will allow for an analysis of how sociodemographic factors relate to shared decision making in practical situations.

There were no significant relationships between sociodemographic factors and control preferences indicating that most people regardless of age, gender, race/ethnicity, or socioeconomic status, prefer to play an active role in their mental health treatment.

However, self-efficacy findings show that although most people desire control when interacting with providers, some are more confident about their ability to engage in shared decision making.

Those with a higher socioeconomic status feel more confident on average in advocating for themselves and engaging in shared decision making compared to those in lower socioeconomic statuses. This finding is important to consider because those with a lower socioeconomic status along with other marginalized groups are more likely to have negative attitudes towards medication (Martin and Pescosolido 2005; Schnittker 2003); furthermore, their mental health problems are more likely to be a result of structural/social inequalities than biological abnormalities (Adams et al. 2015; Economou et al. 2016; Abid et al. 2018; Pieterse et al. 2012)

Therefore, it is especially crucial that they receive care from their providers that follow the fundamentals of shared decision making. More research should be done with a larger sample size of each racial group to adequately test for racial differences regarding self-efficacy scores. Additionally, since research shows that people with higher education are more likely to agree with the biomedical model of care, it is likely that they also agree with the benefits and efficacy of medication (Schnittker 2003). Thus, they would not need the self-efficacy to engage in shared decision making as much as someone who has less education and prefers alternative treatments.

Age was found to be another salient predictor of self-efficacy scores. Older people (over the age of 25 years) felt more confident in engaging in shared decision making. This is important to consider because the onset of mental health related symptoms typically occur in adolescence and early adulthood (Kessler et al. 2008).

Although treatment does not always occur until later in life, trends in diagnostic rates show that diagnoses are beginning to occur more frequently in childhood years (Kessler et al. 2008; Whitaker 2010). Mental health screenings are also becoming routine in primary care visits which increases the likelihood that mental health discussions between providers and consumers will occur at younger ages (Mulvaney-Day 2018). Although this is intended to recognize mental distress early on, it calls attention to the importance of younger people learning ways to engage in shared decision making so that they can make informed choices.

Specific to this population, it is important to consider the prevalence of Adderall use on college campuses. The pressure to achieve in a comparative society where success is closely tied to personal identity is stressful and has been found to increase the use of ADHD medication in college students (Varga 2012). College related stressors could lead to mental distress as well as the desire to use ADHD medication. Either way, receiving medication from a provider should include a collaborative discussion that considers contextual factors (e.g., college related stressors) as well as the benefits and consequences of using medication; this will ensure that young people are given the liberty to make informed choices.

Limitations of Study

Current findings cannot be generalized because participants were found using convenience sampling. The majority of participants were recruited from the college of liberal arts psychology and sociology departments which lends to a potentially biased and unrepresentative sample. The sample was also predominately female and although there were a range of ages, a student sample skews considerably younger than the general

population. It is also important to note that this survey was given during the COVID-19 pandemic which could have affected self-perceived mental health ratings and responses relating to attitudes about mental health.

Areas of Future Research

Future research should be done to address the limitations of this study. Namely, a more representative sample should be used to study similar phenomena. Studies with a representative sample and larger sample sizes are needed to provide reliable and valid comparisons between demographic subgroups. Those who have had actual experiences with providers about mental health care should be looked at exclusively to see if the discrepancies between attitudes about medication and medication outcomes are common. It is also worthwhile to consider the intersectionality of marginalized groups and how that affects self-efficacy in shared decision making.

Since it is difficult to examine socioeconomic status for a college student sample, mother's education was used as a proxy for socioeconomic status. Although mother's education was found to be a significant predictor more research is needed to understand how socioeconomic status affects attitudes toward medication and shared decision making regarding medication.

Shared Decision Making in Action

The shared decision making model of care is especially important for issues that are chronic or long-term in nature because they typically require multiple consumer-provider interactions (Kaplan et al. 1989). As in the case of mental health care, shared decision making is especially important when there are different treatment options available to the consumer (Huang et al. 2020). Implementing shared decision making in

medical care leads to a greater commitment to treatment plans, increases in health literacy, and provides consumers with feelings of empowerment (Huang et al. 2020).

Although shared decision making has proven beneficial and has shown no harm in studies completed thus far, it is less implemented in mental healthcare settings for several reasons. Healthcare policy makers have hesitated to require the implementation of shared decision making in behavioral healthcare because they argue that the lack of research on the topic is insufficient to conclude that it's beneficial (Slade 2017). Barriers also include the widely held belief that people with mental health issues lack insight, societal expectations are that providers have more power/knowledge than consumers, and there are limited financial resources for alternative treatment options (Slade 2017; Huang et al. 2020).

Implementing shared decision making in mental healthcare will likely require widespread use and accessibility of training and tools to help facilitate shared decision making (Slade 2017). Negarandeh et al. (2020) are currently testing the effectiveness of Question Prompt Lists (QPLs) in initiating and enhancing shared decision making for women with breast cancer. The results of their study are not yet published, but a tool such as this could be tried in mental health settings. Alegria et al. (2018) did randomized clinical trials and found that training providers on shared decision making techniques increased shared decision making the most; training consumers only increased patient-reported quality of care but did not increase shared decision making without the provider also being trained.

Although interpersonal interactions were focused on in the context of this research, it is important to consider the structural factors related to inequalities in

consumer-provider relationships. A lack of resources is an issue innate to the American healthcare system as a whole (Slade 2017). This combined with the degrading societal view that people with mental distress lack insight, prohibits proactive change and continues to marginalize people with mental health issues.

In order for shared decision making to become an integrated reality in mental healthcare, societal perceptions of the mentally ill will have to change and the predominately medicalized culture of mental health will have to shift to one that is more inclusive of all sociocultural experiences and preferences regarding mental health care.

APPENDIX SECTION

Appendix A: Survey

- What is your classification?
 - Freshman
 - Sophomore
 - Junior
 - Senior
 - Graduate Student
- What is your age? If you prefer not to answer, please write “prefer not to answer”

 - Prefer not to answer
- What is the highest level of education your MOTHER completed?
 - Less than High School
 - High School or GED
 - Some college
 - College Degree
 - Graduate degree
 - Don't Know

The remainder of the survey will include questions about experiences you have had with your **provider** about your mental health. Here, a provider includes anyone who can prescribe medication (doctors, psychiatrists, nurse practitioners).

- How would you rate your mental health?
 - Very Poor
 - Poor
 - Average
 - Good
 - Excellent
- Have you ever had a mental health disorder such as ADHD/ADD, Bipolar, Depression, Anxiety, Schizophrenia, or Obsessive-Compulsive Disorder)?
 - Yes
 - No
 - I have had a mental disorder, but it is not listed here

- If so, what diagnosis have you been given? Check all that apply
 - ADHD/ADD
 - Bipolar
 - Depression
 - Anxiety
 - Schizophrenia
 - Obsessive Compulsive Disorder
 - Other_____
 - None of the above

- Did a provider ever recommend or prescribe medication for your mental health treatment?
 - Yes
 - No
 - I don't know

- Which of the following describes **how you felt** about this recommendation and/or prescription for medication?
 - I wanted to take medication as a treatment option
 - I was unsure about taking medication as a treatment option
 - I was concerned about taking medication as a treatment option
 - I did NOT want to take medication as a treatment option

- **What happened** when your provider recommended and/or prescribed medication for mental health treatment?
 - I did NOT take medication because of concerns
 - I took medication even though I had concerns
 - I took medication and initially had no concerns but became concerned over time
 - I took medication but had no concerns at any point

What do you believe **causes** mental health problems? Please rank the factors (1 being MOST important cause to 3 being LEAST important cause) you consider in causing such problems.

- Biological (e.g., chemical imbalance in the brain, genetic/inherited)
- Psychological (e.g., disordered thought processes)
- Social/environmental (e.g., family influences, trauma, stressful circumstances)

- Which of the following do you believe is/are **effective** treatment(s) for mental health problems? (select all that apply)
 - Counseling
 - Holistic methods (yoga, meditation, essential oils, nature, exercise, etc.)
 - Prescription medication
 - Talk with family member or friend
 - Other

- Please indicate how you feel about the use of medication for mental health treatment (5-point Likert scale from strongly disagree to strongly agree)
 - Medication helps with mental health symptoms
 - Medications for mental health treatment have negative side effects
 - Medications for mental health treatment are overprescribed
 - Other mental health treatments should be tried before medication

The Control Preferences Scale (Degner et al. 1997)

Please choose which statement best describes **your preferences** regarding decision making with your provider about mental health treatment:

- I prefer to make the decision about which treatment I will receive
- I prefer to make the final decision about my treatment after seriously considering my provider's opinion
- I prefer that my provider and I share responsibility for deciding which treatment is best for me
- I prefer that my provider makes the final decision about which treatment will be used, but seriously considers my opinion
- I prefer to leave all decisions regarding treatment to my provider

Decision Self-Efficacy Scale (O'Connor 1995)

Please imagine that you are speaking with your provider about the option of using medication for a mental health problem. Please rate how confident you feel in doing these things by selecting the number from **0 (NOT at all confident) to 4 (VERY confident)** for each item listed:

I feel **confident** that I can:

- Get the facts about the medication choices available to me
 - Get the facts about the benefits of each choice
 - Get the facts about the risks and side effects of each choice
 - Understand the information enough to be able to make a choice
 - Ask questions without feeling dumb
 - Express my concerns about each choice
 - Ask for advice
 - Figure out the choice that best suits me
 - Handle unwanted pressure from others in making my choice
 - Let the clinic team and/or my provider know what is best for me
 - Delay my decision if I feel I need more time
- Which of the following best describes your GENDER IDENTITY?
- Male
 - Female
 - Transgender male
 - Transgender female
 - Gender variant/non-conforming
 - Other
 - Prefer not to answer

- Are you Hispanic or Latino? (that is, a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
 - o Yes
 - o No
 - o Prefer not to answer

- The answer above is about ETHNICITY, not RACE. No matter what you selected above, please continue to answer the following question to indicate what you consider your RACE to be.

How would you describe yourself? (Choose one or more from the following racial groups.)

- o American or Alaska Native (a person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment)
- o Asian (a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)
- o Black or African American (a person having origins in any of the Black racial groups of Africa, including Caribbean Islanders and others of African origin)
- o Native Hawaiian or Other Pacific Islander (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)
- o White (a person having origins in any of the original peoples of Europe, the Middle East, or North Africa)

REFERENCES

- American Psychological Association. 2012. "Inappropriate Prescribing."
<https://www.apa.org>. Retrieved November 28, 2020
(<https://www.apa.org/monitor/2012/06/prescribing>).
- Abid, Hafsa., Syed Usman Hamdani, Fakhira Shafique, and Muhammad Aadil. 2018
"Parental Psychosocial Attitudes and Opinions on the use of Psychotropic
Medication in Mental Disorders of Childhood." *Pak Armed Forces Med J* 68 (1):
131-36.
- Adams, Wallis E., Irina L. G. Todorova, Mariana T. Guzzardo, and Luis M. Falcón.
2015. "'The Problem Here Is That They Want to Solve Everything with Pills':
Medication Use and Identity among Mainland Puerto Ricans." *Sociology of
Health & Illness* 37(6):904–19.
- Alcalá, Héctor Ernesto, Masako Horino, and Jorge Delva. 2019. "Psychotropic
Medication Use in Children: What Role Does Child Adversity Play?" *Social
Work Research* 43(2):81–90.
- Ashton, Heather. 1994. "Guidelines for the Rational Use of
Benzodiazepines." *Drugs* 48: 25–40.
- Barnett, Erin R., Milangel T. Concepcion-Zayas, Yaara Zisman-Ilani, and Christopher
Bellonci. 2019. "Patient-Centered Psychiatric Care for Youth in Foster Care: A
Systematic and Critical Review." *Journal of Public Child Welfare* 13(4):462–89.
- Bunn, Helen, and Annette O'Connor. 1996. "Validation of Client Decision-Making
Instruments in the Context of Psychiatry *Canadian Journal of Nursing Research*."
28(3): 13-27.

- Byerly, Matthew J., Nakonezny, Paul. A, and Emmeline Lescouflair. 2007. "Antipsychotic Medication Adherence in Schizophrenia." *Psychiatric Clinics of North America*, 30(3): 437–452.
- Clever, Sarah L., Daniel E. Ford, Lisa V. Rubenstein, Kathryn M. Rost, Lisa S. Meredith, Cathy D. Sherbourne, Nae-Yuh Wang, Jose J. Arbelaez, and Lisa A. Cooper. 2006. "Primary Care Patients' Involvement in Decision-Making Is Associated with Improvement in Depression." *Medical Care* 44(5):398–405.
- Conrad, Peter. (1992). "Medicalization and Social Control." *Annual review of Sociology* 18(1): 209-232.
- Conrad, Peter., and Kristin K. Barker. 2010. "The Social Construction of Illness: Key Insights and Policy Implications." *Journal of Health and Social Behavior* 51(1_suppl):S67–79.
- Conrad, Peter, and Caitlin Slodden. 2013. "The Medicalization of Mental Disorder." Pp. 61–73 in *Handbook of the Sociology of Mental Health*, edited by Carol S. Aneshensel, Jo C. Phelan, and Alex Bierman. Dordrecht: Springer Netherlands.
- Degner, Lesley F., Jeff A. Sloan, and Peri Venkatesh. 1997. "The Control Preferences Scale." *Canadian Journal of Nursing Research* 29(3): 21-43.
- De las Cuevas, Carlos., and Wenceslao Penate. 2016. "Validity of the Control Preferences Scale in Patients with Emotional Disorders." 10: 2351-2356.

- DosReis, Susan, Arlene Butz, Paul H. Lipkin, Julia S. Anixt, Courtney L. Weiner, and Robin Chernoff. 2006. "Attitudes About Stimulant Medication for Attention-Deficit/Hyperactivity Disorder Among African American Families in an Inner-City Community." *The Journal of Behavioral Health Services & Research* 33(4):423–30.
- Drake, Robert E., Patricia E. Deegan, and Charles Rapp. 2010. "The Promise of Shared Decision Making in Mental Health." *Psychiatric Rehabilitation Journal* 34(1):7–13.
- Economou, Marina, Joanna Despina Bergiannaki, Lily Evangelia Peppou, Ismini Karayanni, George Skalkotos, Athanasios Patelakis, Kyriakos Souliotis, and Costas Stefanis. 2016. "Attitudes towards Depression, Psychiatric Medication and Help-Seeking Intentions amid Financial Crisis: Findings from Athens Area." *International Journal of Social Psychiatry* 62(3):243–51.
- Emanuel, Ezekiel J., and Linda L. Emanuel. 1992. "Four Models of the Physician-Patient Relationship." *JAMA* 267(16): 2221-2226.
- Everett, Barbara. 1994. "Something is happening: the contemporary consumer and psychiatric survivor movement in historical context." *The Journal of Mind and Behavior*, 15 (1/2), 55-70.
- Farinde, Abimbola. 2014. "An Examination of Co-Occurring Conditions and Management of Psychotropic Medication Use in Soldiers with Traumatic Brain Injury." *Journal of Trauma Nursing*, 21(4): 153–157.

- Frances, Allen. 2013. *Saving Normal: an insider's revolt against out of control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life*. New York, NY: Harper Collins.
- Galik, E., & Resnick, B. 2013. "Psychotropic medication use and association with physical and psychosocial outcomes in nursing home residents." *Journal of Psychiatric and Mental Health Nursing*, 20(3): 244–252.
- Gupta, Swapnil., and Cahill John Daniel. 2016. "A Prescription for "Deprescribing" in Psychiatry." *Psychiatric Services* 67(8): 904–907.
- Hamann, Johannes., S. Leucht, and W. Kissling. 2003. "Shared Decision Making in Psychiatry: Shared Decision Making in Psychiatry." *Acta Psychiatrica Scandinavica* 107(6):403–9.
- Herselman, Stephne. 1996. "Some Problems in Health Communication in a Multicultural Clinical Setting: A South African Experience." *Health Communication* 8(2): 153-170.
- Kaparounaki, Chrysi K., Chrysoula A. Koraka, Eleni S. Kotsi, Anna-Maria P. Ntziovara, Gerasimos C. Kyriakidis, and Konstantinos N. Fountoulakis. 2019. "Greek University Student's Attitudes and Beliefs Concerning Mental Illness and Its Treatment." *International Journal of Social Psychiatry* 65(6):515–26.
- Kaplan, Sherrie H., Sheldon Greenfield, and John E. Ware. 1989. "Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease." *Medical Care* 27(3):S110–27.

- Katz, Shimon., Hadass Goldblatt, Ilanit Hasson-Ohayon, and David Roe. 2019. "Retrospective Accounts of the Process of Using and Discontinuing Psychiatric Medication." *Qualitative Health Research* 29(2):198–210.
- Kuppin, Sara, and Richard M. Carpiano. 2006. "Public Conceptions of Serious Mental Illness and Substance Abuse, Their Causes and Treatments: Findings from the 1996 General Social Survey." *American Journal of Public Health* 96(10):1766–71.
- Lim, Janice. 2016. "Civil Commitment in the 21st Century." *University of San Francisco Law Review* 50(1): 143-163.
- Martin, Jack., Bernice Pescosolido. 2005. *Public Views of Psychiatric Medications in Light of Health and Health Care*. Bloomington, IN: Indiana Consortium for Mental Health Services. <https://icmhsr.sitehost.iu.edu/docs/ICMHSR%20Report%20on%20Public%20Views%20of%20Psych%20Meds.pdf>
- May, Carl. 2007. "The Clinical Encounter and the Problem of Context." *Sociology* 41(1):29–45.
- Mead, Nicola., and Peter Bower. 2002. "Patient-Centred Consultations and Outcomes in Primary Care: A Review of the Literature." *Patient Education and Counseling* 48(1):51–61.
- McLeod, Jane D., Bernice A. Pescosolido, David T. Takeuchi, and Terry Falkenberg White. 2004. "Public Attitudes toward the Use of Psychiatric Medications for Children." *Journal of Health and Social Behavior* 45(1):53–67.

- Morant, Nicola., Kiran Azam., Sonia Johnson., and Joanna Moncrieff. 2018. "The Least Worst Option: User Experiences of Antipsychotic Medication and Lack of Involvement in Medication Decisions in a UK Community Sample." *Journal of Mental Health* 27(4):322–28.
- Morant, Nicola., Emma, Kaminskiy., & Ramon, Shulamit. 2015. "Shared decision making for psychiatric medication management: beyond the micro-social." *Health Expectations*, 19(5): 1002–1014.
- Mulvaney-Day N, Marshall T, Downey Piscopo K, Korsen N, Lynch S, Karnell LH, Moran GE, Daniels AS, Ghose SS. Screening for Behavioral Health Conditions in Primary Care Settings: A Systematic Review of the Literature. *J Gen Intern Med*. 2018 Mar;33(3):335-346.
- Naik, Aanand D., Michael A. Kallen, Annette Walder, and Richard L. Street. 2008. "Improving Hypertension Control in Diabetes Mellitus: The Effects of Collaborative and Proactive Health Communication." *Circulation* 117(11):1361–68.
- Negarandeh, Reza., Zahra Yazdani., Rebecca Lehto., and Marzieh Lashkari. 2020. "The Effect of Using the Question Prompt List on Shared Decision Making, Self-Efficacy in Decision Making, and Preferences for Participation Among Women with Breast Cancer: A Study Protocol." *Int J Cancer Manag*. 13(8): e103873.
- Norvoll, Reidun, and Reidar Pedersen. 2016. "Exploring the Views of People with Mental Health Problems' on the Concept of Coercion: Towards a Broader Socio-Ethical Perspective." *Social Science & Medicine* 156:204–11.

- O'Connor AM. User Manual – Decision Self-Efficacy Scale [document on the Internet].
Ottawa: Ottawa Hospital Research Institute; © 1995 [modified 2002]. 4 p.
Available from
http://decisionaid.ohri.ca/docs/develop/User_Manuals/UM_Decision_SelfEfficacy.pdf
- O'Neal, Erica L., Jared R. Adams, Gregory J. McHugo, Aricca D. Van Citters, Robert E. Drake, and Stephen J. Bartels. 2008. "Preferences of Older and Younger Adults With Serious Mental Illness for Involvement in Decision-Making in Medical and Psychiatric Settings." *The American Journal of Geriatric Psychiatry* 16(10):826–33.
- Ostrow, Laysha., Lauren Jessell., Manton Hurd., Sabrina M. Darrow., and David Cohen. 2017. "Discontinuing Psychiatric Medications: A Survey of Long-Term Users." *Psychiatric Services* 68(12):1232–38.
- Park, Keunhye., Nathanael J. Okpych, and Mark E. Courtney. 2019. "Psychotropic Medication Use and Perceptions of Medication Effects Among Transition-Age Foster Youth." *Child and Adolescent Social Work Journal* 36(6):583–97.
- Perry, B. I., S. E. Cooray, J. Mendis, K. Purandare, A. Wijeratne, S. Manjubhashini, M. Dasari, F. Esan, I. Gunaratna, R. A. Naseem, S. Hoare, V. Chester, A. Roy, J. Devapriam, R. Alexander, and H. F. Kwok. 2018. "Problem Behaviours and Psychotropic Medication Use in Intellectual Disability: A Multinational Cross-Sectional Survey: Problem Behaviours and Their Management in ID." *Journal of Intellectual Disability Research* 62(2):140–49.

- Pieterse, Alex L., Nathan R. Todd., Helen A. Neville., Robert T. Carter. 2012. "Perceived Racism and Mental Health Among Black American Adults: A Meta-Analytic Review." *Journal of Counseling Psychology* 59(1): 1-9.
- Prebble, Kate., Katey Thom., and Elizabeth Hudson. 2015. "Service Users' Experiences of Voluntary Admission to Mental Hospital: A Review of Research Literature." *Psychiatry, Psychology and Law* 22(3):327–36.
- Rhee, Taeho Greg, and Robert A. Rosenheck. 2019. "Initiation of New Psychotropic Prescriptions without a Psychiatric Diagnosis among US Adults: Rates, Correlates, and National Trends from 2006 to 2015." *Health Services Research* 54(1):139–48.
- Rissmiller, David J., and Joshua H. Rissmiller. 2006. "Evolution of the Antipsychiatry Movement Into Mental Health Consumerism." *PSYCHIATRIC SERVICES* 57(6):4.
- Schnittker, Jason. 2003. "Misgivings of Medicine?: African Americans' Skepticism of Psychiatric Medication." *Journal of Health and Social Behavior* 44(4):506–24.
- Schori, Dominik, Matthias Jaeger, Timon Elmer, Susanne Jaeger, Candelaria Mahlke, Kolja Heumann, Anastasia Theodoridou, Gianfranco Zuaboni, Bernd Kozel, and Franziska Rabenschlag. 2018. "Knowledge on Types of Treatment Pressure. A Cross-Sectional Study among Mental Health Professionals." *Archives of Psychiatric Nursing* 32(5):662–69.
- Smith, Dena T. 2014. "The Diminished Resistance to Medicalization in Psychiatry: Psychoanalysis Meets the Medical Model of Mental Illness." *Society and Mental Health* 4(2):75–91.

- Szmukler, George, and Paul S. Appelbaum. 2008. "Treatment Pressures, Leverage, Coercion, and Compulsion in Mental Health Care." *Journal of Mental Health* 17(3):233–44.
- Valenti, Emanuele., Ciara Banks., Alfredo Calcedo-Barba., Cécile M. Bensimon., Karin-Maria Hoffmann., Veikko Peltö-Piri., Tanja Jurin., Octavio Márquez Mendoza., Adrian P. Mundt., Jorun Rugkåsa., Jacopo Tubini., and Stefan Priebe. 2015. "Informal Coercion in Psychiatry: A Focus Group Study of Attitudes and Experiences of Mental Health Professionals in Ten Countries." *Social Psychiatry and Psychiatric Epidemiology* 50(8):1297–1308.
- Van Hulst, Rolf., Arnold B. Bakker., Aart C. Lodder., K. Bart Teeuw., Albert Bakker., and Hubert G. Leufkens. 2003. "The Impact of Attitudes and Beliefs on Length of Benzodiazepine Use: A Study among Inexperienced and Experienced Benzodiazepine Users." *Social Science & Medicine* 56(6):1345–54.
- Van Tosh, Laura., Ralph, Ruth O., and Campbell, Jean. 2000. "The Rise of Consumerism." *Psychiatric Rehabilitation Skills* 4:383-409.
- Varga, M. D. (2012). Adderall abuse on college campuses: a comprehensive literature review. *Journal of evidence-based social work*, 9(3), 293-313.
- Watt, Terling. Toni. 2017. "Paradigm Shifts Don't Come Easy: Confrontations Between the Trauma Perspective and the DSM in Mental Health Treatment for Abused and Neglected Children." *Journal of Child & Adolescent Trauma*." 10, 395-403.
- Whitaker, Robert. 2002. *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York, NY: Basic Books.

- Whitaker, Robert. 2004. "The case against antipsychotic drugs: A 50-year record of doing more harm than good." *Medical Hypotheses* 62(1): 5–13.
- Whitaker, Robert. 2010. *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Crown Publishers.
- Whooley, Owen. 2014. "Nosological reflections: The failure of DSM-5, the emergence of RDoC, and the decontextualization of mental distress." *Society and Mental Health*, 4(2): 92-110.