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Preferences for Participation in Decision Making Among Ethnically Diverse Patients with Anxiety and Depression

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Abstract

This study explored preferences for treatment decision making using the Control Preferences Scale and Problem Solving Decision Making Scale among a sample of ethnically diverse adults ($N = 60$) seeking treatment for anxiety and depression. Most participants expressed a desire for participation in shared decision making. Being Hispanic was significantly associated with a more passive role in decision making. Participants preferred more involvement in decision making versus problem solving tasks for both mental and general health vignettes, and more involvement in mental health versus general health decision-making. More research is needed to confirm tentative results on the influence of sociodemographic variables on preferences for role and participation in treatment decision making and the variation in these preferences. Treatment seeking individuals with anxiety and depression have identifiable preferences for participation in decision making. Asking about patient preferences and a better understanding of variability in preferences may improve patient-provider communication.

Keywords

Shared decision making; Ethnicity; Mental health; Preferences

Introduction

The last decade has seen a shift towards patient-centered approaches to health care delivery (Institute of Medicine 2005). One of the key attributes of patient-centered care is patient-physician communication (Roter and Hall 1993). Patient-physician communication has been associated with patients' perceptions of finding common ground with their physicians (Stewart et al. 2000) and improved health outcomes (Little et al. 2001; Kaplan et al. 1989). Recently, methods to enhance patient-physician communication including patient preferences for participation in treatment decision making have received increased interest (Ottawa Health Research Institute 2008; Deber 1994; Deber 1994; Strull et al. 1984; Vick and Scott 1998; Ende et al. 1989). One method, which advocates a more active, participatory role for patients and a tailored approach to patient education, is known as shared decision making. Shared decision making (SDM) takes place when patient and physician share information about treatment options, take steps in sharing a treatment decision and together arrive at a consensus

regarding the preferred treatment option (Charles et al. 1999). There is a growing body of literature that shows that shared decision-making interventions or tools such as decision aids increase patients' knowledge about their illness and reduce decisional conflict during the treatment decision-making process. Information and active participation has been shown to increase satisfaction, facilitates treatment adherence, and in some cases improves clinical outcome (O'Connor et al. 1999; Coulter 1997).

Research evaluating SDM for medical illness, utilizing a variety of methodological approaches, has shown that demographic variables influence preferences for participation including age and education level (Strull et al. 1984; Vick and Scott 1998; Ende et al. 1989; Degner and Sloan 1992; Blanchard et al. 1988), gender (Vick and Scott 1998; Levinson et al. 2005), health status and severity of health problem (Vick and Scott 1998; Ende et al. 1989; Degner and Sloan 1992). There is a need for research that explores the role of ethnicity in preferences for participation in decision making (Cooper 2006; Charles et al. 2006). Inadequate patient-physician communication has been proposed as a mechanism for health disparities particularly for Asians, African Americans and Hispanics (Smedley et al. 2002). Current research shows that Asians, African Americans and Hispanics are more likely than non-Hispanic whites to feel disenfranchised in the decision-making process, receive less health related information, and perceive a lack of respect for their preferences (Ngo-Metzger et al. 2006). This may be especially important in Hispanics, the largest ethnic group (Ramirez and de la Cruz 2002) comprising 13% of the US population, who frequently underutilize or discontinue treatment for mental health relative to non-Hispanic Whites (Lara et al. 2005; Vega et al. 1999; Grant et al. 2004; Barrio et al. 2003; Padgett et al. 1994; Greenberg and Rosenheck 2003).

Although there have not been a great number of SDM studies in mental health to date, patients are increasingly recognized as key decision makers in the mental healthcare treatment process (Wills and Holmes-Rovner 2006). SDM may be especially important for mental health treatment decision making given general public reliance on the Internet for treatment of mental health conditions which overall yields poor quality information (Griffiths and Christenson 2000; Lissman and Boehnlein 2001), treatment preferences (Dwight-Johnson et al. 2000), and stigma associated with seeking mental health services (Link et al. 2001; Rost et al. 1993; Cooper-Patrick et al. 1997). A recent review of SDM in individuals with schizophrenia and depression (Patel et al. 2008) concluded that although barriers to SDM exist in mental health decision making at the patient and physician-level, patients and physicians found SDM acceptable and engage in SDM which results in improvement in patients' knowledge about their illness, a higher level of perceived involvement in decision-making (Hamann et al. 2006), and in some cases improvement in self-management, rate of treatment dropout, and recovery (Hamann et al. 2006; Adams et al. 2007; Ludman et al. 2003; Clever et al. 2006; Loh et al. 2007). A recent study found that involvement in decision-making for depression was better than usual care for improving patient participation in treatment decision making and satisfaction with care without increasing consultation time (Loh et al. 2007).

In addition to an exploration of patient preferences for participation in treatment decision making, a close examination of the decision making process warrants further study. Degner et al. (1997) underscored the importance of characterizing the preferred role in decision making defined as, "degree of control an individual wants to assume when decisions are being made about medical treatment." Deber et al. (Vick and Scott 1998; Deber et al. 1996) argued that the decision making process consists of two dimension of choice, problem-solving and decision making. Problem-solving identifies the correct solution(s) to the problem and decision making involves choice between several alternatives. Studies that have found that patients wished to be more involved in decision making tasks as opposed to problem solving tasks (Vick and Scott 1998; Hamann et al. 2006). Understanding preferred role and level of involvement in

dimensions of decision making are important factors that might contribute to the potential for shared decision making and possibly improved clinical outcome.

The main purpose of this exploratory study was to determine preferred role and level of involvement in treatment decision making for mental health and general health in a culturally diverse group of people seeking outpatient treatment for anxiety and depression. The study addressed three research questions:

1. What role do patients prefer in mental health (MH) treatment decision making and what are the sociodemographic variables associated with preferred role in MH decision making?
2. What is the preferred level of patient involvement in MH treatment decision making and general health (GH) decision making and what are the sociodemographic variables associated with preferred level of involvement in MH and GH decision making?
3. Do patient preferences for involvement in decision making vary by type of health problem (mental health vs. general health) or type of task (problem solving vs. decision making)?

Methods

We explored preferences for decision-making in a convenience sample of 60 adults with anxiety or depressive disorders seeking treatment between January 1, 2007 and April 30, 2008 at an outpatient research clinic, the Anxiety Disorders Clinic (ADC) of the New York State Psychiatric Institute (NYSPI). The ADC has a specialty program, the Hispanic Treatment Program (HTP), which serves the Hispanic community in Washington Heights by offering culturally sensitive treatment by bicultural and bilingual staff. Participants presented for treatment at the ADC and if they self-identify as Hispanic they are then referred to the HTP for treatment. Participants who presented for treatment to the ADC and HTP were included in this sample. All participants met criteria for an anxiety or depressive disorder according to a clinical interview and confirmed by the Structured Clinical Interview for DSM-IV Disorders (First et al. 2002). The Institutional Review Board for the NYSPI approved this study and written informed consent was obtained.

Upon checking into the clinic for their appointment, a Master's- level research assistant explained the study and asked patients if they would be willing to participate in a study about preferences for making treatment decisions. With their consent, they were asked to fill out two self-report surveys (Control Preferences Scale (CPS) (Degner et al. 1997) and the Problem-Solving Decision Making Scale (PSDMS) (Deber et al. 1996)) in their preferred language (English or Spanish). Both surveys were forward and back translated into Spanish by the first author (SRP) and two bilingual (Spanish) members of the HTP. Within mental health, no instruments are available to measure decision making and these questionnaires are among the most widely used instruments for the assessment of decision making preferences in medical populations thereby allowing for results to be compared among studies. The CPS characterizes preferred role in decision making on the spectrum between paternalistic (passive role for patient) and being informed (active role for the patient) (Degner et al. 1997). The CPS consists of five cards that each portrays a different role in treatment decision-making using a statement and a cartoon. These roles range from: (1) I prefer to make the decision about which treatment I will receive (active role); (2) I prefer to make the final decision about my treatment after seriously considering my doctor's opinion, (3) I prefer that my doctor and I share the responsibility for deciding which treatment is best for me; (4) I prefer that my doctor make the final decision about which treatment will be used, but seriously considers my opinion; and (5) I prefer to leave all decisions regarding treatment to my doctor (passive role). Higher scores

on the CPS indicate preferences for passive role in decision-making. The CPS typically involves subjects in making a series of paired comparisons to provide their total preference order over the five cards. In this study, the CPS was adapted for use in a mental health setting and for ease of administration, the choice experiment approach (choose one) for assessing stated preferences (Janz et al. 2004; Louviere et al. 2000) was used. We used the choice experiment approach because it emulates realistic tasks that people perform everyday, the task of choosing one item among several options and this method has been widely used in various areas including health research, marketing, and public welfare analysis (Louviere et al. 2000; Ryan and Gerard 2003; Ryan 1999). Participants were presented with the following statement, “When deciding on what treatment is best for your emotional/mental health problems, what is your preferred role in treatment decision- making?” Participants were asked to read the 5 different roles and pick one role that fell closest to their preferred role. The CPS has proven to be an easily administered, valid, and reliable measure of preferred roles in health-care decision-making in a variety of populations (Chapple et al. 2003; Neufeld et al. 1993) however it has also been criticized as misleading for classifying patients as “active” or “passive” with regard to healthcare decision making since patients have different desires for different dimensions of the decision making process (Flynn et al. 2006).

The PSDMS (Deber et al. 1996) examines two aspects of choice behavior: problem solving (PSDMS-PS) and decision-making (PSDMS-DM). Problem solving tasks can be conceptualized as the information exchange part of the DM process. PS tasks are defined as those that require factual knowledge: diagnosis, treatment options, risks and benefits, and determining probability of risks and benefits. DM tasks are defined as those that incorporate both factual knowledge and individual preferences: acceptability of risks and benefits and selection of treatment option (Deber et al. 1996). The PSDMS was adapted for this study to include two clinical (MH: Mental and GH: General Health) vignettes: (1) “Suppose you are experiencing emotional difficulties like anxiety or depressed mood and have decided that you should visit your doctor about this”; (2) “Suppose you had mild chest pain for 3 days and decided that you should visit your doctor about this.” For each vignette, participants were asked to indicate for a set of four PS tasks and two DM tasks, “Who should determine/decide...” using a 5 point scale: (1) Doctor alone; (2) Mostly the doctor; (3) Both equally; (4) Mostly me; and (5) Me alone. Higher scores on the PSDMS indicate preferences for active roles in the decision-making process. Reliabilities of the PSDMS are very good to excellent: full scale— $\alpha = .71-.90$, PS— $\alpha = .79-.90$, and DM—.67-.93 (Kraetschmer 1994).

Statistical analyses included descriptive frequencies, means and standard deviations for sociodemographic characteristics (including age, gender, ethnicity, and education) and survey items. We examined relationships between sociodemographics and overall CPS score, overall PSDMS-MH, overall PSDMS-GH scores using Pearson correlations and *t*-tests. Paired samples *t*-tests were explored within vignette differences in decision making (e.g. problem solving versus decision making) and between vignette differences in decision making (e.g. mental and general health vignettes). Associations between the CPS and PSDMS scores on mental health decision making were tested using Pearson correlations.

Results

All participants who were approached to participate in this study agreed and completed surveys. Fifty-eight percent of the participants completed the surveys in Spanish; the remainder completed the survey in English. The sample ($n = 60$) was 50% female with a mean age of 42 years and an average of 13 years of education. The sample self-identified as Hispanic (58%), followed by non-Hispanic White (29%), Asian (8%), and African American (5%). Given the distribution of the sample, ethnicity was defined as Hispanic versus non-Hispanic (including non-Hispanic White, Asian, and African American) a method used by the US census and the

National Institutes of Health (U.S. Bureau of the Census, Population Division, Special Population Staff 2007; NIH Policy on reporting race and ethnicity data: Subjects in clinical research. Retrieved Feb 11 2010). Ninety-five percent of the participants in this sample had already made a decision about their mental health treatment. Table 1 presents the CPS frequency data and mean scores on the PSDMS for the overall sample.

Control Preferences Scale

According to the CPS, 98% of the overall sample preferred to participate in some level of shared decision-making (semi-passive to semi-active) during the mental health treatment decision-making process. *T*-tests revealed a statistically significant relationship between ethnic groups and scores on the CPS, $t(58) = -2.88, P < .05$, that is being Hispanic was associated with higher scores on the CPS, preference for a more passive role in decision making. No other demographic variables were significantly associated with preferred role in decision making for mental health.

Problem Solving Decision Making Scale

Mean scores on the PSDMS revealed that a majority of participants in the overall sample preferred between, 'mostly the doctor,' and, 'doctor and you equally,' for problem solving and decision making tasks of each clinical vignette with some variation between vignettes. Analyses of demographic data and PSDMS scores reveal that being female was associated with preference for more involvement in mental health decision making compared to males, $t(58) = 2.00, P < .05$. No other demographic variables were significantly associated with the PSDMS scores.

Paired sample *t*-tests for within vignette differences revealed that for both mental health, $t(59) = -4.90, P < .001$; and general health vignettes, $t(59) = -6.50, P < .001$; participants preferred more involvement in decision-making tasks as compared to problem solving tasks. In addition, paired samples *t*-tests for between vignette differences revealed preference for more involvement in mental health decision making compared to general health decision making $t(59) = 5.14, P < .001$.

CPS and PSDMS

Scores on the CPS were significantly associated with scores on the PSDMS MH vignette $r = -0.35, P < .05$ and the DM task question for the mental health vignette (e.g. Given all the information about risks and benefits of the possible treatments, who should decide which treatment option should be selected?) $r = -0.34, P < .05$.

Discussion

This study revealed that people seeking outpatient treatment for anxiety and/or depression have identifiable preferences regarding participation and role in treatment decision making for mental health problems. Most participants indicated a preference for participation in mental health decision making that is amenable to shared decision making interventions. Consistent with previous studies, participants preferred more involvement in decision making versus problem solving tasks (Deber et al. 1996) and mental health decision making versus general health decision-making (Adams et al. 2007). It is possible that participants preferences were influenced because they were being treated for mental health problems and they all had made a recent decision about mental health treatment. We also found that females preferred more involvement in decision making (Levinson et al. 2005) particularly for mental health problems; however because this was an exploratory study we conducted a large number of significance tests and the gender difference found at the $P < .05$ is not significant based on a Bonferroni correction to keep the family wise error rate below .01.

Differences between Hispanics' and non-Hispanics' preferred role in decision making emerged in our sample. Hispanics preferred a more passive role in mental health decision making while non-Hispanics in this sample preferred more active roles. A recent population based study of public preferences for participation in decision making among English speaking adults also found that Hispanics were more likely than non-Hispanic Whites to prefer leaving decisions about medical care up to their doctors (Levinson et al. 2005). Several patient-level reasons are hypothesized for these findings. First, Hispanic patients' health worldview including health belief model or attribution of symptoms, expectations for the visit, acceptability of treatments, treatment preferences, and involvement of family or social network may vary and influence their preferences for participation in decision making (Cabassa et al. 2007; Cooper et al. 2003; Dwight-Johnson et al. 2004). Second, participants' preferences for passivity may be the result of a perceived lack of knowledge (Dwight-Johnson et al. 2006), low health literacy, lack of self-efficacy or a learned response influenced by cultural attitudes (Alegria et al. 2008). In the only intervention targeting patient-physician communication in Hispanics retrieved in our review of the literature, the Right-Question Project-Mental Health, Alegria and colleagues (Cortes et al. 2008) found that patient self-reported activation, attendance to scheduled visits and retention in treatment improved for Hispanics seeking treatment in community mental health clinics. Qualitative findings on the process of activation/empowerment suggest that cultural (i.e. concerns about hurting physician's feelings or offending by asking questions considering their views as of physicians as figures of authority) and contextual (i.e. degree of familiarity with the US health care system and the potential to be perceived as intimidating) factors can influence the experience for Hispanics regarding participation in health care interactions (Alegria et al. 2008). Third, stigma towards mental health treatment may exist in Hispanic cultures (Interian et al. 2007). It is important to also recognize that physician-level reasons may contribute to variation in preferences for participation and role in decision making. Physician gender and ethnicity, beliefs about patient expectations, interpretations of symptoms, and engagement in decision making, and bias towards different racial/ethnic groups may influence patient preferences (Cooper-Patrick et al. 1999; Jahng et al. 2005; Roter et al. 2002; Robinson and Thomson 2001).

Charles and colleagues (2006) challenge the assumptions of a "one size fits all contexts" model of shared decision making and the assumption of a common meaning and application across different cultural groups. Findings from this study underscore the need for further research to explore the influence of culture in mental healthcare decision making and other important variables, such as knowledge and stigma. Attitudes and experiences of some cultures may represent facilitators or barriers to participation in decision-making, and research needs to determine whether this is the case. The incorporation of such data into the development of decision aids is important so that a balance can be struck between assisting diverse groups to play an active role in the treatment decision-making process, without disregarding genuine preferences for participation.

Several study limitations must be acknowledged. First, the generalizability of the findings is limited to a small convenience sample in an outpatient specialty research clinic for people whose decision about treatment had already been made. It is likely that individuals who have not made a decision or are not yet in the position to make a decision about treatment may have different preferences. Additionally, receiving treatment in a specialty treatment program for Hispanics may have influenced decision making preferences in this sample and these may vary if this sample was seen in a different setting that caters to White non-Hispanic individuals or African Americans. Second, we examined preferences using an adapted chronic mental health vignette versus an acute general health vignette for which the decision-making preferences are likely to vary. Third, we limited our analysis to Hispanics versus non-Hispanics and cannot make generalizations regarding other groups (i.e. non-Hispanic whites, Asians and African Americans) and did not include measures of acculturation. Lastly, although both measures

were significantly correlated and provided some evidence of reliability, we are limited by quantitative measurement of preferences. Future research will need to assess a larger more representative sample to examine whether the findings of this study extend to other minority groups in diverse mental health settings using several health vignettes and qualitative or market research methods (Ryan and Farrar 2000; Kennelly and Bowling 2001) to allow for comparisons of preference patterns. In addition, it will be important to capture individuals at different stages of their help seeking to better understand how these preferences vary and determine appropriate timing for a shared decision making intervention.

To our knowledge this is the first quantitative study of preferences for role and participation in treatment decision among adults seeking treatment for anxiety and depression in an outpatient clinic setting. The results bring to light the variation in preferences for participation and role in decision making that exist: the variation in preferred role in treatment decision making among ethnically diverse populations; and in preferences for involvement in decision making by gender, tasks involved in decision making process, and clinical vignette. If physicians ask their patients about their preferences for decision making during the consultation it may improve communication, congruence and expectations between patient and physician.

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References

- Adams JR, Drake RE, Wolford GL. Shared decision-making preferences of people with severe mental illness. *Psychiatric Services* 2007;58:1219–1221. [PubMed: 17766569]
- Alegria M, Polo A, Gao S, Santana L, Rothstein D, Jiménez A, et al. Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care* 2008;46(3):247–256. [PubMed: 18388839]
- Barrio C, Yamada AM, Hough R, Hawthorne W, Garcia P, Jeste DV. Ethnic disparities in utilization of public mental health care management services among clients with schizophrenia. *Psychiatric Services* 2003;54:1264–1270. [PubMed: 12954944]
- Blanchard C, Labrecque MS, Ruckdeschel JC, Blanchard EB. Information and decision-making preferences of hospitalized adult cancer patients. *Social Science and Medicine* 1988;27:1139–1145. [PubMed: 3206248]
- Cabassa LJ, Lester R, Zayas LH. “It’s like being in a labyrinth.” Hispanic immigrants’ perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health* 2007;9:1–16. [PubMed: 17001516]
- Chapple H, Shah S, Caress A, Kay EJ. Exploring dental patients’ preferred roles in treatment decision-making. *British Dental Journal* 2003;194:321–327. [PubMed: 12682659]
- Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: Revisiting the shared treatment decision-making model. *Social Science and Medicine* 1999;49(5):651–661. [PubMed: 10452420]
- Charles CA, Gafni A, Whelan T, O’Brien MA. Cultural influences on the physician-patient encounter: The case of shared treatment decision-making. *Patient Education & Counseling* 2006;63:262–267. [PubMed: 17000073]
- Clever SL, Ford DE, Rubenstein LV, Rost KM, Meredith LS, Sherbourne CD, et al. Primary care patients’ involvement in decision-making is associated with improvement in depression. *Medical Care* 2006;44:398–403. [PubMed: 16641657]
- Cooper LA. Commentary: At the center of decision making in mental health services and interventions research: Patients, clinicians, or relationships? *Clinical Psychology Science and Practice* 2006;13(1): 26–29.

- Cooper LA, Gonzales JJ, Gallo JJ, Rost KM, Meredith LS, Rubenstein LV, et al. The acceptability of treatment for depression among African-American, hispanic, and white primary care patients. *Medical Care* 2003;41(4):479–489. [PubMed: 12665712]
- Cooper-Patrick L, Powe NR, Jenckes MW, Gonzales JJ, Levine DM, Ford DE. Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine* 1997;12:431–438. [PubMed: 9229282]
- Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, et al. Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association* 1999;282:583–589. [PubMed: 10450723]
- Cortes DE, Mulvaney-Day N, Fortuna L, Reinfeld S, Alegría M. Patient-provider communication: Understanding the role of patients activation for Latinos in mental health treatment. *Health Education and Behavior* 2008;36(1):138–154. [PubMed: 18413668]
- Coulter A. Partnerships with patients: The pros and cons of shared clinical decision-making. *Journal of Health Services Research & Policy* 1997;2:112–121. [PubMed: 10180362]
- Deber R. Physicians in health care management. 8. The patient-physician partnership: Decision-making, problem solving and the desire to participate. *Canadian Medical Association Journal* 1994a;151:423–427. [PubMed: 8055402]
- Deber R. The patient-physician partnership: 7. Changing roles, and the desire for information. *Canadian Medical Association Journal* 1994b;151:171–176. [PubMed: 8039062]
- Deber RB, Kraetschmer N, Irvine J. What role do patients wish to play in treatment decision-making? *Archives of Internal Medicine* 1996;156:1414–1420. [PubMed: 8678709]
- Degner LF, Sloan JA. Decision making during serious illness: What role do patients really want to play? *Journal of Clinical Epidemiology* 1992;45:941–950. [PubMed: 1432023]
- Degner LF, Sloan JA, Venkatesh P. The control preferences scale. *Canadian Journal of Nursing Research* 1997;29:21–43. [PubMed: 9505581]
- Dwight-Johnson M, Sherbourne CD, Liao D, Wells K. Treatment preferences among depressed primary care patients. *Journal of General Internal Medicine* 2000;15:527–534. [PubMed: 10940143]
- Dwight-Johnson M, Lagomasino IT, Aisenberg E, Hay J. Using conjoint analysis to assess depression treatment preferences among low-income Latinos. *Psychiatric Services* 2004;55:934–936. [PubMed: 15292545]
- Dwight-Johnson M, Meredith LS, Hickey SC, Wells KB. Influence of patient preference and primary care clinician proclivity for watchful waiting on receipt of depression treatment. *General Hospital Psychiatry* 2006;28:379–386. [PubMed: 16950372]
- Ende J, Kazis L, Ash A, Moskowitz MA. Measuring patients' desire for autonomy: Decision-making and information seeking preferences among medical patients. *Journal of General Internal Medicine* 1989;4:23–30. [PubMed: 2644407]
- First, MB.; Spitzer, RL.; Gibbon, M.; Williams, JBW. Structured clinical interview for DSM-IV-TR axis I disorders research version, patient edition (SCID-I/P). New York: Biometrics Research, New York State Psychiatric Institute; 2002.
- Flynn KE, Smith MA, Vanness D. A typology of preferences for participation in healthcare decision-making. *Social Science and Medicine* 2006;63(5):1158–1169. [PubMed: 16697096]
- Grant BF, Stinson FS, Hasin DS, Dawson DA, Chou SP, Anderson K. Immigration and lifetime prevalence of DSM-IV psychiatric disorders among Mexican Americans and non-hispanic whites in the United States: Results from the national epidemiologic survey on alcohol and related conditions. *Archives of General Psychiatry* 2004;61:1226–1233. [PubMed: 15583114]
- Greenberg GA, Rosenheck RA. Change in mental health service delivery among blacks, whites, and hispanics in the department of veterans affairs. *Administration and Policy In Mental Health* 2003;31:31–43. [PubMed: 14650647]
- Griffiths KM, Christenson H. Quality of web based information on treatment of depression: Cross sectional survey. *British Medical Journal* 2000;321:1511–1515. [PubMed: 11118181]
- Hamann J, Langer B, Winkler V, Busch R, Cohen R, Leucht S, et al. Shared decision-making for in-patients with schizophrenia. *Acta Psychiatrica Scandinavica* 2006;11(4):265–273. [PubMed: 16968364]

- Institute of Medicine. Improving the quality of health care for mental and substance use conditions: Quality chasm series. Washington, DC: National Academies Press; 2005.
- Interian A, Martínez IE, Guarnaccia PJ, Vega WA, Escobar JI. A qualitative analysis of the perception of stigma among Latinos receiving antidepressants. *Psychiatric Services* 2007;58:1591–1594. [PubMed: 18048562]
- Jahng KH, Martin LR, Golin CE, Di Matteo R. Preferences for medical collaboration: Patient-physician congruence and patient outcomes. *Patient Education & Counseling* 2005;57:308–314. [PubMed: 15893213]
- Janz NK, Wren PA, Copeland LA, Lowery JC, Goldfarb SL, Wilkins EG. Patient-physician concordance: Preferences, perceptions, and factors influencing the breast cancer surgical decision. *Journal of Clinical Oncology* 2004;22:3091–3098. [PubMed: 15284259]
- Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care* 1989;27:S110–S127. [PubMed: 2646486]
- Kennelly C, Bowling A. Suffering in deference: A focus group study of older cardiac patients' preferences for treatment and perceptions of risk. *Quality in Health Care* 2001;10 Supplement 1:i23–i28. [PubMed: 11533434]
- Kraetschmer, N. Thesis, Graduate Department of Community Health. Toronto, Ontario: University of Toronto; 1994. Preferences of patients undergoing angiogram for participation in treatment decisions: Coping style and problem solving decision-making scale.
- Lara M, Gamboa C, Kahramanian MI, Morales LS, Bautista DE. Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context. *Annual Review of Public Health* 2005;26:367–397.
- Levinson W, Kao A, Kuby A, Thisted RA. Not all patients want to participate in decision making. *Journal of General Internal Medicine* 2005;20:531–535. [PubMed: 15987329]
- Link B, Struening E, Neese-Todd S, Asmussen S, Phelan J. The consequences of stigma for the self-esteem of people with mental illness. *Psychiatric Services* 2001;52(12):1621–1626. [PubMed: 11726753]
- Lissman T, Boehnlein J. A critical review of internet information about depression. *Psychiatric Services* 2001;52(8):1046–1050. [PubMed: 11474049]
- Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. Observational study of effect of patient centeredness and positive approach on outcomes of general practice consultations. *British Medical Journal* 2001;323:908–911. [PubMed: 11668137]
- Loh A, Simon D, Wills CE, Kriston L, Niebling W, Härter M. The effects of a shared decision-making intervention in primary care of depression: A cluster-randomized controlled trial. *Patient Education & Counseling* 2007;67:324–332. [PubMed: 17509808]
- Louviere, JJ.; Hensher, DA.; Swait, JD. Stated choice methods: analysis and application. Cambridge: Cambridge University Press; 2000.
- Ludman E, Katon W, Bush C, Rutter C, Lin E, Simon G, et al. Behavioural factors associated with symptom outcomes in primary care-based depression prevention intervention trial. *Psychological Medicine* 2003;33:1061–1070. [PubMed: 12946090]
- Neufeld KR, Degner LF, Dick JAM. A nursing intervention study to foster patient involvement in treatment decisions. *Oncology Nursing Forum* 1993;20:631–635. [PubMed: 8321704]
- Ngo-Metzger Q, Telfair J, Sorkin DH, et al. Cultural competency and quality of care: Obtaining the patient's perspective. The Commonwealth Fund. 2006
- NIH Policy on reporting race and ethnicity data: Subjects in clinical research. [Retrieved Feb 11, 2010]. from <http://grants.nih.gov/grants/guide/notice-files/NOT-OD-01-053.html>
- O'Connor A, Rostom A, Fiset V, Tetroe J, Entwistle V, Llewellyn-Thomas H, et al. Decision aids for patients facing health treatment or screening decisions: Systematic review. *British Medical Journal* 1999;319:731–734. [PubMed: 10487995]
- Ottawa Health Research Institute. Patient decision aids. 2008 from <http://decisionaid.ohri.ca/index.html>.
- Padgett DK, Patrick C, Burns BJ, Schlesinger HJ. Ethnicity and the use of outpatient mental health services in a national insured population. *American Journal of Public Health* 1994;84:222–226. [PubMed: 8296944]

- Patel SR, Bakken S, Ruland CM. Recent advances in shared decision making for mental health. *Current Opinion in Psychiatry* 2008;21:606–612. [PubMed: 18852569]
- Ramirez, RR.; de la Cruz, GP. *Current Population Reports, P20-545*. Washington, DC: US Census Bureau; 2002. The hispanic population in the United States: March 2002.
- Robinson A, Thomson R. Variability in patient preferences for participating in medical decision-making: Implication for the use of decision support tools. *Quality in Health Care* 2001;10(Supplement 1):i34–i38. [PubMed: 11533436]
- Rost K, Smith GR, Taylor JL. Rural-urban differences in stigma and the use of care for depressive disorders. *Journal of Rural Health* 1993;9(1):57–62. [PubMed: 10124199]
- Roter, DL.; Hall, JA. *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits*. Westport, CT: Auburn House; 1993. p. 21-38.
- Roter DL, Hall JA, Aoki Y. Physician gender effects in medical communication: A meta-analytic review. *Journal of the American Medical Association* 2002;288:756–764. [PubMed: 12169083]
- Ryan M. Using conjoint analysis to take account of patient preferences and go beyond health outcomes: An application to in vitro fertilisation. *Social Science and Medicine* 1999;48:535–546. [PubMed: 10075178]
- Ryan M, Farrar S. Using conjoint analysis to elicit preferences for health care. *British Medical Journal* 2000;320:530–533. [PubMed: 10688542]
- Ryan M, Gerard K. Using choice experiment to value health care programmes: Current practice and future prospects. *Applied Health Economics Policy Annals* 2003;2:55–64.
- Smedley, BD.; Stith, AY.; Nelson, AR. *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press; 2002.
- Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. *Journal of Family Practice* 2000;49:796–804. [PubMed: 11032203]
- Strull W, Bernard L, Charles G. Do patients want to participate in medical decision-making? *Journal of the American Medical Association* 1984;252:2990–2994. [PubMed: 6502860]
- U.S. Bureau of the Census, Population Division, Special Population Staff. Racial and ethnic classifications used in the census in 2000 and beyond. 2007 [Retrieved Feb 21, 2007]. from www.census.gov/population/www/socdemo/race/racefactcb.html
- Vega WA, Kolody B, Aguilar-Gaxiola S, Catalano R. Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry* 1999;156:928–934. [PubMed: 10360134]
- Vick S, Scott A. Agency in health care. Examining patients' preferences for attributes of the doctor-patient relationship. *Journal of Health Economics* 1998;17:587–605. [PubMed: 10185513]
- Wills CE, Holmes-Rovner M. Integrating decision-making and mental health interventions research: Research directions. *Clinical Psychology-Science and Practice* 2006;13:9–25. [PubMed: 16724158]

Table 1Control Preferences Scale and Problem Solving Decision Making Scale results ($N = 60$)

Scale	Overall $N = 60$
<i>Control Preferences Scale</i>	N (%)
Preferred role	
Active	–
Semi-active	15 (25%)
Collaborative	32 (53%)
Semi-passive	12 (20%)
Passive	1 (2%)
<i>Problem Solving Decision Making Scale</i>	M (SD)
Mental health vignette	2.4 (0.6)
Problem solving tasks:	2.2 (0.7)
Diagnosis	2.2 (0.9)
Treatment options	2.3 (0.8)
Risks/benefits	2.1 (1.0)
Probabilities	2.1 (1.1)
Decision making tasks:	2.9 (1.1)
Utilities	3.0 (1.2)
What is done	3.0 (1.1)
General health vignette	2.1 (0.7)
Problem solving tasks:	1.8 (0.7)
Diagnosis	1.8 (0.8)
Treatment options	1.8 (0.9)
Risks/benefits	1.8 (1.0)
Probabilities	1.8 (0.9)
Decision making tasks:	2.7 (1.1)
Utilities	2.8 (1.3)
What is done	2.7 (1.2)