



5-2024

Examining the Shared Decision-Making Preferences of Adult Black Men with Hypertension in the U.S. Mid-South Region: A Mixed Methods Approach

Samantha Faith Calhoun
University of Tennessee Health Science Center

Follow this and additional works at: <https://dc.uthsc.edu/dissertations>



Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Calhoun, Samantha Faith (0000-0002-2532-3135), "Examining the Shared Decision-Making Preferences of Adult Black Men with Hypertension in the U.S. Mid-South Region: A Mixed Methods Approach" (2024). *Theses and Dissertations (ETD)*. Paper 670. <http://dx.doi.org/10.21007/etd.cghs.2024.0654>.

This Dissertation is brought to you for free and open access by the College of Graduate Health Sciences at UTHSC Digital Commons. It has been accepted for inclusion in Theses and Dissertations (ETD) by an authorized administrator of UTHSC Digital Commons. For more information, please contact jwelch30@uthsc.edu.

Examining the Shared Decision-Making Preferences of Adult Black Men with Hypertension in the U.S. Mid-South Region: A Mixed Methods Approach

Abstract

Purpose. This study aimed to explore what factors are related to Black men's shared decision-making (SDM) preferences for selecting hypertension (HTN) treatment and management options with a healthcare clinician. **Methods.** Researchers employed an exploratory sequential mixed methods design to explore factors influencing Black adult men's preferences for involvement in SDM regarding HTN treatment. Qualitative interviews with N=16 Black men identified factors related to SDM involvement, while a quantitative phase with N=105 Black men examined factors that could predict the level of involvement in SDM for HTN treatment. **Results.** Trust and having a female clinician were a significant independent predictor of decision-making involvement among men in this study ($b = 9.09$; $t(102) = 3.07$; $p = .003$). Engaging in the SDM process with a female clinician increased the desired level of decision-making involvement for HTN treatment and management. **Conclusion.** Findings from this study suggest that clinician gender is a key factor that influences SDM involvement preferences. Future research should focus on targeted questions to delve deeper into the specific aspects of SDM in gender-discordant patient-clinician relationships.

Document Type

Dissertation

Degree Name

Doctor of Philosophy (PhD)

Program

Nursing Science

Research Advisor

Janeane N. Anderson, PhD

Keywords

African American men;Black men;High Blood Pressure;Hypertension;Mixed-Methods;Shared Decision-Making

Subject Categories

Medicine and Health Sciences

UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

DOCTORAL DISSERTATION

**Examining the Shared Decision-Making Preferences of
Adult Black Men with Hypertension in the U.S. Mid-South
Region: A Mixed Methods Approach**

Author:

Samantha Faith Calhoun 

Advisor:

Janeane N. Anderson, PhD 

*A Dissertation Presented for The Graduate Studies Council of
The University of Tennessee Health Science Center
in Partial Fulfillment of the Requirements for the Doctor of Philosophy degree from
The University of Tennessee*

in

*Nursing Science
College of Graduate Health Sciences*

April 2024

Copyright © 2024 by Samantha Faith Calhoun.
All rights reserved.

DEDICATION

I want to dedicate my dissertation to the loving memory of my late brother, Mr. Antonio D. Taylor. My only regret is that he could not be here to celebrate this milestone moment, for he was my biggest source of inspiration to push me over the finish line. If I could trade in seeing your smile one more day for this degree, I would do it without hesitation. I love you and miss you more than I can express. I'll forever cherish your memory. Your baby sister, "Sammy."

I also want to dedicate my research to the Black men who participated in this research study. Thank you for your honesty. I will cherish every conversation and getting a small glimpse into your life that will contribute to the change I hope to see in medical encounters involving Black men.

ACKNOWLEDGMENTS

I would first like to acknowledge the support of my hardworking research advisor and committee members. Each of you mentored and encouraged me throughout this journey. First, to Dr. Janeane Anderson for your tough love approach and for challenging me to rise to the occasion with every decision I made in every phase of this process. You pushed and taught me not to settle— Every conversation ended like this: “Just do good science, Sam.” You taught me the importance of honoring the lives and voices of my participants, and I cannot thank you enough for your financial support that made this research study possible.

Dr. Loretia Carroll, you were the first to sit down with me when I first applied to the Ph.D. program. You walked with me, both literally and figuratively, each step of the way. Thank you for every sacrifice you made to answer questions and teach me how to honor the methods. Dr. Jennifer Valli, I cherish every conversation we have shared about the importance of this work. You challenged me to show up as my authentic self and made it clear that this goal was obtainable. Thank you for all of your support. Dr. Sherree Donaldson, or Dr. D, as I love to call you, you have shown me that if I want it, I should go for it. Thank you so much for normalizing every feeling I have felt along this journey. You made me feel human when I thought I was inadequate or was not good enough. Last but certainly not least, to Dr. Tolley, you taught me the learning process. You encouraged, challenged, and mentored me in statistics and overall as an educator. I adapt learning strategies in my practice based on how you guided me, which has made a huge difference with my students.

To my family. First, I want to acknowledge my husband, best friend, and coach, Mr. Jeremy B. Calhoun. Thank you for your support, love, challenge, and sacrifice to see me reach this milestone goal. You have been with me since nursing school and when I failed my nursing boards. You were the first to call me a nurse before I could see my dream become a reality. I know deep down that God brought you into my life to pull out the best in me by pushing me to do it, especially when I am afraid. I would still be on the sidelines looking at what my life could have been if I had not met you. You bring out the best in every person who knows you. Thank you for holding us down while I figured this thing out.

Thank you to my incredible parents, Lonzie Turner Sr. and Deborah Turner. You instilled values that still carry me into adulthood. Thank you for every sacrifice, teaching me how to honor God, and showing me the faith to trust God no matter what. I carry my faith as a badge of honor, and it's because of watching your example. Thank you for nurturing me to keep fighting for my dreams. I also want to thank my father and mother-in-law, Sean Calhoun Sr. and La'Keshia Calhoun. Your prayers have carried me throughout this process, and I thank you so much for believing in me. To my siblings, Brittini Turner, Lonzie Turner, Jr., Sean Jr., and Livy, thank you for allowing me to be me and laugh out loud! I know you will ensure I do not start acting brand new.

To my nursing students. I cannot even express how much of an impact you all have made on this journey. If you read this body of work, I want you to know that you can do it, too, and I will be here to help you. Lastly, to God, my father. I truly understand that all things work together for good to those who love God and are called according to His purpose. Thank you for trusting me to use my life in such a way. Without you, I know that I could not have reached this milestone. This work proves that God can use anyone and that nothing is too hard for you.

PREFACE

The body of this dissertation is organized in a way that first introduces readers to our rationale for choosing the research topic and objectives, as well as presents an overview of the literature. A discussion of the materials and methods used then leads to a presentation of the research and a final analysis with a discussion of our findings. A concluding chapter relates all research elements to our final thoughts about the findings and their significance.

NOTE ON PDF NAVIGATION: Document navigation is greatly facilitated by using Adobe Acrobat's "Previous view" and "Next view" functions. For "Previous view," use quick keys Alt/Ctrl+Left Arrow on PC or Command+Left Arrow on Mac. For "Next view," use Alt/Ctrl+Right Arrow on PC or Command+Right Arrow on Mac. Using these quick keys in tandem allows the reader to toggle between document locations. Since every scroll represents a new view; depending on how much scrolling is done for a specific view destination, more than one press of the back or forward arrows may be needed. For additional navigational tips, click View at the top of the PDF, then Page Navigation. These Adobe Acrobat functions may not be functional for other PDF readers or for PDFs opened in web browsers.

ABSTRACT

Purpose. This study aimed to explore what factors are related to Black men's shared decision-making (SDM) preferences for selecting hypertension (HTN) treatment and management options with a healthcare clinician.

Methods. Researchers employed an exploratory sequential mixed methods design to explore factors influencing Black adult men's preferences for involvement in SDM regarding HTN treatment. Qualitative interviews with $n=16$ Black men identified related factors, while a quantitative phase with $N=105$ Black men examined predictors of involvement in SDM for HTN treatment.

Results. Trust and having a female clinician were a significant independent predictor of SDM involvement among men in this study ($b = 9.09$; $t(102) = 3.07$; $p = .003$). Engaging in the SDM process with a female clinician increased the desired level of decision-making involvement for HTN treatment and management.

Conclusion. Findings from this sample suggest that clinician gender is a key factor that influences Black men's SDM involvement preferences. Future research should focus on targeted questions to delve deeper into the specific aspects of SDM in gender-discordant patient-clinician relationships.

TABLE OF CONTENTS

CHAPTER 1. INTRODUCTION	1
Problem Statement	3
Purpose of the Study	3
Conceptual Model	4
Research Questions	8
Significance of the Study	9
Summary of Methodology	9
Research Design Overview	10
Recruitment	10
Sample	11
Recruitment	11
Instrumentation	12
Qualitative Pre-Interview Online Survey	12
Qualitative Instrument: Semi-structured Interview Guide	12
Information-Seeking	12
Blood Pressure Management	12
Patient-Clinician Relationship	13
Involvement in SDM	13
Empowerment	14
Quantitative Instrument: 100-item Survey Using Validated Measures	14
Demographic and Patient Characteristics	14
Independent Variables	14
MMI	14
TPS	15
Autonomy Support	15
Health Care Climate Questionnaire	15
WAI-GP	15
Dependent Variable: Autonomy Preference Index	15
Data Analysis	16
Assumptions	16
Credibility and Validity	16
Limitations	17
Summary	17
CHAPTER 2. REVIEW OF LITERATURE	18
Standard Guidelines for HTN Treatment and Management	18
Antihypertensive Medications	19
HTN Among Black Individuals in the United States	19
HTN Treatment and Management Challenges	20
Poor Blood Pressure Control and Medication Non-Adherence	21
Medication Side Effects	21
Treatment-Induced Sexual Dysfunction and Corollary Factors	22

Sociocultural and Historical Experiences of Black Adult Men with the U.S. Healthcare System	23
Intrapersonal Factors and Interpersonal Factors	24
Patient-Clinician Relationship and Communication.....	24
Clinician-Related Factors Contributing to Poor Blood Pressure Control	26
Theory of SDM.....	26
SDM in a Clinical Context.....	27
Challenges of SDM.....	27
SDM Among Black Adult Patients with Chronic Conditions	29
Decision-Making Preferences Among Black Patients	29
Summary.....	30
CHAPTER 3. METHODOLOGY.....	31
Study Design.....	31
Theoretical Approach.....	31
Methodological Orientation	32
Sample and Setting	32
Recruitment.....	36
Qualitative Instrumentation	36
Pre-Interview Online Survey	36
Semi-Structured Interview Guide	37
Pilot Testing Semi-Structured Interview Guide.....	37
Quantitative Instrumentation	38
Online Survey	38
SDM Preferences	38
Perception of Working Alliance in Relationship with Clinician	39
Perception of Autonomy Support Received from Clinician.....	40
Perceptions of Trust and Mistrust Among Black Men with HTN	41
TPS.....	41
MMI-7.....	41
Pilot Testing Quantitative Survey Instrument.....	41
Procedures.....	42
Qualitative Data Analysis	43
Quantitative Data Analysis	44
Ethical Considerations of Human Subjects	46
CHAPTER 4. RESULTS.....	48
Phase 1: Qualitative Exploration of SDM Preferences of Black Men with HTN in the U.S. Mid-South.....	48
Participant Characteristics	49
Patient-Related Factors Influencing Involvement in SDM.....	49
Race Congruence/Cultural Congruence.....	49
Gender Congruence	52
Patient Ability to Negotiate Power with Clinician	53
Stereotype Threat	55
Clinician-Related Factors Influencing Involvement in SDM	55

Clinicians Disclosing Personal Experience with Blood Pressure Medications Influence Black Men’s Involvement in SDM.....	55
Clinicians’ Lack of Investigation into the Root Cause of Participants’ High Blood Pressure Negatively Influenced Their Desire to Engage in SDM	57
Clinicians’ Use of a “Medication-Heavy” Approach to HTN Treatment Limit Opportunities to Discuss Alternative Treatment Options with Black Men	57
Patients	57
Characteristics of an Optimal SDM Environment for Black Men with HTN	58
Therapeutic Working Alliance.....	58
Respect for Patients’ Decision-Making Autonomy in HTN Management.....	60
Trusting Patient-Clinician Relationships	61
Phase 2: Quantitative Examination of Factors Influencing SDM Involvement Among Black Men with HTN In The U.S. Mid-South	62
Descriptive Statistics of Quantitative Participants.....	62
Characteristics of Quantitative Participants	62
Descriptive Statistics of Study Scales	64
Reliability of Study Scales.....	64
Quantitative Research Phase: Findings.....	67
Relationships and Associations Among Decision-Making Involvement, Patient (Age and Education), Clinician (Gender and Race) and Relationship Factors (Trust, Autonomy Support, Working Alliance)	67
Findings from Correlation Analysis.....	68
Findings from Simple Linear Regression Analysis	68
Predictors of SDM Involvement Among Black Men with HTN	70
Summary of Quantitative Findings	70
Phase 3: Integration of Qualitative and Quantitative Results	70
Mixed Methods Results	70
CHAPTER 5. DISCUSSION	74
Limitations	80
Conclusion	80
LIST OF REFERENCES.....	83
APPENDIX A. RESEARCH RECRUITMENT FLYERS.....	110
APPENDIX B. QUALITATIVE PRE-INTERVIEW ONLINE SURVEY	112
APPENDIX C. QUALITATIVE SEMI-STRUCTURED INTERVIEW GUIDE ...	117
APPENDIX D. QUANTITATIVE WEB-SURVEY.....	120
VITA.....	127

LIST OF TABLES

Table 3-1.	Exploratory Sequential Mixed Methods Study Design.	33
Table 3-2.	Operationalization of Main Study Concepts.....	34
Table 4-1.	Characteristics of Qualitative Interview Participants.	50
Table 4-2.	Patient-Related Factors.	51
Table 4-3.	Clinician-Related Factors.....	56
Table 4-4.	Findings from Thematic Analyses with Supporting Quotes.....	59
Table 4-5.	Characteristics of Quantitative Participants.....	65
Table 4-6.	Descriptive Statistics of Study Scale Scores.....	66
Table 4-7.	Reliability of Study Scales.....	66
Table 4-8.	Spearman Correlation Matrix Among Key Study Variables.	69
Table 4-9.	Simple Linear Regression with Clinicians' Gender.....	69
Table 4-10.	Simple Linear Regression with Trust.	69
Table 4-11.	Trust and Clinicians' Gender.	71
Table 4-12.	Integrated Findings for Shared Decision-Making.....	73

LIST OF FIGURES

Figure 1-1. Peek et al.'s (2016) Conceptual Framework for Understanding Shared-Decision Making Among African-American LGBT Patients and Their Clinicians.....	5
Figure 1-2. Conceptual Model for Examining the Shared Decision-Making Preferences of Adult Black Men with HTN in the U.S. Mid-South Region.	7
Figure 4-1. Flow Diagram of Survey Participants Included in Analyses.	63

LIST OF ABBREVIATIONS

API	Autonomy Preference Index.
API-DM	Autonomy Preference Index- Decision Making.
CDC	Centers for Disease Control and Prevention.
ED	Erectile dysfunction.
HCCQ	Health Care Climate Questionnaire.
HIV	Human immunodeficiency virus.
HTN	Hypertension.
MMI	Medical Mistrust Index.
MMI-7	Medical Mistrust Index-7.
MMR	Mixed methods research.
SDM	Shared decision-making.
SES	Socioeconomic status.
TPS	Trust in physician scale.
WAI-GP	Working Alliance Inventory-General Practice.

CHAPTER 1. INTRODUCTION

In the United States, hypertension (HTN) is the primary, preventable risk factor for heart disease, accounting for \$131 billion in annual healthcare costs (Benjamin et al., 2019; Kirkland et al., 2018). Non-Hispanic Black men in the United States have the highest HTN prevalence, with 58.3%, followed by non-Hispanic White men (51%) and Hispanic men (50.6%; Tsao et al., 2022). Unfortunately, this high prevalence has persisted since 1999 (Benjamin et al., 2019; Gadson, 2006; Tsao et al., 2022). For Black individuals, HTN management extends beyond clinical settings, including biophysical, psychosocial, and social factors, thus making antihypertensive treatment and management in Black patients more complex (Bell et al., 2010; Gabriel et al., 2020; Schoenthaler et al., 2019). Specifically, social support, experiences with racism, provider mistrust, provider communication barriers, attitudes, and health beliefs affect treatment outcomes for Black patients with HTN (Benjamin et al., 2019; Ha et al., 2018; Lewis et al., 2012; Whelton et al., 2018). These factors contribute to a heightened vulnerability among Black patients to suboptimal blood pressure control, which can lead to increased morbidity and premature death (Chen et al., 2019).

In the U.S. healthcare system, the effects of structural racism have led to disparities and mistrust among Black men within relationships with clinicians (Brondolo et al., 2023; Coleman-Kirumba et al., 2023). Medical mistrust stemming from historical healthcare injustices involving Black patients such as the Tuskegee Syphilis Study (Alsan & Wanamaker, 2018; Butler, 1973; Corbie-Smith et al., 2002; Williams et al., 2003) contribute to underlying medical mistrust and communication barriers among Black patients that hinder effective engagement in health promotion behaviors, such as seeking a usual source of healthcare (Murray et al., 2017; Stewart et al., 2019). Also, medical mistrust contributes to power imbalances between Black male patients and their clinicians (Hammond, 2010), shaping patients' perceptions of their roles and abilities as active participants in their healthcare decisions (Gilbert et al., 2016), including the ability to ask questions or challenge treatment decisions (Brown et al., 2023). The patient-clinician relationship, involving communication, partnership, power, and trust, is pivotal in addressing healthcare disparities and ensuring effective treatment (Cooper et al., 2006). Studies show that racial and ethnic concordance between patients and healthcare providers improves communication and medication adherence in people with HTN (Alsan et al., 2019; Cooper et al., 2003; Nguyen et al., 2020). In the case of HTN treatment among adult Black men, HTN treatment effectiveness is achieved through a combination of short follow-up intervals and consistent therapy adjustments (Victor et al., 2018). This underscores the importance of establishing a long-term, consistent relationship with a healthcare clinician for adequate blood pressure control for Black men, who are often reported not to have an established primary care clinician (Arnett et al., 2016). Studies have also shown that Black patients are more likely to follow medical recommendations when treated by Black physicians (Alsan et al., 2019; Nguyen et al., 2020). Findings from a recent randomized clinical trial of 1,300 Black men suggest that men assigned to a Black doctor are more likely to discuss health concerns and undergo diabetes, HTN, and cholesterol screenings post-consultation (Alsan et al., 2019).

Unfortunately, Black physicians are underrepresented, accounting for only 5% of the healthcare workforce (Snyder et al., 2023). This finding suggests that cultural barriers during interactions with Black male patients and healthcare clinicians may be a common experience for Black male patients. It may be important to understand how cultural factors may influence Black male patients' communication and interactions with healthcare clinicians and their overall impact on health outcomes.

Current HTN clinical guidelines from the American College of Cardiology and the American Heart Association emphasize the importance of shared decision-making (SDM) between patients and clinicians when selecting appropriate antihypertensive medications (Whelton et al., 2018). SDM is a systematic process designed to improve communication challenges and foster collaboration between patients and clinicians by making mutually agreed-upon treatment decisions (Elwyn et al., 2023). This patient-centered approach integrates patients' preferences and values, enabling clinicians to clarify patients' values and empower patients to engage in their care by selecting treatment options aligned with their preferences (Elwyn et al., 2023). Specifically, HTN guidelines encourage clinicians and patients to use SDM when choosing blood pressure treatment options to achieve blood pressure control (Whelton et al., 2018). However, guidelines do not offer instructions on how to incorporate this recommendation into routine clinical HTN care.

Implementing SDM requires clinicians to acknowledge biases, understand patients' preferences, and provide tailored information to reduce communication barriers (Bailo et al., 2019; Elwyn et al., 2017). One critical factor, especially among marginalized patients, including Black men, immigrants, the unemployed, and the chronically ill (Baah et al., 2019), is clinicians' unconscious bias toward 'patients' decision-making capacity or adherence to treatment options (Turkson-Ocran et al., 2021). Clinicians must recognize the factors that affect patients' involvement in SDM, particularly in marginalized patient populations, to understand and address unique barriers that might restrict these patients from actively participating in creating patient-centered treatment plans aligned with their values and goals. Patients' knowledge about their health condition and perceptions of power are critical in SDM utilization (Joseph-Williams et al., 2014). Knowledge encompasses patients' preferences, goals, and awareness of available treatments, while power relates to their perception of their influence in decision-making encounters. Patients' perception of power includes having permission to participate, self-efficacy in communication skills, and confidence in their ability to use these communication skills effectively in clinical encounters with clinicians (Joseph-Williams et al., 2014). Power imbalances in the patient-clinician relationship are a concern at the patient and clinician levels (Peek et al., 2009). Power imbalances are further exacerbated among racial and ethnic minority patients (Peek et al., 2016). Identifying and understanding the factors influencing SDM from the patient's perspective, particularly their preferences for SDM, is necessary for optimal patient engagement in the SDM process.

Problem Statement

Adult Black men in the United States are disproportionately affected by disparities in HTN-related outcomes such as younger age of disease onset, stroke, cardiovascular disease, and end-stage renal disease (Ferdinand et al., 2017; Gu et al., 2017; Mozaffarian et al., 2015; Spence & Rayner, 2018). SDM is advocated to help decrease disparities in HTN-related outcomes by enhancing patient engagement through integrating patient preferences into treatment plans (Langford et al., 2019), fostering collaborations (US Preventive Services Task Force et al., 2022), and increasing trust between patients and clinicians (Whitney et al., 2021). Limited literature is available regarding Black men's SDM preferences outside healthcare contexts like oncology, diabetes, and human immunodeficiency virus (HIV) clinical care. From the existing research about other healthcare contexts, factors affecting SDM involvement among Black men may vary, and more information is needed to understand what factors are relevant to SDM specific to HTN treatment and management. Also, there is a notable disparity in the frequency of SDM conversations, with these conversations being less common among Black men than White men (Crittendon et al., 2022; Gordon et al., 2019). Another barrier to the widespread adoption of SDM among adult Black men in HTN care appears to be the lack of comprehensive information about their preferences for involvement in SDM. Patients' preferences for engagement in medication decision-making can vary, which may change over time for the same patient (Cuypers et al., 2016). Among Black adults with diabetes, a study involving 18 Black men found that preferences for SDM were influenced by factors such as mistrust and clinician communication (Zisman-Ilani et al., 2023). Preferences for SDM involvement were also associated with various patient demographic factors, including age, higher education level (Park et al., 2014), relationship status (Allen et al., 2018), and the specific types of decisions being made (Joseph-Williams et al., 2014).

The scope of literature remains limited in what factors are relevant to consider when engaging Black men in SDM for selecting HTN treatment options (i.e., blood pressure medication), which is critical because Black men continue to suffer from uncontrolled HTN due to medication non-adherence (Ferdinand & Graham, 2019). This study aimed to identify Black male patients with HTN preferences for SDM with a healthcare clinician for selecting HTN treatment and management options.

Purpose of the Study

Researchers and scholars widely advocate for SDM as the gold standard in patient-centered care (Elwyn, 2021; Montori et al., 2006). It is seen as a valuable tool for enhancing patient-clinician communication by actively involving patients in treatment decisions and considering their values and preferences (Turkson-Ocran et al., 2021). However, insights from prior SDM studies across various disease contexts, including oncology (Allen et al., 2022; Echeverri et al., 2022), diabetes management (Moin et al., 2019); Peek et al., 2009; Serrano et al., 2016), HIV management (Ajiboye et al., 2022; Dangerfield et al., 2022; Okoli et al., 2021), and cardiovascular clinical care (Dennison

Himmelfarb et al., 2023; Mitropoulou et al., 2023; Schoenthaler et al., 2018), reveal diverse patient preferences regarding SDM. Not every patient may be prepared for, or desire SDM (Eliacin et al., 2015; Galletta et al., 2022; Keij et al., 2021). It is important to recognize that patients and clinicians may have differing experiences of SDM within the clinical encounter (Allen et al., 2022). These discrepancies emphasize the need for a culturally relevant understanding of the factors influencing hypertensive Black men SDM experiences from their perspectives. Such insights can help better support patients in advocating for their communication needs and preferences.

Knowing patients' SDM preferences may benefit clinicians in supporting patients' active engagement in SDM for those who desire it (Keij et al., 2021; Levinson et al., 2005). SDM implementation in HTN care has been slow due to a lack of robust research and education about its use in routine clinical care (Maskrey, 2019). Limited patient-reported data from Black men with HTN on SDM exacerbates the existing knowledge-practice gap between conceptual understanding of SDM and its application in the clinical management of HTN among Black adult men. This gap highlights a pressing need for a clearer understanding of how SDM can be effectively integrated into the routine care of Black male patients with HTN. It underscores the necessity for culturally sensitive and practical strategies to facilitate the meaningful incorporation of SDM within this context.

This exploratory sequential mixed methods study aimed to identify Black men's SDM preferences and factors that may predict men's desire for involvement in SDM with a clinician for routine HTN treatment and management. In the study's first phase, individual semi-structured interviews with adult Black men with HTN in the U.S. Mid-South region ($n=16$) were used to explore SDM preferences among this patient population. Qualitative data analysis revealed key themes that defined SDM preference measures among Black men in the study: patient-related factors, clinician-related factors, and patient-clinician relationship characteristics that influence the environment for involvement in SDM. Relationship factors include preferences for trusting clinician relationships, autonomy support from clinicians, and therapeutic alliance with their clinicians. In the second phase of the study, a 100-item survey using validated scales that measured preferences for decision-making involvement, trust, autonomy support, and therapeutic working alliance was administered to a larger sample of adult Black men with HTN living in the U.S. Mid-South region ($n=105$) to examine SDM preferences and determine if preferences predicted behavioral involvement in SDM.

Conceptual Model

This study utilized Peek et al.'s (2016) SDM conceptual model (**Figure 1-1**) as the guiding framework for this research study. Peek et al. defined *SDM* as a collaborative decision-making process in which patients and healthcare clinicians work together to establish treatment goals and plans that align with patients' needs and preferences. The

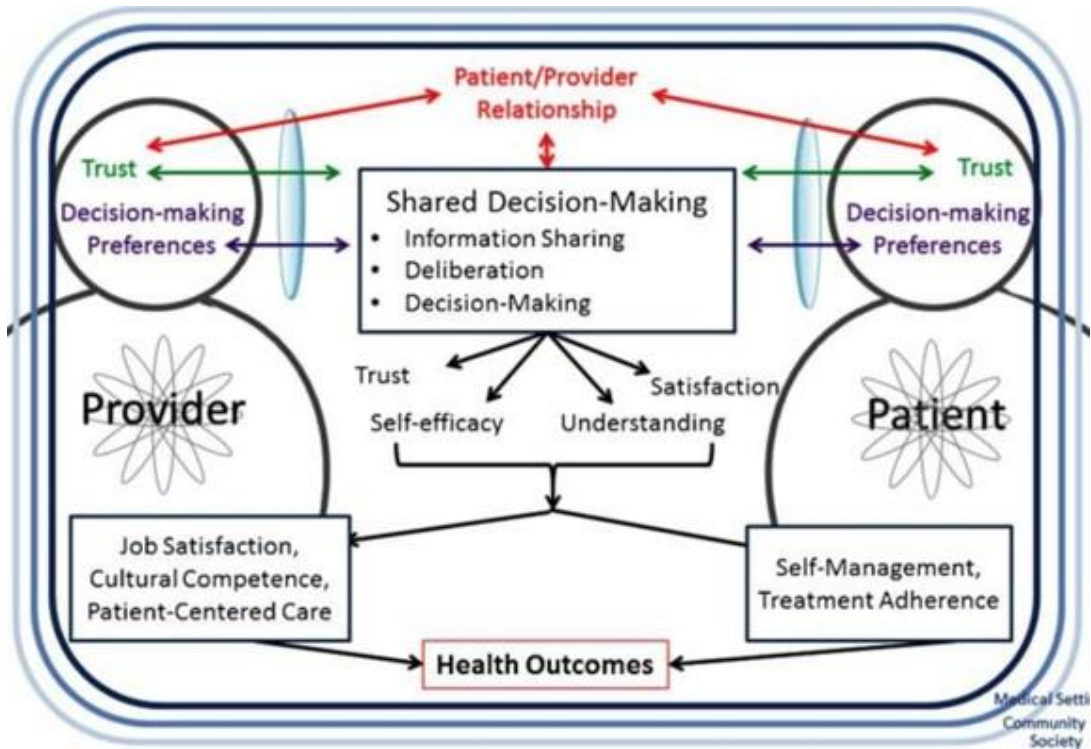


Figure 1-1. Peek et al.’s (2016) Conceptual Framework for Understanding Shared-Decision Making Among African-American LGBT Patients and Their Clinicians.

Reproduced with permission from Springer Nature. Peek, M. E., Lopez, F. Y., Williams, H. S., Xu, L. J., McNulty, M. C., Acree, M. E., & Schneider, J. A. (2016). Development of a conceptual framework for understanding shared decision making among African-American LGBT patients and their clinicians. *Journal of General Internal Medicine*, 31(6), 677–687. <https://doi.org/10.1007/s11606-016-3616-3>

current study focuses on the decision-making process related to HTN treatment options, which encompasses initiating antihypertensive medications, adjusting medications, or discontinuing the use of these medications, for example.

Peek et al.'s model identifies three key domains that comprise the SDM process. The first domain, information sharing, involves a two-way exchange of information between patients and clinicians regarding disease symptoms, diagnoses, and lifestyle factors relevant to choosing a treatment plan. In this study, information sharing pertains to clinicians' sharing information about HTN diagnosis, treatment, and management options, while clinicians use easily understandable language to promote patient understanding. Equally, patients are encouraged to express their concerns about treatment options and have their experiences validated. The second domain, deliberation, involves healthcare clinicians offering treatment recommendations based on a comprehensive disclosure of all available treatment options. In the current study, deliberation involves discussing the pros and cons of different HTN treatment options, including medication side effects. This phase actively seeks patient preferences, ensuring that their viewpoint is an integral part of the decision-making process.

The third domain, decision-making, involves patients and physicians agreeing on a treatment plan. In the current study, the focus is on the decisions of Black men to initiate HTN treatment options, whether it be anti HTN medications or implementing lifestyle and behavioral changes such as diet and exercise, or a combination of both.

Peek et al.'s conceptual model incorporates the idea of intersectionality (Collins, 2015), illustrating how a person's multiple social group identities (i.e., being Black and male) influence their perceptions, expectations, and behaviors during clinical visits, subsequently affecting communication and the SDM process. Past experiences with unconscious biases, prejudices, and stereotypes in healthcare settings may influence patients' perceptions of their healthcare clinician and the clinical encounter. An individual's experiences with their ethnicity, gender, or social status outside of the clinical encounter can impact how they (i.e., patients and clinicians) perceive and communicate with each other in the clinical encounter. For example, patients who anticipate racism or unconscious bias may adjust their behavior or withhold personal information to influence how clinicians perceive them.

The choice of Peek et al.'s model as the framework for the current study is grounded in the belief that effective, SDM among marginalized patients in healthcare settings depends on understanding patients' decision-making preferences. While Peek et al.'s model emphasizes diagnosing a patient's preference for medical decision-making to comprehend their engagement in the SDM process, the current study clarifies that decision-making preferences are determined by how much involvement patients desire in the process.

The current study uses selected concepts from Peek et al.'s model to investigate various aspects of the SDM process involving Black male patients and their clinicians in HTN clinical care. In this study, the major concepts, (**Figure 1-2**), include patients'

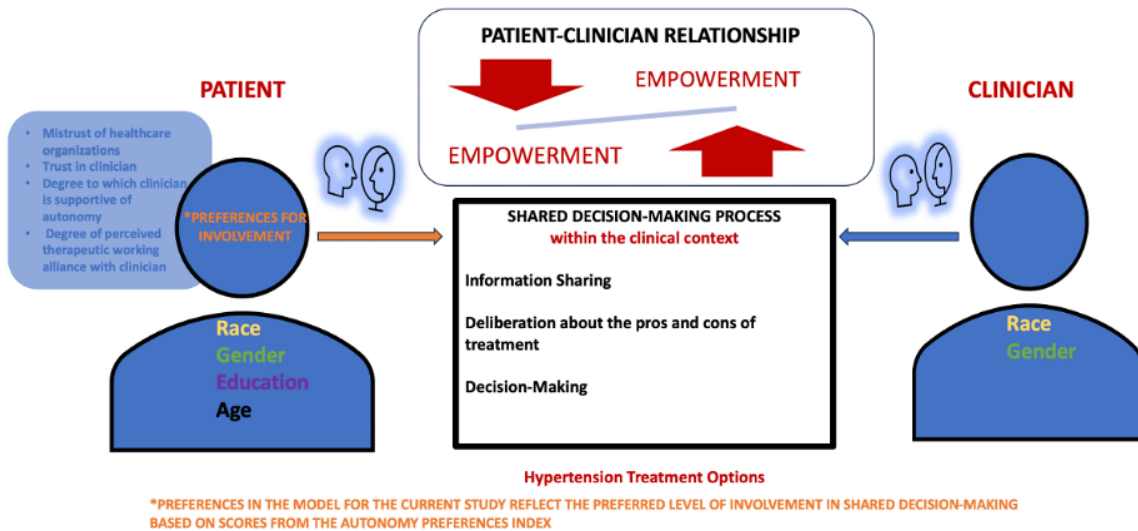


Figure 1-2. Conceptual Model for Examining the Shared Decision-Making Preferences of Adult Black Men with HTN in the U.S. Mid-South Region.

Adapted with permission from Springer Nature. Peek, M. E., Lopez, F. Y., Williams, H. S., Xu, L. J., McNulty, M. C., Acree, M. E., & Schneider, J. A. (2016). Development of a conceptual framework for understanding shared decision making among African-American LGBT patients and their clinicians. *Journal of General Internal Medicine*, 31(6), 677–687. <https://doi.org/10.1007/s11606-016-3616-3>

preferences for involvement in the SDM process with healthcare clinicians for HTN treatment options within the clinical context. The study also explores patients' perceptions of their relationship with the healthcare clinician, their self-perception of social identity (race, gender, education, age), their perceptions of their healthcare clinician's social identity (race and gender), and expectations and stereotypes associated with these social roles and identities. Furthermore, this study explores how Black male patients' perceptions of social identities and roles influence their expectations of clinical encounters with their healthcare clinicians and their preference for involvement in the SDM process for deciding HTN treatment options.

Finally, the current study examines how Black male patients perceive their relationship with their clinician, focusing on their perceptions of trust and medical mistrust, the level of autonomy support received from their clinician, empowerment, the strength of the therapeutic working alliance, and how these factors affect the patients' preferred level of SDM involvement for HTN treatment and management among Black men living in the U.S. south.

Research Questions

Intrapersonal and interpersonal factors shape patient involvement and engagement in medical treatment decision-making (Perez Jolles et al., 2019). Interpersonal factors encompass elements such as the quality of the patient-clinician relationship, effective communication between healthcare clinicians and patients, and the trust established within this relationship for example (Perez Jolles et al., 2019). On the other hand, intrapersonal factors include the patient's perceptions and expectations that may stem from their cultural background, values, and personal preferences (Perez Jolles et al., 2019). This study examined both intrapersonal and interpersonal factors influencing SDM involvement among adult Black men with HTN living in the U.S. Mid-South region by seeking to answer the following research questions:

1. What are the SDM preferences of adult Black men with a HTN diagnosis living in the U.S. Mid-South region? (*Qualitative research question*)
2. What factors such as patient age and education, clinician race and gender, patient-perceived trust in the patient-clinician relationship, patient-perceived autonomy support from their clinician, and patient-perceived therapeutic working alliance with their clinician predict the level of SDM involvement about HTN treatment and management among adult Black men with HTN? (*Quantitative research question*)
3. How do the themes regarding SDM involvement, identified through qualitative interviews (RQ1), relate to the predicted factors of SDM involvement for HTN treatment and management measured by a survey (RQ2) among adult Black men with HTN? (*Mixed methods research [MMR] question*)

Significance of the Study

This research study addressed a gap in empirical studies on SDM in HTN treatment among adult Black men in the Mid-South. This study employed qualitative and quantitative methodologies to gain comprehensive insights into the factors influencing engagement in SDM with healthcare providers. Geographic disparities in HTN prevalence persist among Black adults, notably in southern states such as Tennessee, Mississippi, and Arkansas (Centers for Disease Control and Prevention [CDC], 2023; Kershaw et al., 2010). HTN management is challenging, and over the past decade, blood pressure control rates in the United States have worsened, particularly among racial and ethnic minority groups. Black adults continue to have lower blood pressure control rates than their non-white counterparts (Abrahamowicz et al., 2023), highlighting the complexity of blood pressure management in this population. Certain blood pressure medications may be less effective for African Americans (Brewster & Seedat, 2013). Effective HTN management among Black adults necessitates frequent interactions with clinicians to achieve optimal blood pressure control. Given the potential variations in medication effectiveness for African Americans (Brewster & Seedat, 2013), it becomes crucial to facilitate effective communication between Black adults and their healthcare providers for selecting the most suitable blood pressure medications. Patients must actively engage in discussions about how blood pressure treatment affects them so that clinicians can make informed decisions regarding the optimal management plan.

This study aimed to clarify the factors that may influence the involvement of Black men in SDM environments for HTN treatment and management. Understanding these factors can inform the development of culturally sensitive SDM interventions, ultimately enhancing health outcomes for this demographic. The study may guide healthcare clinicians in discussing HTN treatment and management options with their Black male patients more effectively. This study holds significance due to the high prevalence of HTN among Black men in the U.S. South, the challenges in controlling blood pressure within this population, and the necessity for targeted research to examine SDM among Black men, with the potential to shape culturally relevant clinical guidelines in the future.

Summary of Methodology

This study's primary objective was to identify relevant factors that Black men consider when deciding to engage in the SDM process with their healthcare clinician (i.e., nurse practitioner, medical doctor) for HTN treatment and management and to describe how factors may shape the SDM environment for Black men interacting with clinicians in the HTN context.

Research Design Overview

This study applied an exploratory sequential mixed methods design to investigate the factors influencing Black adult men's preferences for involvement in shared decision-making with healthcare clinicians concerning HTN treatment and management. The rationale for mixing both data types is that neither quantitative nor qualitative methods thoroughly capture the multilayered experiences of Black men discussing HTN treatment in the clinical encounter (Haile et al., 2017). An exploratory mixed methods approach was used because it offers a more holistic understanding of the phenomenon being studied by capturing individuals' lived experiences (qualitative) and the patterns and trends across a larger sample (quantitative; Creswell & Plano Clark, 2018). The initial qualitative phase explored personal and relational factors that impact their engagement in the decision-making process, specifically discussions with clinicians about blood pressure management and treatment strategies, such as when to initiate medications into the treatment plan. Qualitative data were obtained from individual semi-structured interviews. The qualitative findings informed the subsequent quantitative phase, identifying relevant factors through thematic analyses, empirical literature, and Peek et al.'s (2016) shared decision-making process conceptual model constructs (i.e., patient-clinician relationship, trust, and decision-making preferences). Selected factors from thematic analyses were operationalized and measured using existing scales and examined in a cross-sectional online survey to gain more generalizable insights into Black adult men's preferences for engaging in SDM for HTN-related decisions. Integrating quantitative and qualitative findings enabled comparisons and inferences, extending and generalizing the initial qualitative results.

Recruitment

Research recruitment strategies targeted participant recruitment for both qualitative and quantitative research phases. Two research flyers (**Appendix A**) were used to recruit participants for each phase. The qualitative research flyer listed study details (i.e., 60–90-minute interview procedures, inclusion and exclusion criteria, study's principal investigator contact information, and participant compensation information (i.e., \$25 electronic merchant gift). The quantitative research flyer was modified slightly to reflect quantitative study details (i.e., 30-45-minute online survey procedures) and participant compensation (i.e., \$40 electronic merchant gift). The flyer also featured a QR code linking to an online Qualtrics survey with pre-screening questions to determine participation eligibility. Eligible participants for the quantitative phases were first identified based on answering “yes” to all pre-screening questions.

Sample

Given the study's research questions and aims, the increased prevalence of HTN in the region, and the longstanding historical underrepresentation of Blacks in US health research (Etti et al., 2021; Green et al., 2023) participants had to meet the following criteria for enrollment into the study. The study's principal investigator recruited eligible qualitative and quantitative participants between September 2020 and March 2023. Inclusion criteria for this study were as follows: participants were required to self-identify as Black or African American males and be at least 18 years of age or older. Additionally, they had to have a diagnosis of HTN or high blood pressure and reside in the Mid-South region, which encompasses Tennessee, Mississippi, and Arkansas. Proficiency in reading and speaking English was another essential requirement, as was access to a web-enabled device. Conversely, exclusion criteria for this study were as follows: individuals who declined to provide consent or could not read and speak English were not considered for enrollment.

Recruitment

Study information was disseminated through various methods, including social media platforms (i.e., Facebook, LinkedIn, and Instagram) and physical locations in primary care clinics, libraries, churches, and barbershops. Research flyers were prominently displayed in these locations, with a QR code that directed interested individuals to a dedicated webpage administered through Qualtrics Online Study Information. This webpage provided comprehensive study details, a consent form, and a pre-screening questionnaire to assess eligibility and collect contact information. Each consented participant ($n=16$) participated in a semi-structured interview with the average interview length lasting approximately one hour (SD : 20 minutes). The interviews were conducted by the study principal investigator in Memphis, Tennessee, between September 2020 and March 2021 via Zoom ($n=14$) and telephone ($n=2$) to avoid safety concerns posed by the COVID-19 pandemic. Participants were given a \$25 electronic merchant gift card for participating in the qualitative interviews. Quantitative data were collected through surveys administered to a convenience sample of adult Black men ($n=105$) who reported having HTN residing in the Mid-South region (Tennessee, Mississippi, and Arkansas between December 2022 and April 2023). Enrolled participants for the quantitative phase were those who met the criteria for consent, passed the pre-screening eligibility assessment, and were deemed trustworthy after fraud detection safeguards were reviewed. Each participant in the quantitative phase was given a \$40 electronic merchant gift card after validation procedures were completed. Approval from the University of Tennessee Health Science Center (UTHSC) Institutional Review Board (IRB) was granted before the study's principal investigator conducted recruitment and data collection procedures (IRB Study Number: 20-07532-XP).

Instrumentation

Qualitative Pre-Interview Online Survey

Before conducting individual semi-structured interviews, participants received an online pre-interview survey via email (**Appendix B**). The survey included an online consent form and gathered sociodemographic information (i.e., age and highest education level), patient characteristics (i.e., length of time diagnosed with HTN names of blood pressure medications), and healthcare clinician characteristics (gender, age, and race).

Qualitative Instrument: Semi-structured Interview Guide

Peek et al.'s (2016) SDM process model guided the development of topics included in the semi-structured interview guide. Specifically, the 24-item interview guide explores patient-related factors to understand the impact of patient preferences in shaping the SDM experience in the HTN management context. The semi-structured interview guide included several key domains (i.e., health information-seeking, blood pressure management, patient-clinician relationships, patient-clinician communication, involvement in SDM, and empowerment). Each interview domain consisted of specific questions and probes to gain insights into participants' experiences regarding HTN management and their interactions with healthcare clinicians. These include the following: The complete interview guide, comprising all interview questions, can be found in the (**Appendix C**).

Information-Seeking

This domain explored how participants sought health information about their HTN diagnosis and how to manage it. Participants were asked about their information-seeking strategies and whether they sought additional information outside of the clinical encounter with their clinician following their diagnosis. They were asked to reflect on their experiences during clinic visits and whether they needed further information about their condition. Example questions included, "When you have a health-related question, how do you find the information you seek?" "Think back to the day you were diagnosed with high blood pressure. Tell me about what happened during your clinic visit; did you seek additional information about your condition? Why or why not?"

Blood Pressure Management

This domain explored participants' approaches to blood pressure management. Questions elicited participants' opinions about the most effective treatment strategies for controlling blood pressure. Additionally, participants were asked whether they had engaged in discussions with their healthcare clinicians regarding experiences with side effects, including sexual side effects of their blood pressure medication. This domain included questions about the settings and circumstances of these conversations and the

content discussed. Further probing included questions about who (i.e., the patient or clinician) initiated these sexual health discussions and how it impacted participants' overall treatment plans. Example questions included, "What treatment strategy(s) do you find most effective for controlling your blood pressure? Have you had a conversation about the sexual side effects of your blood pressure medication? Describe the setting or surroundings where you had this conversation and what was discussed during the conversation."

Patient-Clinician Relationship

This domain explored participants' descriptions of their relationships with their healthcare clinicians. An analogy involving a football team was used to characterize these relationships, allowing participants to choose from three options: a) both patient and clinician on the same team with shared goals, b) the clinician as the coach and the patient as the player, or c) patient and clinician on separate teams with different goals. This analogy provided a framework for understanding the dynamics and perceptions of the patient-clinician relationships.

Example questions: "Describe your relationship with your provider; if you can characterize your relationship with your provider as a football team, would you say that a) you are both on the same team with the same goal, b) your provider is the coach, and you are the player, or c) you are on two different teams with two different goals?"

Involvement in SDM

This domain explored participants' self-assessed levels of involvement in decision-making regarding their blood pressure treatment and management. Participants were asked to rate their involvement as high or low and to provide reasons for their chosen rating. This domain helped uncover the factors influencing their perceptions of involvement in SDM.

Example questions: "Describe your level of involvement, either being high or low, in decision-making about your blood pressure treatment and/or management. Why do you give yourself this rating?"

Patient-Clinician Communication

This domain aimed to uncover the factors that might discourage Black men from engaging in certain conversations with their healthcare providers. This domain provided insights into potential barriers hindering effective communication.

Example Question: "What might influence Black men to avoid conversations with their health care provider?"

Empowerment

Lastly, participants were asked to discuss what empowered them to initiate discussions about their blood pressure treatment with their healthcare clinicians during the clinical encounter. They were asked to identify the factors or circumstances facilitating their empowerment to discuss blood pressure treatment with their clinicians.

Example Question: "Describe what empowers you to discuss your blood pressure treatment with your healthcare provider?"

Quantitative Instrument: 100-item Survey Using Validated Measures

Findings from thematic analyses (i.e., patient, clinician, and relationship factors that influence involvement in SDM) informed the variables tested in an online cross-sectional questionnaire to examine their relationship with decision-making involvement in HTN care among a different sample of Black men living with HTN in the mid-south region ($n=105$). This survey assessed patient and clinician demographics, behavioral involvement in the SDM process (Autonomy Preference Index [API]; Ende et al., 1989), mistrust of healthcare organizations, (Medical Mistrust Index [MMI]; LaVeist et al., 2009), trust in their clinician (Trust in Physician Scale [TPS]; Anderson & Dedrick, 1990), autonomy support from their clinician (Health Care Climate Questionnaire; Williams et al., 1998), and therapeutic working alliance (Working Alliance Inventory-General Practice [WAI-GP]; Sturgis et al., 2018).

Demographic and Patient Characteristics

The online survey (**Appendix D**) included a self-report questionnaire that queried participants' demographic data, including race and ethnicity, age, education level, annual household income, and relationship/partnership status. Additional participant characteristics data were collected, including health insurance status, self-rated health, tobacco and alcohol consumption, health management strategies (i.e., stress reduction), age of HTN onset, and number of antihypertensive medications.

Independent Variables

MMI

The MMI (LaVeist et al., 2009) is a 7-item measure that assesses a respondent's interpersonal mistrust in healthcare organizations. Sample items are: "Health care organizations have sometimes done harmful experiments on their patients without their knowledge, and "Sometimes I wonder if healthcare organizations really know what they are doing." The four-point Likert scale ranges from 1 (strongly disagree) to 4 (strongly agree). The Medical Mistrust Index has reported a Cronbach's alpha of 0.76 (LaVeist et al., 2009).

TPS

The TPS (Anderson & Dedrick, 1990) is an 11-item self-report tool designed to measure a respondent's trust in their physician. Sample items include "I trust my doctor so much I always try to follow his/her advice," "If my doctor tells me something is so, then it must be true," and "I trust my doctor's judgments about my medical care.." The five-point Likert scale ranges from 1 (strongly disagree) to 5 (strongly agree). The scale has a reported Cronbach alpha greater than 0.85.

Autonomy Support

Health Care Climate Questionnaire

The Health Care Climate Questionnaire (Williams et al., 1998) is a 6-item self-report survey that assesses a respondent's opinion of the degree to which their physician or team of health care clinicians is supportive of their autonomy: Sample items include: "My doctor listens to how I would like to do things.", and "My doctor conveys confidence in my ability to make changes." The seven-point Likert scale ranges from 1 (strongly disagree) to 7 (strongly agree). The reported Cronbach alpha for the scale is 0.90.

WAI-GP

The WAI-GP was used to measure the degree to which Black men in the study perceived the therapeutic working alliance in interactions with their clinicians for HTN treatment and management. The WAI-GP was adapted and validated in clinical settings (i.e., primary care) to measure the therapeutic working alliance in the clinician-patient relationship. The scale consists of 12 items that ask patients to rate their disagreement (i.e., 1= Strongly Disagree) or agreement (i.e., 5= strongly agree) with statements about their interactions with their primary care clinicians (i.e., Even though I may do things that my health care provider does not advise or suggest, I know they still care about me. The scale has a reported Cronbach alpha of 0.94.

Dependent Variable: Autonomy Preference Index

The Autonomy-Preference-Index (Ende, 1989) is a 23-item, self-report tool that assesses a respondent's preferences for information and involvement in medical decision-making. Response options range from 0 ("strongly disagree") to 4 ("strongly agree"). The questionnaire is divided into two subscales, the Information-Sharing Subscale (8 items) and the Decision-Making Subscale (15 items). For the decision-making subscale, six questions examine involvement in general decision-making, while the other nine pertain to specific medical scenarios. Both subscales have an internal consistency of 0.82, and their test-retest reliability is 0.84 for the preference for decision-making involvement and 0.83 for the preference for information.

Data Analysis

Qualitative and quantitative analytic procedures were conducted to answer three primary research questions. Data analyses began with thematic analyses of transcripts from semi-structured interviews to address research question one. The qualitative analysis was completed first to better understand patient, clinician, and relationship factors that may influence SDM involvement among Black men with HTN were operationalized into key concepts and testable variables that were examined further in the quantitative phase to answer research question two. To address research question three, the results from both the qualitative and quantitative subsamples were examined for the convergence and divergence of factors related to SDM involvement. The data analysis procedures are detailed in Chapter 3.

Assumptions

For the purposes of this study, it was assumed that all participants meet certain criteria: they have been diagnosed with HTN by a qualified medical professional, are at least 18 years old, possess a full comprehension of the consent process and study procedures, and provide honest responses to pre-screening eligibility questions. Furthermore, it is assumed that respondents answer survey questions truthfully and understand the questions asked.

Credibility and Validity

To assess trustworthiness, credibility, and reliability were considered (Creswell, 2015). Credibility was addressed by selecting a heterogeneous sample of Black men with HTN in the U.S. Mid-South. During interviews, intensive listening, careful probing for rich data, audio recording for transcription, and accuracy checks were employed through data collection. Respondent validation or member checking was conducted during interviews to ensure clarity of intended meanings. A pilot test involved a subset of participants five Black men with HTN who met study inclusion criteria to validate the appropriateness, accuracy, and consistency of selected SDM constructs and measures. Feedback on research procedures and instrument appropriateness was addressed before full-scale implementation. Internal consistency was statistically quantified using Cronbach's alpha (0.7-0.9). Experts in patient-clinician health communication, SDM, and HTN treatment on the research team reviewed all instruments (i.e., questionnaire and interview guide) before use. SDM constructs were consistently operationalized in qualitative and quantitative data collection to mitigate internal validity threats. Questionnaires and interview guides were aligned with the conceptual model, prior research, and themes from interviews with Black men with HTN. SDM measures were selected based on psychometric properties and close alignment with study concepts.

Limitations

This research study used self-administered online questionnaires. Self-reports are valuable in socio-behavioral investigations, but they have limitations related to response bias, including social desirability bias (Yeom & Lee, 2022). Participation is voluntary, so views of Black men uncomfortable discussing their health condition or interactions with a clinician are not included. The sample for this study lacked diversity in education level as most men attained a higher level of education and were married. Findings from the qualitative phase may be transferable to Black men with HTN in other geographic contexts and other health conditions that require management and SDM. A mixed methods study is conducted to enhance the reliability and validity of the study findings. Collecting varied types of information (i.e., qualitative and quantitative) about SDM in Black men with HTN through two instruments (i.e., semi-structured in-depth interview guide and a multi-scale questionnaire) enhances the study's dependability.

Summary

This study aimed to investigate SDM among Black men with HTN, focusing on identifying the factors influencing their participation in the SDM process for HTN treatment and management. Specifically, a mixed methods approach was employed, gathering both qualitative and quantitative data to address the following research questions: 1. What are the SDM preferences of adult Black men diagnosed with HTN and residing in the U.S. Mid-South region? (Qualitative research question); 2. What factors predict the level of involvement in SDM regarding HTN treatment and management among adult Black men with HTN? (Quantitative research question); and 3. How do the themes related to SDM involvement, as identified through qualitative interviews (RQ1), correlate with the predicted factors influencing SDM involvement in HTN treatment and management measured through a survey (RQ2) among adult Black men with HTN? (MMR question). The findings from this research inform patient-related and clinician factors that shape the optimal SDM environment for Black men to engage in the SDM process for HTN treatment and management among Black men in the U.S. Mid-South.

CHAPTER 2. REVIEW OF LITERATURE

Standard Guidelines for HTN Treatment and Management

HTN is the leading cause of cardiovascular disease and mortality, disproportionately impacting Black adults in the United States (CDC, 2020; Ogunniyi et al., 2021). HTN in Black adults in the United States has an earlier onset, higher prevalence, and increased severity than other racial/ethnic populations (Ferdinand et al., 2023; Thomas et al., 2018). Consequently, Black adults continue to face a higher cardiovascular disease and mortality burden, including stroke, premature cardiovascular death, and shorter life expectancy (Ferdinand, 2022; Kibria et al., 2023; Nambiar et al., 2020).

Elevated cardiovascular disease rates in the southern region of the United States can be attributed to a combination of limited healthcare access (Churchwell et al., 2020), suboptimal risk control (Hayes et al., 2022), and the lasting effects of historical structural racism that have disproportionately impacted the health outcomes of Black individuals and other marginalized groups (Brondolo et al., 2011; Dolezsar et al., 2014; Ferdinand, 2022; Javed et al., 2022). SDM has proven to be beneficial in addressing health disparities for chronic health conditions among Black adult patients, including diabetes (Peek et al., 2013), chronic kidney disease (Komatsu, 2023), and asthma (George et al., 2020). When patients are knowledgeable about their health and actively participate in decision-making, they are more likely to adhere to lifestyle changes and medications (Cao et al., 2023; Ferdinand, 2022), understand treatment and risk benefits (Galletta et al., 2022), make choices that align with their preferences and values (Montori et al., 2023), and aid in fostering trusting patient-clinician relationships (Whitney et al., 2021). Unfortunately, Black patients often lack trust in healthcare due to past mistreatment and racism in medical care and research, which is a barrier to engaging in the SDM process (Ferdinand, 2022; Peek et al., 2011). Recently, researchers have examined SDM among Black patients (Mhaimed et al., 2023) in different disease contexts (i.e., chronic kidney disease (Frazier et al., 2022) and HTN (Chang et al., 2021) and diabetes (Zisman-Ilani et al., 2023), suggesting a shift in a positive direction in focusing research efforts in understanding shared decision making with a focus on Black adult populations. For example, researchers have examined SDM in older adults with advanced chronic kidney disease faced with the decision to initiate dialysis; participants did not engage in SDM despite existing guidelines to incorporate an SDM approach into treatment (Frazier et al., 2022).

Still, empirical studies reporting on factors significant to Black men's involvement in the SDM process across different care contexts (i.e., HTN) remain limited compared to other diseases (i.e., prostate cancer and HIV). A recent study examining engagement in SDM for prostate cancer screening found that Black men were less likely to report having discussions or being given options by their clinicians regarding prostate cancer screenings compared to non-Hispanic White men in the study (Miller et al., 2023). In the context of HTN, researchers discovered that racial and ethnic minority groups

consistently reported poorer experiences with treatment decision involvement and medication information for HTN treatment compared to non-Hispanic whites in the same clinic setting (Chung et al., 2020). SDM engagement among Black patients is limited in understanding, particularly, factors that are salient to engage their Black patients in the decision-making process across contexts (Zisman-Ilani et al., 2023). SDM scholars agree that is essential to elicit essential patient's individual preferences for engaging in SDM (Elwyn et al., 2017; Peek et al., 2016) to determine if SDM was achieved in the clinical encounter. Authors report that clinicians often underestimate their patient's desire to be engaged in decision-making discussions across different contexts (Joseph-Williams et al., 2014; Say et al., 2006), suggesting the critical need to understand factors that are relevant to SDM engagement, especially among patients who can benefit from it, such as those belonging to vulnerable populations.

Antihypertensive Medications

A critical aspect of HTN management involves selecting effective antihypertensive medications. Multiple medication options exist, offering varying benefits and consequences for patients (Al-Makki et al., 2022). Medication options encompass fixed-dose combinations, monotherapy, and lifestyle modification interventions (Lu et al., 2022; Solomons et al., 2020). Researchers have examined the efficacy, safety profiles, and impact on quality of life associated with different medication choices. Understanding the range of treatment modalities available empowers clinicians to tailor treatment plans to individual patient needs and preferences. Controlling blood pressure remains a persistent challenge with a greater impact on Black men due to challenges with uncontrolled blood pressure in this population (Muntner et al., 2020; Ogunniyet al., 2021). To effectively engage Black male patients in the management of their blood pressure between visits, it is crucial to enhance the availability of approaches that enable patients to choose treatment alternatives that are most compatible with their lifestyle and preferences, thereby empowering them to adhere to the prescribed regimen and overcome barriers to treatment (Gu et al., 2017).

HTN Among Black Individuals in the United States

HTN, or high blood pressure, involves consistently elevated pressure in the blood vessels, straining the heart's pumping ability (CDC, 2021; World Health Organization [WHO], 2023). Clinically, it is defined as a reading of $\geq 130/80$ mm Hg in U.S. adults (CDC, 2023) and stands as a significant preventable contributor to cardiovascular disease and premature death worldwide (CDC, 2023; Mills et al., 2020). Often referred to as the "silent killer," HTN is usually symptomless, especially in its early stages (American Heart Association, 2023). Notably, Black adults face a disproportionate burden, experiencing higher prevalence than other racial and ethnic groups (WHO, 2023; CDC, 2021). Black adults also tend to develop HTN earlier and face elevated risks, including a greater likelihood of fatal stroke, cardiovascular mortality, and end-stage renal disease (Hardy et al., 2021). Disparities in managing HTN persist, particularly among Black

adults who exhibit a 10% lower blood pressure control rate than non-Hispanic Whites (Abrahamowicz et al., 2023). Barriers to effective management are multifaceted and encompass limited access to healthcare (Gu et al., 2017), inadequate availability of healthy foods (Sacks et al., 2001; Te Vazquez et al., 2021), and psychosocial stressors such as experiences of racism and discrimination (Brondolo et al., 2011; Dolezsar et al., 2014; Lee et al., 2019). Although lower socioeconomic status (SES) is generally linked to poorer blood pressure control, this relationship is not consistent among Black adults. Even those with higher income and education can exhibit a high prevalence of HTN (Glover et al., 2020; James, 1994), revealing the intricate role of non-clinical factors that contribute to ineffective HTN treatment and management.

HTN is a pressing health concern in the southern region of the United States. The prevalence of HTN in the South is notably higher compared to other regions (Kershaw et al., 2010). This elevated prevalence contributes to a higher burden of cardiovascular diseases and related complications, placing individuals in the South at increased risk for heart attacks, strokes, and other health complications. The South is marked by substantial socioeconomic disparities that are crucial to HTN's prevalence and impact. Factors such as lower income levels, limited access to healthcare services, and unequal distribution of resources contribute to higher rates of HTN among populations in the South (Sampson et al., 2014). Socioeconomic challenges exacerbate barriers to proper blood pressure management, increasing regional health disparities.

The legacy of racial segregation in the South has contributed to systemic barriers to access to quality health care (Braveman et al., 2022). Williams (2022), who investigated Black adults living in racially segregated neighborhoods, found that participants were more likely to develop high blood pressure than their nonsegregated counterparts. The chronic stress from living in a segregated neighborhood with limited access to services, education, and economic opportunities increases the risk of HTN (Williams, 2022). Cultural and lifestyle factors unique to the South, such as dietary habits that include high consumption of salty and fried foods and higher rates of obesity, are prevalent in the region and contribute to HTN risk (Akpa et al., 2020). One study reported findings that a southern dietary pattern significantly mediates HTN incidence, accounting for 51.6% of Black men's excess risk (Howard et al., 2018). The prevalence of HTN in the southern region of the United States is notably higher, contributing to an increased burden of cardiovascular diseases and complications. Socioeconomic disparities, a legacy of racial segregation, and unique cultural and lifestyle factors all drive these regional health disparities. In conclusion, addressing these multifaceted challenges is crucial to improving HTN management and reducing the health inequalities individuals in the South face.

HTN Treatment and Management Challenges

For Black individuals, HTN management extends beyond clinical settings, including biophysical, psychosocial, and social factors, thus making antihypertensive treatment and management in Black patients more complex (Bell et al., 2010; Gabriel et

al., 2020; Schoenthaler et al., 2019). Specifically, social support, experiences with racism, provider mistrust, provider communication barriers, attitudes, and health beliefs all affect treatment outcomes for Black patients (Benjamin et al., 2019; Ha et al., 2018; Lewis, 2012; Whelton et al., 2018). These factors contribute to a heightened vulnerability among Black patients to suboptimal blood pressure control.

Poor Blood Pressure Control and Medication Non-Adherence

Poor blood pressure control can be attributed to multiple patient and clinician factors. Regarding Black patients, it is cited that HTN non-adherence, distrust of the healthcare system, beliefs about medications, and HTN play a significant role (Saeed et al., 2020). There are disparities that exist in antihypertensive medication use among Black patients and other racial groups (Saeed et al., 2020). There has been an upward trend in using preferred treatments like diuretics and calcium channel blockers among Black patients in recent years (Saeed et al., 2020). However, using multiple antihypertensive medications among this population poses a risk to medication adherence. Studies show associations among patients' trust in their provider and their adherence, healthcare utilization, and quality of communication with their provider (Jacobs et al., 2006). Clinician trust has been found to be more important than treatment satisfaction in predicting adherence to recommendations and overall satisfaction with care (Piette et al., 2005). Trust in clinicians is also associated with accepting new medications, intending to follow clinicians' advice, perceiving care effectiveness, and reporting improved health status (Piette et al., 2005). Patients who trust their clinicians are more likely to value their prescription drugs and maintain adherence, especially when costs are manageable (Piette et al., 2005).

Medication Side Effects

Antihypertensive medications cause serious side effects that affect sexual functioning (Bager et al., 2023; Nicolai et al., 2014). This study is limited to discussing only those that affect male sexual dysfunction for those males who identify as cisgender. Many different types of antihypertensive medications, mainly older-generation beta blockers and diuretics, negatively affect sexual functioning and decrease medication adherence. This becomes particularly problematic for those men with HTN (Bager et al., 2018; Nicolai et al., 2014). When compared to individuals whose quality of life is unaffected, patients with HTN who experience side effects are more likely to not adhere to treatment and have a higher rate of discontinuing the medication (Hamrahan et al., 2022; Manolis & Doumas, 2012; Nicolai et al., 2014). Sexual dysfunction is a broad concept encompassing erectile dysfunction (ED), which is a common side effect in males who take antihypertensive medications (Lou et al., 2023; Tsoutsos & Kotsis, 2023). The exact mechanism is not precise and contributes to providers not counseling their patients about this serious side effect (Chrysant, 2015; Steinke et al., 2013). Lack of discussion and understanding about these side effects in men may contribute to medication nonadherence.

Treatment-Induced Sexual Dysfunction and Corollary Factors

It is essential to understand the complexity of identifying the primary and secondary factors that impact erectile functioning, especially in men with HTN. There can be many factors that complicate treatment, including providers not being aware of the sexual side effects of blood pressure medications. Since penile erection is mostly a hemodynamic process, anything that affects the vascular space may contribute to multiple underlying factors that may interfere with the process of erection (Nicolai et al., 2014). Specifically, for men with HTN, the most apparent cause is a weakened vascular system, and ED being a side effect of most medications used to treat high blood pressure.

In men treated for HTN, the combined effect of a weakened vascular system and side effects of most antihypertensive medications require a holistic approach, thus a biopsychosocial approach to therapy. Before laying out the different treatment options for treating ED, it is vital to note that ED has implications for self-esteem, relationship problems, and overall quality of life (Metz & McCarthy, 2004). Before an intervention to treat ED is recommended, it is essential to comprehensively assess and identify the primary and related causes of poor erectile function. Several factors can be found. Etiological factors may be related to hormonal, neurological, behavioral, and cardiovascular changes (Chen et al., 2019). A thorough health history, physical examination, and blood testing will be made to help specify the root cause of ED (Dhaliwal & Gupta, 2023). For vascular causes, phosphodiesterase inhibitors can help correct ED. It may be administered as a diagnostic approach to determine if the vascular system is adequate (Dhaliwal & Gupta, 2023) If the medication is ineffective, the patient may be referred to a urologist for evaluation to differentiate between physical and psychological ED (Dhaliwal & Gupta, 2023) Specifically, they may administer injection testing and ultrasound of the penis to examine its vascular system (Dhaliwal & Gupta, 2023). In men with HTN, medical treatment may be further complicated due to the potent effects of combining medications to treat both ED and HTN. For example, individuals using PDE-5 inhibitors need to be aware that these medications can cause death if taken with anti-hypertensive drugs such as alpha-blockers and nitrates (Dhaliwal & Gupta, 2023). These medications have a potent effect on lowering blood pressure and can cause a heart attack (Dhaliwal & Gupta, 2023). A biopsychical approach to treatment, involving the appropriate referral to a sexual therapist can help with coping strategies to help foster intimacy with partners. It is imperative to note that the patient will need therapy in combination with any other treatment to be effective.

SDM can be beneficial to help Black men with understanding the different treatment options related to ED and to help establish realistic goals for treatment that does not interfere with HTN treatment. Specifically, SDM can help with the communication process between patients and providers. It will allow men to discuss any concerns with treatments, set mutual goals, and create the opportunity to make the appropriate referrals. Providers' lack of awareness and knowledge about the side-effects of antihypertensive medication and its impact on sexual function could limit patients from communicating about the issue. It may be challenging to have these conversations due to its sensitive nature and, for men, may be viewed as a sign of weakness. Healthcare

clinicians, specifically general practitioners and cardiologists must be willing to talk with patients about their sexual health, but studies report that these conversations are not happening with patients (Nicolai et al., 2014).

Sociocultural and Historical Experiences of Black Adult Men with the U.S. Healthcare System

Racism's deep integration into the U.S. healthcare system has sustained healthcare inequalities and fostered mistrust among Black male patients. The infamous Tuskegee experiment serves as a glaring example, where Black men were deceived into a study that withheld treatment for syphilis (Wells & Gowda, 2020). Historic policies of segregation and discrimination perpetuated disparities in education, income, and health, reinforcing health inequities for Black individuals (Williams & Mohammed, 2013). This legacy persists, and this is evident in income gaps, life expectancies, and insurance rates (Bailey et al., 2017).

Systemic racism also influences the healthcare workforce's diversity, impacting patient-provider relationships. The underrepresentation of Black physicians contributes to cultural barriers during interactions with Black patients (Snyder et al., 2023; Hoffman et al., 2016) due to cultural differences, discordant race relationships between patients and healthcare providers hinder effective communication. The lack of race-concordant relationships exacerbates communication barriers. Black male patients often face difficulties communicating with healthcare providers, and their reliance on emergency departments exacerbates the issue (Stewart et al., 2019; Brown et al., 2012). Uninsured or underinsured status, geographical constraints, and a shortage of qualified health professionals compound the problem (Snyder et al., 2023).

Healthcare providers must recognize the sociohistorical factors that shape Black male patients' attitudes toward the patient-provider relationship. Addressing communication barriers requires cultural competence. Acknowledging mistrust, providers should approach interactions sensitively and avoid phrases that evoke doubt. SDM is crucial to fostering trust and collaboration. Implementing SDM entails acknowledging biases, learning patients' preferences, and providing information tailored to their needs.

Understanding the sociohistorical context of racism is pivotal for healthcare providers aiming to bridge gaps in patient-provider relationships with Black male patients. Addressing communication barriers through cultural competence and embracing SDM can help build trust and improve healthcare experiences for this marginalized population. Mueller et al. (2015) used the ecological model to identify complex barriers to poor HTN control in Black patients at multiple levels, including individual patients (poor adherence to self-management behaviors), *family* (social support; family dynamics), *provider* (quality of communication, trustworthiness), *healthcare system* (access and use of care), and *local community* (*neighborhood-level* poverty and racism). Evidence-based care for Black hypertensive patients requires collaboration across

multiple levels, including patients, families, providers, healthcare systems, and communities (Odedosu et al., 2012).

Intrapersonal Factors and Interpersonal Factors

Historical experiences of medical mistreatment and systemic racism contribute to a heightened sense of mistrust among Black men. This mistrust can lead to skepticism about healthcare recommendations, delayed care-seeking, and reluctance to perform regular health screenings (Cheatham et al., 2008; Hewins-Maroney et al., 2005; Powell et al., 2019). Experiences with racism, discrimination, and socioeconomic disparities create psychosocial stress and contribute to chronic stress for Black men, which can directly affect their physical and mental health (Hoskin, 2022; Motley & Banks, 2018;). High stress levels can exacerbate HTN and other health conditions, making effective management more challenging (American Heart Association, 2021; Barnes et al., 1997; Williams et al., 2018). Cultural beliefs and norms within the Black community may influence how Black men perceive and respond to health issues. For example, traditional masculinity norms may discourage men from seeking medical care or expressing vulnerability, impacting their healthcare-seeking behavior (Hammond, 2010).

Interpersonal factors include social support from family and friends. Social support from family, friends, and romantic partners can significantly impact Black men's healthcare interactions (Woodward et al., 2011). Support can encourage healthy behaviors and adherence to treatment plans, while negative or unsupportive social networks may discourage healthcare engagement (Bell et al., 2010). A study found that higher levels of family support and feelings of belongingness were associated with lower odds of HTN (Tomaka et al., 2006). Social support also moderated the relationship between race and HTN, with Black-White disparities greater among those with less support (Bell et al., 2010).

These intrapersonal and interpersonal factors collectively shape the healthcare experiences of Black men within the U.S. healthcare system. Addressing these factors, such as building trust, fostering culturally competent care, and promoting supportive social networks, is essential to improving healthcare access, engagement, and outcomes for Black men, particularly in the context of HTN management.

Patient-Clinician Relationship and Communication

The quality of the patient-clinician relationship plays a crucial role in healthcare interactions. Black men who have experienced past instances of perceived discrimination or poor communication with healthcare providers may approach future interactions with caution or reluctance. Effective communication with clinicians is essential for SDM and treatment adherence. However, differences in communication styles and potential biases held by healthcare professionals can create barriers to clear and open dialogue, impacting the quality of care received. These intrapersonal and interpersonal factors collectively

shape the healthcare experiences of Black men within the U.S. healthcare system. Addressing these factors, such as building trust, fostering culturally competent care, and promoting supportive social networks, is essential to improving healthcare access, engagement, and outcomes for Black men, particularly in the context of HTN management.

To increase adherence among Black adults with HTN, patient-clinician interaction and involvement in SDM are critical indicators of optimal antihypertensive medication adherence (Chang et al., 2021). Specifically, it empowers patients to take an active role in their care and ownership of patient-centered management plans to practice self-management (Bosworth et al., 2010). Disparities in patient-provider communication exist, with physicians being more verbally dominant and less participatory with Black patients, leading to shorter visits and fewer biomedical, psychosocial, and rapport-building statements (Cené et al., 2009; Johnson et al., 2004). HTN guidelines recommend that providers discuss medication side effects before starting therapy (Al Khaja et al., 2016). Providers' lack of awareness and knowledge about the side effects of antihypertensive medication and its impact on sexual function could limit patients from communicating about the issue. One study reported that neither general practice physicians nor cardiologists routinely discuss medication-induced sexual dysfunction (La Torre et al., 2015). Notably, health for men encompasses sexual health, which should be addressed. More than 65% of hypertensive men with Erectile Dysfunction are undiagnosed even though they wish they had treatment (Chun & Carson, 2001; Giuliano et al., 2004; Nicolai et al., 2014). Explanations for the lack of provider's attention toward sexual health are unclear; studies say that it may be due to a lack of responsibility, lack of time, lack of training, and lack of experience regarding the communication and treatment of sexual dysfunction (Nicolai et al., 2014). The overall lack of attention creates a neglected issue for these men. If providers are not having a conversation about the impact on sexual function before initiating treatment, chances of nonadherence increase. As such, few attempts have been made to investigate the provider's role in addressing this issue.

Patients with HTN are likely to have positive outcomes when they have consistent interactions with the same healthcare providers (CDC, 2010; Ha et al., 2018). This factor is critical regarding medication adherence. Unfortunately, Black patients are less likely to routinely see the same healthcare provider (CDC, 2010). Clinicians must be culturally competent and aware of their own biases when treating these patients, as this can present a communication barrier between the patients. Another study addressed this issue with an intervention to screen HTN in a barbershop. Barber-based care is a growing type of intervention that addresses HTN in Black males studied in public health. Men in this study were more receptive to receiving information about their blood pressure from their barber because they trusted them, received social support, and enjoyed peer-to-peer interaction (CDC, 2010; Williams et al., 2008). Another growing trend in addressing blood pressure in Black individuals is with faith-based communities (Chan et al., 2023; Ferdinand et al., 2020). Research methods to address medication adherence in Black men must be willing to integrate into their community to get positive results.

Clinician-Related Factors Contributing to Poor Blood Pressure Control

Achieving optimal blood pressure control is paramount to preventing various cardiovascular diseases. Clinicians may exhibit biases, clinical and cultural uncertainty, personal beliefs, and stereotypes when treating minority patients, leading to disparities in the quality of care and clinical inertia (Hall et al., 2015; Oliver et al., 2014). Clinical inertia refers to the failure of clinicians to initiate or intensify antihypertensive therapy when blood pressure goals are not met (Oliver et al., 2014). It has been identified as a significant factor contributing to inadequate blood pressure treatment and control rates (Oliver et al., 2014). According to an analysis by Bellows et al. (2019), among various interventions to achieve blood pressure control, medication intensification was found to be the most impactful. Medication intensification has been identified as a key intervention to improve blood pressure control; however, Black patients may not receive the full benefit due to underlying sociocultural factors (Sulaica et al., 2020) including biases about patients' ability to adhere to treatment (Shawahna et al., 2021)

Theory of SDM

Before the 1980s, paternalism was the prevailing health decision-making approach in U.S. healthcare systems, wherein physicians held dominant roles in making treatment decisions (Gallagher, 1998). Several assumptions contributed to this model, including the belief that most diseases had a single optimal treatment, that doctors possessed up-to-date clinical knowledge, and that they applied this knowledge when making decisions for their patients (Gallagher, 1998). Furthermore, it was assumed that doctors were best equipped to weigh the benefits and drawbacks of different treatments and select the most appropriate course of action (Gallagher, 1998). These assumptions led to the expectation that doctors would play a significant role in treatment decisions, resulting in power imbalances during medical encounters, influenced by patient-doctor status differences in gender, wealth, and education (Gallagher, 1998). Studies revealed significant differences in treatment patterns, suggesting that some doctors were either unaware of best practices for specific conditions or chose not to follow recommended guidelines (Gallagher, 1998). SDM emerged as a response to this shift from paternalism (Charles et al., 1997). It recognized that patients had a stake in their treatment choices and should be active participants in decision-making. As a result, SDM models sought to empower patients, acknowledge their preferences, and involve them collaboratively in healthcare decisions alongside their physicians (Charles et al., 1997; Montori et al., 2017). This concept has garnered significant attention, especially in the context of managing chronic conditions like HTN (Hamann et al., 2007; Langford et al., 2019). For example, studies have investigated patient preferences for participating in healthcare decisions and the potential impact of SDM on health outcomes. One approach involves exploring patient preferences for their level of involvement in healthcare decisions. However, it is important to note that findings from these studies indicate a need for more consistency in how scholars measure preferences for SDM. For instance, Hamann et al. (2007) discovered that age, gender, and education significantly influence preferences for involvement in SDM. In contrast, Hart et al. (2009) conducted a study among Black men

recruited from barbershops, revealing that these men preferred collaborative or active roles in health decision-making. This discrepancy highlights the need for researchers to provide clear conceptual definitions of SDM preferences when conducting studies on this topic.

SDM, if used in the clinical encounter, can empower patients to participate in deciding treatment options that fit closely with their lifestyle while self-managing their chronic illnesses (Charles et al., 1997; Peek et al., 2016). A clinical encounter that successfully uses SDM is one in which both the patient and health care clinician share information and deliberate about the benefits and consequences of treatment (Charles et al., 1997; Elwyn et al., 2023). The patient and provider mutually decide on selecting and implementing a treatment.

SDM in a Clinical Context

SDM is a collaborative approach that involves healthcare providers and patients jointly making decisions based on the best available evidence and patient preferences (Charles et al., 1997). In HTN care for Black patients, SDM can serve as a crucial tool to address clinician inertia and poor adherence. By actively involving patients in decision-making, SDM enables a deeper understanding of their preferences, beliefs, and concerns regarding medications and HTN management. This approach facilitates the exploration of individualized treatment options, thereby promoting patient empowerment and concordance in decision-making.

Various models have been developed to explain the SDM process (Elwyn et al., 2012; Makoul & Clayman, 2006; Peek et al., 2016). Additionally, there are several instruments used in research and clinical practice to measure SDM (Gagnon et al., 2006; Kriston et al., 2010; Scholl et al., 2011). While these models may differ, scholars generally agree on the central components of SDM, which include information-sharing, deliberation about decisions, and the actual decision itself. For this research, Peek's model was utilized as it extends previous models by considering the intersectional aspects of social identities, such as race and age, to determine the factors necessary for engaging minority patients in each aspect of the SDM process with their clinicians (Peek et al., 2016). Importantly, this model highlights the significance of patients' decision-making preferences as essential factors contributing to their engagement in the SDM process for treatment decisions.

Challenges of SDM

SDM has emerged as a relatively new interest in the context of HTN care (Lu et al., 2022; Turkson-Ocran et al., 2021). However, there are still knowledge gaps regarding its implementation and how to measure its impact on HTN health outcomes effectively (Ahmad et al., 2020). One critical aspect that necessitates additional well-designed studies is gaining a deeper understanding of individual decision-making preferences

among patients (Bailo et al., 2019). It is essential for clinicians to refrain from making assumptions about patients' suitability for SDM based solely on their sociodemographic characteristics or the clinical situation (Légaré et al., 2008).

The preference for patient engagement in medical decision-making varies among individuals, subgroups, and types of decisions (Ruhnke et al., 2020). While patients generally desire to receive information (Deber et al., 1996), they may prefer to delegate decision-making to clinicians (Ruhnke et al., 2020). Patient preferences for engagement in decisions can differ based on both technical aspects of the decision and subjective factors related to the outcomes (Deber et al., 1996; Frosch & Kaplan, 1999) and their individual preferences for engaging in decision-making (Elwyn et al., 2017; Ruhnke et al., 2020). Preferences for patient engagement can be influenced by both the technical components of the decision and subjective considerations regarding the outcomes.

Studies focused on HTN have recommended involving patients in SDM to overcome barriers to blood pressure control (Harmon et al., 2006; Osterberg & Blaschke, 2005). Engaging patients in the decision-making process allows healthcare clinicians to identify and address factors that may hinder optimal blood pressure management, such as medication adherence and lifestyle changes (Harmon et al., 2006). However, despite these recommendations, research on the implementation of SDM in routine clinical practice specifically among Black patients with HTN remains relatively limited (Mhaimed et al., 2023).

One aspect that deserves attention is the lack of knowledge on how to engage Black patients in SDM effectively. Clinicians are tasked with determining which patients to involve in SDM, but they may lack the necessary tools or training to do so. Consequently, clinicians may overestimate or underestimate the desired level of SDM among patients, which can vary significantly from one individual to another. It is important to acknowledge that multiple factors, including sociocultural influences, can impact patients' preferences for SDM (Perez Jolles et al., 2019). Therefore, assuming that patients with the same diagnosis, such as HTN, all desire the same level of involvement in treatment decisions based on shared social identities (i.e., race, gender, age) would be inaccurate.

Barriers to implementing SDM in HTN care include the lack of consistent evidence regarding its clinical effectiveness on health outcomes, patient-level factors, and conceptual challenges (Perez Jolles et al., 2019). The absence of standardized guidelines further complicates the implementation process.

While recommendations for SDM in HTN care exist, research on its implementation in routine clinical practice among Black patients is limited. Clinicians may face challenges in effectively engaging patients in SDM, and it is crucial to consider individual patient preferences rather than making assumptions based on shared social identities. Barriers to implementation include the lack of consistent evidence, patient-level factors, conceptual challenges, and the absence of standardized guidelines.

SDM Among Black Adult Patients with Chronic Conditions

Patients with chronic illnesses benefit from actively selecting treatment options that align with their preferences, values, and lifestyles (Montori et al., 2006). A patient's participation in their medical decision-making is facilitated by a positive patient-provider relationship (Deniz et al., 2021). For patients with HTN, particularly Black men, patient-centered relationships with members of their healthcare teams are crucial to effective HTN management adherence (Martin et al., 2013; Schoenthaler et al., 2009). Patients' active participation in their treatment regimen allows them to express their concerns, lifestyle, and priorities to their healthcare provider, enhancing their likelihood of adherence (Heisler, 2008). HTN is often a silent condition with no noticeable symptoms. By actively monitoring their blood pressure and participating in regular check-ups, Black men can detect HTN early and take preventative measures to avoid complications. (Cao et al., 2023; Chang et al., 2021). Achieving and maintaining control requires an ongoing relationship to monitor treatment effects. A successful patient-clinician relationship consists of emotional and informational aspects, as described by Di Blasi and colleagues (Blasi et al., 2001). Mutual trust, empathy, respect, sincerity, acceptance, and warmth are all components of emotional care (Kelley et al., 2014). Information collecting, medical information sharing, patient education, and expectation management are all part of cognitive care (Blasi et al., 2001).

Decision-Making Preferences Among Black Patients

Decision-making preferences vary among Black men. Different social stratifications influence experiences and preferences for SDM, even among members of the same social group (i.e., race, gender, age) (Peek et al., 2016). Considering HTN is a leading cause of stroke chronic kidney disease among Black men, a greater understanding of Black men's preferences for SDM (i.e., information sharing, deliberation about the pros and cons of treatment, decision-making) in the context of blood pressure management is key to engaging them in selecting among treatment options that align with their lifestyle to increase adherence and optimal blood pressure control. However, it is unclear what factors empower Black men to engage in the SDM process with their healthcare clinicians in the clinical setting for HTN treatment and management.

Hart et al. (2009) reported that 50% of Black men in their study preferred a collaborative role relative to an active or passive role in general healthcare decisions with a healthcare provider. Similarly, in another qualitative study of Black men, researchers found that having a trusting relationship with their healthcare provider was the primary reason for choosing a collaborative or shared role in health decisions (Hood et al., 2012). Each study examined SDM preferences among Black men (Hart et al. (2009) and Williams et al. (2008)). Hart et al. examined only the men's preferences for decision-making. Not identifying patient's decision-making preferences limits the full understanding of participants' specific needs for making decisions with their healthcare providers. On the other hand, Williams et al. looked at demographics specific to men's prostate cancer knowledge. These investigators found that men with less knowledge

about the disorder preferred a passive role in medical decision-making, choosing to defer to the physician's medical expertise. In contrast, men in a study by Hood et al. (2012) reported that their providers were their primary source of information about their HTN, and they preferred instances when their physicians took the time to thoroughly explain all options instead of only giving them the option that the clinician recommended (Hood et al., 2012). In a qualitative study of Black men deciding on prostate cancer screenings, researchers found a common theme wherein Black men seek and rely on health advice from informal and familiar sources such as family members and friends (Jones et al., 2010). Also, having a trusting relationship with their healthcare provider was essential in their decision-making process (Jones et al., 2010). This finding is similar to the finding from another study that reported that men relied on getting information from outside sources to help them assume a more active role in decision-making (Hooper et al., 2017). Black men in the study wanted more information from their healthcare clinicians but reported feeling rushed during the medical encounter, and they did not have enough time to make the decision they preferred (Hooper et al., 2017). This finding identifies how patient-provider communication barriers can inhibit SDM for Black men. While studies generally focus on role preferences when discussing SDM preferences, less attention has focused on the underlying factors Black men consider when deciding whether to engage in a SDM encounter.

Summary

SDM preferences among Black men exhibit variability shaped by different social stratifications, including race, gender, and age (Peek et al., 2016). Considering HTN's severe consequences in this demographic, understanding Black men's SDM preferences becomes essential. A nuanced comprehension of preferences for decision-making in the context of blood pressure management is vital to engage Black men in selecting treatment options aligning with their lifestyle, promoting adherence, and optimal blood pressure control. Despite existing research focusing on role preferences in medical decision-making, limited attention has been given to the underlying factors influencing Black men's decisions to engage in SDM encounters. This literature review underscores the gap in knowledge regarding the factors influencing Black men's participation in SDM with healthcare clinicians in the clinical setting for HTN treatment and management. This research aims to address this gap, contributing to a more comprehensive understanding of SDM preferences among Black men with HTN and the factors influencing their engagement in the decision-making process. By comprehensively understanding decision-making preferences and the factors influencing engagement, future research endeavors can contribute to more tailored and effective interventions, ultimately improving HTN outcomes in this demographic.

CHAPTER 3. METHODOLOGY

This exploratory sequential MMR study aimed to identify factors that impact Black adult men's preferences for involvement in the SDM process with their clinician regarding HTN treatment and management decisions. In the initial qualitative phase, individual, semi-structured interviews were conducted with Black adult men with HTN to inform factors influencing involvement in SDM. Subsequently, the quantitative phase involved examining factors in a survey-based study with a separate sample of Black adult men with HTN.

Qualitative and quantitative findings were analyzed to answer three primary research questions:

1. What are the SDM preferences of adult Black men with a HTN diagnosis living in the U.S. Mid-South region? (*Qualitative research question*)
2. What factors predict the level of SDM involvement about HTN treatment and management among adult Black men with HTN? (*Quantitative research question*)
3. How do the themes regarding SDM involvement, identified through qualitative interviews (RQ1), relate to the predicted factors of SDM involvement for HTN treatment and management measured by a survey (RQ2) among adult Black men with HTN? (*MMR question*)

Study Design

Theoretical Approach

The qualitative methodology used in this study is grounded in the theoretical underpinnings of phenomenology (Husserl, 2012) to gain insight into adult Black men's experiences with SDM. Specifically, this study focused on understanding Black men's lived experiences as they communicate with their healthcare clinicians during discussions about HTN treatment and management. The phenomenological approach aimed to uncover interpersonal and intrapersonal factors surrounding Black men's involvement in the SDM process for HTN treatment and to describe the "core essence of their experience" (Starks & Brown Trinidad, 2007, p. 1373). Intrapersonal and interpersonal factors include how participants interpret their social identities within the healthcare setting as Black men, their dynamic relationships with their healthcare clinicians, their perceptions about HTN and blood pressure management, and notably, their thoughts about their roles, compared to their clinician's role in achieving optimal blood pressure control. Through the phenomenological lens, the study sought to understand the experiences that shape Black men's medical encounters which contributes to a deeper understanding of the dynamics of SDM involvement within the HTN context. A phenomenological inquiry was essential to studying Black men with HTN in the southern

region, whose historical and current healthcare experiences are embedded within multilayered factors that may restrict opportunities for honest and open patient-clinician communication, relationships, and SDM.

Methodological Orientation

This study applied an exploratory sequential mixed methods design to investigate the factors influencing Black adult men's preferences for involvement in SDM with healthcare clinicians concerning HTN treatment and management (**Table 3-1**). An exploratory sequential mixed methods approach was chosen for several key reasons. Inconsistent use of the concept of SDM preferences among researchers has been noted in the literature, with variations in conceptual definitions and measurement methods across studies (Kunneman et al., 2019; Scholl et al., 2011). Preferences have been defined as patients' preferred roles in decision-making, encompassing their desire for an active or passive role in healthcare decisions (Sepucha & Scholl, 2014). Preferences have been associated with patients' desires for involvement in decision-making (Ende et al., 1989; Nease & Brooks, 1995) or their preference for a SDM approach in medical decision-making (Peek et al., 2009). There remains limited literature on SDM preferences among Black men, particularly outside of prostate cancer screenings (Fong et al., 2023; Perez Jolles et al., 2019). Creswell and Creswell (2023) emphasized the significance of the exploratory sequential approach, especially when examining concepts or measures related to minority populations. This approach ensures a comprehensive analysis by leveraging the strengths of both qualitative and quantitative methods, as Creswell and Creswell (2023) highlighted.

The initial qualitative phase explored personal and relational factors that impact their engagement in the decision-making process, specifically discussions with clinicians on blood pressure management and treatment strategies, such as when to initiate medications into the treatment plan. Qualitative data were obtained from individual semi-structured interviews. The qualitative findings informed the subsequent quantitative phase, identifying relevant factors through thematic analyses, empirical literature, and Peek et al.'s (2016) SDM process conceptual model constructs (i.e., patient-provider relationship, trust, and decision-making preferences). Selected factors from thematic analyses were operationalized and measured using existing scales and examined in a cross-sectional online survey to gain more generalizable insights into Black adult men's preferences for engaging in SDM for HTN-related decisions (**Table 3-2**). Integrating quantitative and qualitative findings enabled comparisons and inferences, extending, and generalizing the initial qualitative results.

Sample and Setting

The target population for this study was Black adult men with HTN residing in the Mid-South region (Tennessee, Mississippi, and Arkansas) to identify factors that influence their involvement in the SDM process with their healthcare clinician regarding

Table 3-1. Exploratory Sequential Mixed Methods Study Design.¹

Phase	Procedure	Product
Phase 1 (Aim 1): Qualitative data collection	Individual semi-structured interviews with Black men regarding SDM preferences in HTN treatment (<i>n</i> =16)	Transcripts
Qualitative data analysis	Open coding and reflexive thematic analysis	Key themes regarding SDM ¹ preferences
Phase 2: (Aim 2) Qualitative findings inform quantitative survey (Variable selection)	Operationalize testable variables based on QUAL ² themes	Cross-sectional survey measuring variables adapted from existing scales
Phase 3: (Aim 3) Quantitative data collection	Survey of Black men with HTN (<i>n</i> =105)	Demographic data, Survey scale scores
Phase 4: (Aim 3) Integration of Qualitative and Quantitative Results	Interpretation of Qualitative and Quantitative Results	Integrated discussions on how SDM preferences relate to/confirm the predicted factors of SDM

¹Shared Decision-Making Preferences of Black Men with Hypertension in the U.S. Mid-South Region. ²Qualitative.

Table 3-2. Operationalization of Main Study Concepts.

Main study concepts	Qualitative operational definitions ¹	Quantitative operational definitions instrument ²
Patient demographics (age, education)	Qualitative pre-interview participant demographic online form	Quantitative web survey- Patient demographic and characteristics form
Clinician demographics (race, gender)	Qualitative pre-interview participant demographic online form	Quantitative web survey- Patient demographic and characteristics form
Preferences for SDM involvement	<p>12). Describe your level of involvement, either being high or low, in decision making about your blood pressure treatment and/or management. Why do you give yourself this rating?</p> <p>[For participants who describe high involvement]</p> <p>Probe #1: Give me an example when you were proud of yourself for advocating for your treatment preferences.</p> <p>Probe #2: What motivates you to remain involved in your healthcare? How do you deal with barriers when they arise?</p> <p>[For participants who describe low involvement]</p> <p>Probe #1: Describe a time when you wanted to be involved but felt you weren't able to?</p>	API- DM 6 scale scores
Perception of trust and mistrust in the patient-clinician relationship	<p>9). Describe your relationship with Dr... [refer to patient's demographic form for provider's information]</p> <p>11). If you can characterize your relationship with your provider as a football team, would you say that a) you are both on the same team with the same goal, b) your provider is the coach and you are the player, or c) you are on two different teams with two different goals?</p>	<p>MMI-7 scale scores</p> <p>TPS scale scores</p>
Perception of autonomy support received from clinicians	10). How does Dr.... help you control your blood pressure?	HCCQ- 6 scale scores
Perception of therapeutic working alliance in the patient-clinician relationship	<p>10). How does Dr.... help you control your blood pressure?</p> <p>13). How do you ensure that your preferences for blood pressure management, including lifestyle changes and medication, are addressed?</p>	WAI- GP scale scores

¹Key study concepts operationalized through the interview guide questions (**Appendix C**).²Key study concepts operationalized through individual scales included in the quantitative web-survey questions (**Appendix D**). SDM= shared decision-making.

routine HTN care. A combination of purposive and convenience (i.e., snowball sampling) methods was used to recruit participants for the qualitative and quantitative phases of the research study. A purposive sample of Black adult men with HTN living in the US Mid-South region was deliberately recruited for the qualitative research phase to explore the factors influencing their participation in the SDM process for HTN treatment with their healthcare clinicians. A purposeful sampling strategy, as described in the following recruitment section, was the most suitable approach for understanding and addressing the research questions (Creswell & Creswell, 2023). The qualitative sample size was determined when data saturation was reached. No new insights or themes related to the key study concepts emerged while conducting interviews and analyzing interview transcripts throughout the data collection period.

A convenience sampling method was employed to recruit Black men in this study due to its practicality and accessibility given the unique challenges faced with recruiting underrepresented groups (i.e., Black men) into health research. The primary challenges in recruiting Black men into health research stem from historical instances of mistrust and distrust in healthcare and research, most notably the Tuskegee Syphilis Study (Freimuth et al., 2001), which has led to a perception of researchers having exploitative intentions (George et al., 2014). Studies have reported that the guinea pig syndrome, where minorities fear being exploited for the benefit of the researcher (Quinn et al., 2007), is a significant concern, even in observational studies where medication or procedures are not required (Barrett et al., 2017; Jones & Jablonski, 2014; Nguyen et al., 2021). Researchers' inadequate cultural competency is cited as a barrier to recruiting underrepresented groups into research (Graham et al., 2018). By using a convenience sample approach, the goal was to overcome some of these barriers, providing a more accessible and convenient means of participation, which was essential for addressing the study's specific research questions and objectives.

A convenience sampling strategy was applied to recruit the participants in the quantitative study. An *a priori* power analysis was conducted using G*Power version 3.1.9.7 (Faul et al., 2007) for sample size estimation for the sample in the quantitative phase based on data reported in the published literature regarding study variables (i.e., SDM preferences) (Fuertes et al., 2017; Perez Jolles et al., 2019; Yeom & Lee, 2022). Considering a significance level (α) of 0.05, a medium effect size (0.15) based on Cohen (2013), a power of 0.90 ($1-\beta$ error probability), and five predictors, a minimum of 103 participants was determined as the required sample size. To account for potential dropouts and missing values in completed questionnaires, the target recruitment sample size was set at 130. After validating web survey responses, the quantitative sample comprised a convenience sample of ($n=105$) participants who responded to the online survey conducted between December 2022 and April 2023.

The snowball recruitment techniques were effective, with participants from the qualitative interviews referring their peers and family members to the quantitative survey phase. Notably, those who participated in the qualitative interviews did not enroll in the quantitative phase to minimize potential bias, thus facilitating a comprehensive analysis and interpretation of each dataset individually.

Recruitment

Research recruitment strategies targeted participant recruitment for both qualitative and quantitative research phases. Study participants were identified using research flyers posted in local churches, digital flyers promoted on Facebook, and referrals from health professionals (i.e., nurses and nurse practitioners) who practiced in the Mid-South region. The study principal investigator also contacted members of her professional network (i.e., nurses, medical assistants) and members of Historically Black Greek-letter organizations (i.e., fraternities and sororities) to disseminate flyers among their professional and social networks. Two research flyers were used to recruit participants for each phase. The qualitative research flyer listed study details (i.e., 60–90-minute interview procedures, inclusion and exclusion criteria, study’s principal investigator contact information, and participant compensation information (i.e., \$25 electronic merchant gift; **Appendix A**). The quantitative research flyer was modified slightly to reflect quantitative study details (i.e., 30-45-minute online survey procedures) and participant compensation (i.e., \$40 electronic merchant gift. The flyer also featured a QR code linking to an online Qualtrics survey (Quantitative web-survey) with pre-screening questions to determine participation eligibility (**Appendix A**). Eligible participants for the quantitative phases were first identified based on answering “yes” to all pre-screening questions. Considering the study’s research questions and objectives, coupled with the heightened prevalence of HTN in the region and the historical underrepresentation of Blacks in US health research (Fisher & Kalbaugh, 2011), specific criteria were established for participant enrollment. The study’s principal investigator recruited eligible individuals for both qualitative and quantitative aspects of the study, spanning from September 2020 to March 2023. Inclusion criteria necessitated participants to self-identify as Black or African American men, be 18 years of age or older, have a reported diagnosis of HTN, reside in the Mid-South region (Tennessee, Mississippi, Arkansas), possess English language proficiency, and have access to a web-enabled device. Conversely, exclusion criteria encompassed individuals who declined to provide consent and those unable to read and speak English.

Qualitative Instrumentation

Pre-Interview Online Survey

Before participating in individual semi-structured interviews, participants received an online pre-interview survey via email. The survey included an online consent form and gathered sociodemographic information (i.e., age and highest education level), patient characteristics (i.e., length of time diagnosed with HTN names of blood pressure medications), and health care clinician characteristics (gender, age, and race). By collecting data through this survey, the study’s principal investigator ensured the selection of eligible participants and gained valuable insights that laid the foundation for conducting in-depth individual interviews (**Appendix C**).

Semi-Structured Interview Guide

The semi-structured qualitative interview method was chosen because it allowed for the same topics to be discussed with all participants, the flexibility to ask follow-up questions to understand each topic's relative importance, and clarity from participants regarding discussion topics (Green & Thorogood, 2018). The interview guide explored concepts from Peek et al.'s (2016) SDM Process Conceptual Model, including elements of the SDM process such as information sharing, deliberation, and decision-making, as well as decision-making preferences, the social identity of both the patient and the clinician, and the dynamics within the patient-clinician relationship. Related literature about the role of the patient-clinician relationship in HTN management among Black adults also informed the semi-structured interview guide topics and questions (Chang et al., 2021; Langford et al., 2019; Schoenthaler et al., 2009). Interview domains included participants' experiences of their relationship with their clinicians, medical trust, and distrust, how participants expressed their HTN-related treatment decisions with their healthcare clinician, and SDM preferences. Topics also explored participants' involvement in various aspects of the SDM process with their healthcare clinicians during routine HTN treatment discussions (i.e., information-sharing about HTN diagnosis, deliberation about HTN treatment options, and decision-making about treatment goals and treatment strategies). Sub-topics explored within the interview guide asked participants to share whether and how specific characteristics such as their healthcare clinician's social identity (i.e., race and gender) influenced their perceptions of the patient-clinician relationship, as well as how their healthcare clinician assisted them with HTN self-management and dealing with side effects of HTN treatment (i.e., sexual side effects of blood pressure medications). Particularly their experiences communicating sexual health-related issues and how it impacted their HTN treatment plan.

Pilot Testing Semi-Structured Interview Guide

To enhance content validity, the semi-structured interview guide underwent review by subject experts, including a health communication researcher and scholar, a MMR methodologist, and a family nurse practitioner specializing in treating HTN among Black men in the U.S. South. Following this expert review, the study's principal investigator piloted the interview guide with two adult Black men diagnosed with HTN. During the pilot interviews, participants provided feedback on the interview's length and the clarity of the questions. The first pilot participant, a 30-year-old man who was diagnosed with HTN six months prior to the interview, completed the interview in 59 minutes. He commented positively on the clarity of the questions and how the study's principal investigator approach of getting to know him at the start of the interview made him feel comfortable and open to sharing his experiences with clinicians. He also found the questions to be relevant to his experiences. The second pilot participant, a 60-year-old man with a 15-year history of HTN completed the interview in 47 minutes. He provided feedback on the terminology used in the interview, suggesting that terms such as "antihypertensive medications" be changed to "high blood pressure" or "blood pressure" medications. Based on the feedback from both content experts and pilot participants, the

semi-structured interview guide questions were modified to reflect the language modification (**Appendix C**).

Quantitative Instrumentation

Online Survey

The online survey included a self-report questionnaire (**Appendix D**) that queried participants' demographic data, including race and ethnicity, age, education level, annual household income, and relationship/partnership status. Additional participant characteristics data were collected, including health insurance status, self-rated health, tobacco and alcohol consumption, health management strategies (i.e., stress reduction), age of HTN onset, and number of antihypertensive medications. While sexual dysfunction, specifically erectile dysfunction, is a primary concern regarding the side effects of medication, it was only mentioned with ($n=2$) participants. As a result, it did not hold the same weight as a primary theme. However, even though sexual dysfunction was not a primary focus, it was addressed in the quantitative survey, where participants had greater anonymity to respond openly. Therefore, the International Index of Erectile Function (IIEF-5) scale was added to the survey. Additionally, information about the participants' healthcare clinicians who treated their HTN was collected, including the clinician's race and ethnicity, gender, and duration of the patient-clinician relationship. Validated scales were used to measure the relationships among the main study variables, including SDM preferences, perception of working alliance in the patient-clinician relationship, perception of autonomy support from clinicians, and perception of trust and mistrust in the patient-clinician relationship.

SDM Preferences

Participants' preferences for involvement in SDM about HTN treatment were measured using the Autonomy Preference Index (API; Ende et al., 1989). The API measures a patient's preferences for health information and involvement in healthcare-related decision-making. The total scale consists of 23 items, further divided into two subscales: Preference for Decision Making (15 items) and Preference for Information Seeking (eight items). The Preference for Decision-Making subscale is divided into two subscales that measure a patient's preferences for involvement in general medical decision-making (six items) and preference for involvement in decisions according to disease severity (i.e., mild, moderate, severe, (nine items)).

The general decision-making subscale assesses patients' preferences for involvement in general medical decisions using six items (i.e., "The important medical decisions should be made by your doctor, not by you."). Items are coded on a scale of 1 to 5, with a score of 5 representing the strongest preference for involvement in decision-making and a score of 1 indicating the weakest preference for involvement. The sum of the scores is converted to a linear score (0–100), where 0 indicates a very low preference, 100 indicates a very high preference, and 50 indicates a neutral attitude towards being

involved in decision-making. The reported Cronbach's alpha for the general decision-making subscale is 0.82.

The disease-specific decision-making subscale assesses patients' preferences for who should make decisions in three different clinical vignettes categorized according to their severity level. Responses choices were coded on a five-point scale and ranged from "you alone" "to the "doctor alone." The clinical vignettes were upper respiratory tract illness, indicating mild disease; HTN, representing moderate disease (i.e., "Who should decide whether you should be treated with medication or diet?); and myocardial infarction, representing severe disease. Clinical vignette scores range from 0 to 10, where a score of 0 reflects a desire for the doctor to have complete control, a score of 5 indicates a desire for SDM between doctor and patient, and a score of 10 indicates a preference for the patient to have complete control in decision-making. The reported Cronbach's alpha for the disease-specific subscale is 0.82.

The Preference for Information Seeking subscale consists of 8 items to assess a patient's preference for information (i.e., "Information about your illness is as important to you as treatment.") Items are coded on a scale of 1 to 5, with a score of 5 representing the strongest preference for information and a score of 1 indicating the weakest preference for information. The scores are expressed on a linear scale that ranges from 0 to 100, where 0 refers to strong disagreement with statements preferring to be informed, 50 refers to a neutral attitude towards statements about being informed, 100 refers to a strong agreement to patients being informed. The reported Cronbach's alpha for the information preference subscale is 0.82.

Perception of Working Alliance in Relationship with Clinician

The WAI-GP (Sturgiss et al., 2018) was used to measure the degree to which study participants perceived the therapeutic working alliance in interactions with their clinicians for HTN treatment and management. Working alliance is a concept derived from the psychotherapy discipline and used to describe a type of therapeutic relationship between therapist and their clients (Bordin, 1979; Horvath, 2018). Over time, it has been adapted for use in general practice healthcare settings (i.e., client-patient relationships in primary care) (Fuentes et al., 2017; Sturgiss et al., 2018). The conceptual definition of alliance varies (Flückiger et al., 2018). However, most scholars agree that alliance refers to the collaborative aspect of the professional-client relationship (Horvath, 2018); moreover, it describes how well each individual in the relationship (i.e., clinician and client) works together to reach an agreement about a shared outcomes (Horvath, 2018).To measure alliance in the therapeutic relationship, one examines evidence that both individuals have developed a collaborative working relationship within a specific context at the time of assessment and observation (Horvath, 2018). The original WAI-GP Scale consisted of 36 items to measure three domains of the working alliance: (a) the bond between two parties, (b) collaborative goal setting, and (c) agreement on the required tasks to reach the goals (Horvath & Greenberg, 1989).

Recently, the WAI-GP was adopted and validated for use in primary care to measure the therapeutic working alliance in the clinician-patient relationship (Sturgiss et al., 2018). The scale consists of 12 items that ask patients to rate their disagreement (i.e., 1= strongly disagree) or agreement (i.e., 5= strongly agree) with statements about their interactions with their primary care clinicians (i.e., Even though I may do things that my health care provider does not advise or suggest, I know they still care about me (Sturgiss et al., 2018). The scale has a reported Cronbach alpha of 0.94, with higher scores representing a greater perception of a therapeutic working alliance with the clinician.

Perception of Autonomy Support Received from Clinician

Participants' perception of autonomy support from their primary care clinician was measured using a short-form version of the Health Care Climate Questionnaire (HCCQ; Williams et al., 1996). The HCCQ is a self-administered questionnaire that assesses how strongly individuals perceive autonomy support during interactions with health professionals. The scale is based on the self-determination theory, which suggests that autonomy is a concept that affects motivation and behavioral regulation to achieve a goal (Deci & Ryan, 1980). The scale has been used in health research and clinical practice settings to look at the role of autonomy in various patient-clinician interactions (i.e., nurse practitioners, medical doctors) and health behaviors in weight loss (Williams et al., 1996), blood glucose control (Williams et al., 1998), medication adherence (Czajkowska et al., 2017), and HTN (Yeom & Lee, 2022). The original scale consists of 15 items designed to assess behaviors in medical interactions, such as having to voice opinions, ask questions, and discuss choices (Williams et al., 1996).

Each item is rated on a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree), with the level of perceived autonomy support being evaluated by averaging the score of the items, with higher scores indicating greater perceived autonomy support (Williams et al., 1996). The 15-item scale has a reported Cronbach alpha of 0.90, indicating good internal validity (Tavakol & Dennick, 2011; Williams et al., 1996) and was modified to a shorter 6-item version (HCCQ-6) with a reported Cronbach alphas of 0.82 (Williams et al., 2018).

In this study, the HCCQ-6 scale was used to measure participants' perceived level of autonomy support in HTN treatment and management decisions with their primary care clinicians. Participants were instructed that primary care clinicians indicated the clinician who oversaw their HTN treatment and management (i.e., physician, nurse practitioner, physician assistant) as applicable. Items were modified slightly to reference HTN. For example, one item was reworded: "I feel that my primary care clinician has provided me choices and options for my HTN treatment." Average HCCQ-6 scale scores were used to determine this sample's perceived autonomy support level. HCCQ-6 scale scores were used in this study to represent participants' perceived autonomy support from their clinicians who treated them for HTN. Moreover, HCCQ-6 scores were used to examine how autonomy support may impact their preferred involvement in SDM with a clinician for HTN treatment and management.

Perceptions of Trust and Mistrust Among Black Men with HTN

Measuring patient trust in the healthcare system is nuanced based on the lack of conceptual clarity and convergence of what is being measured when describing trust in healthcare (i.e., trust in communication, clinicians, trust in a healthcare organization) (Taylor et al., 2023). During qualitative interviews, participants in this study discussed trust in two main categories: general trust in healthcare systems and trust in their clinicians. Therefore, trust was measured using two separate scales, the TPS (Anderson & Dedrick, 1990) and the Medical Mistrust Index-7 (MMI-7; LaVeist et al., 2009) to assess their correlations in this sample and to get a more robust understanding of how trust and mistrust impact SDM. This decision was also informed by the literature that reports empirical evidence that trust and mistrust are related but have distinct relationships to health behaviors (Pellowski et al., 2017).

TPS

The TPS is a validated, psychometric, self-administered scale that measures the extent of an individual’s interpersonal trust in their physician’s counsel, judgment, and medical treatment (Anderson & Dedrick, 1990). The scale has 11 items that ask respondents to self-rate their disagreement (i.e., 1= strongly disagree) or agreement (i.e., 5=strongly agree) with statements about their clinicians (i.e., “I trust my doctor’s judgment about my medical care). The TPS has a reported Cronbach alpha of 0.90, with higher scores representing greater trust in their clinician. TPS scale scores were used in this study to represent participants’ trust in their clinicians who treated them for HTN. TPS scores were used to examine how trust may impact their preferred involvement in SDM with a clinician for HTN treatment and management.

MMI-7

Medical mistrust was assessed using the MMI-7 (LaVeist et al., 2009). The MMI-7 is a self-administered scale that has been psychometrically tested in Black patients to assess their perceptions of medical mistrust of healthcare organizations (LaVeist et al., 2009; Powell et al., 2019; Williamson & Bigman, 2018). The scale contains seven items that ask respondents to rate their level of disagreement (i.e., 1=strongly disagree) or agreement (i.e., 5=strongly agree) with statements about health care organizations (i.e., “You’d better be cautious when dealing with health care organizations) (LaVeist et al., 2009). The scale has an acceptable Cronbach alpha of 0.76, with higher scores on the scale that represent greater mistrust in healthcare organizations (LaVeist et al., 2009). MMI-7 scale scores were used in this study to examine Black men’s perception of medical mistrust and how medical mistrust may impact their preferred involvement in SDM with a clinician for HTN treatment and management.

Pilot Testing Quantitative Survey Instrument

Before enrolling participants in the quantitative phase of this study, the questionnaire underwent pilot testing using two methods. Content validity and reliability

were addressed by having members of the research team to ensure theoretical, clinical, and methodological relevance. Five Black men with HTN (referred to as pilot participants in this section), whose ages ranged from 33 years to 62 years with an average of seven years since their HTN diagnosis, were recruited to pilot the survey to assess question comprehension, duration, and overall flow. Based on pilot feedback, revisions to the questionnaire flow were made. For instance, instructions were added at the beginning of the questionnaire to define “health care provider or clinician” as a medical professional who provides treatment and oversees HTN management (i.e., physician or nurse practitioner).

Pilot participants recommended breaking up sections of the questionnaire to distinguish between similar questions to reduce confusion. Clarifying statements were added at the beginning and end of the question sections to aid in the survey flow. Pilot participants stated that it helped transition their focus throughout the survey. For example, questions about their relationship with their healthcare clinician (therapeutic working alliance and autonomy support received from the clinician) were grouped into sections. Pilot participants were alerted with a brief sentence at the beginning and end of each section (i.e., “Thank you for answering questions about your relationship with your health care clinician; we will now transition to the next set of questions.”) Feedback indicated that the survey took 15–25 minutes to complete, shorter than initially projected. Pilot participants were not included in the final study sample. However, they were compensated with a \$40 gift card for their time.

Procedures

Study information was disseminated through social media platforms (i.e., Facebook, LinkedIn, Instagram) and physical locations in primary care clinics, libraries, churches, and barbershops. Research flyers in these locations displayed a QR code that directed interested individuals to a dedicated webpage administered through Qualtrics. This webpage provided comprehensive study details, a consent form, and a pre-screening questionnaire to assess eligibility and collect contact information.

Social media recruitment was chosen due to its ability to target diverse sociodemographic groups (i.e., age, education level, and location) and convenience (Carter-Harris, 2016). However, acknowledging the risk of potential fraudulent data, such as bots or duplicate responses, are important, which could impact the sample’s integrity (Bragard et al., 2020). Recruiting participants online proved efficient and cost-effective; however, it also introduced the risk of fraudulent survey responses. Ensuring sample validity was a priority during the data design stage (Pozzar et al., 2020). Although standardized guidelines for online survey research through social media are lacking, insights from health research scientists using similar data collection methods (Bragard et al., 2020) were considered for this study. Steps were taken to detect internet bots and fraudulent responses, including recruiting participants from offline, in-person locations, utilizing Qualtrics features to identify duplicate responses and bots, and verifying respondents’ locations through IP addresses and contact information.

Various strategies were implemented to validate survey responses. The study procedures included redirecting interested individuals to a dedicated webpage through a QR code on the research flyers, rather than directly posting the survey links. The webpage incorporated a CAPTCHA feature to mitigate fraudulent participation (Teitcher et al., 2015; Watson et al., 2018). After completing an interest form, individuals were reviewed for flags indicating potential bots, fraud, or duplicate responses. Eligible participants received the consent and eligibility questionnaire via email, and upon completing the process, they were instructed to contact the study principal investigator directly for the survey link. The trustworthiness of entries was evaluated based on factors such as completion time, IP addresses, time stamps, addresses, and duplicate detection measures (Bybee et al., 2022; Teitcher et al., 2015; Watson et al., 2018).

Research flyers were distributed to patients during check-out in primary care clinics that served predominantly Black patients to reach eligible individuals or those who could refer eligible participants. The decision to recruit Black men from barbershops and churches was based on recommendations from qualitative interviews and supported by existing literature that has shown success in recruiting Black men for research studies in these various settings (Hess et al., 2007; Ravenell et al., 2023; Shabazz, 2016; Victor et al., 2018, 2019). Barbershops have successfully recruited Black men for HTN research studies, as they hold significant sociocultural meaning and provide a trusted environment for discussions (Coy et al., 2023; Hood et al., 2018; Mendy et al., 2014; Palmer et al., 2020; Palmer et al., 2021; Shabazz, 2016; Victor et al., 2021).

During the qualitative phase, each consenting participant participated in a semi-structured interview with an average duration of 57 minutes (30-90 minutes; $n=16$). The interviews were conducted by the study's principal investigator in Memphis, Tennessee, between September 2020 and March 2021, using Zoom ($n=14$) and telephone ($n=2$) to address safety concerns related to the COVID-19 pandemic. Participants received a \$25 electronic merchant gift card for participating in the qualitative interviews. In the quantitative phase, data were collected from a convenience sample of 105 Black adult men who self-reported a HTN diagnosis and resided in the mid-south region (Tennessee, Mississippi, Arkansas) who responded to the web survey. Upon completing the web survey, participants were given a \$40 electronic merchant gift card.

Qualitative Data Analysis

Qualitative interviews were digitally recorded and transcribed verbatim by a third-party vendor to aid in data analysis. Each transcript was read line-by-line by the study's principal investigator to review for accuracy, familiarize with the data, and facilitate the coding process. The process started with an open-coding approach, wherein each data line was coded to stick true to the participants' voices. This coding approach facilitated an in-depth understanding of the data. Multiple rounds of coding were conducted throughout the data collection and analysis phases, continuing until codes were grouped into coherent categories. These categories, in turn, provided the foundation for a thorough thematic analysis.

Qualitative interview data were analyzed using reflexive thematic analysis (Braun & Clarke, 2006, 2019). Reflexive thematic analysis is a flexible, reiterative approach to qualitative data analysis, emphasizing the interpretation of the data rather than describing and summarizing it (Braun & Clarke, 2022). A core assumption is that the “researcher’s subjectivity is a primary tool for knowledge generation and should not be gotten rid of or controlled” (Braun & Clarke, 2022, p. 7). As such, the study’s principal investigator reflected on their positionality through the analysis, particularly how their overlapping positions as a Registered Nurse, researcher, and Black woman who has relationships with family members similar to study participants influenced their evolving comprehension of SDM.

The analysis began with data familiarization, entailing a detailed review of each interview transcript line by line. The study’s principal investigator conducted this initial review, making anecdotal notes and recording initial impressions and observations from each interview to prepare for the subsequent coding phase. A second research team member independently read each interview transcript and developed codes. In addition to achieving consensus on the data description, Braun and Clarke (2022) emphasized that collaboration with a second coder aims to “enhance understanding, interpretation, and reflexivity.” The second coder in this study offered opposing viewpoints, provoking discussion about the overall significance of each code in relation to the SDM process that study participants reported.

Next, initial themes were developed. Specifically, each research team member worked independently to derive preliminary themes based on the coded data and identified patterns. A critical review and refining of themes took place, where both researchers (study principal investigator and second coder) met with a third research team member to dissect and reach a consensus on major themes that most accurately ‘fit’ the data—specifically, patient-related factors, clinician-related factors, and relationship factors impacting the SDM process were the patterns that were observed. This process involved the study’s principal investigator conducting an additional review of the coded data and interview transcripts to align the themes with the entire dataset. While gathering and analyzing the data, this reflective process led to a more nuanced and thorough examination of the main themes that emerged from the data. Lastly, research team members collectively finalized the themes. This step served as the foundational framework for the focus of the subsequent quantitative research study phase.

Quantitative Data Analysis

Quantitative survey response data collected from study participants were downloaded from Qualtrics into a Microsoft Excel® spreadsheet and imported into IBM SPSS Statistics for Windows, Version 28.0. (Armonk, NY: IBM Corp) for analyses. Descriptive statistics (means, medians, standard deviations, counts, frequencies, and percentages) were computed to describe the study sample and analyze scores from scales. Patient-related factors that were examined were age and highest level of education

attainment. Clinician-related factors that were examined were clinician race and gender. Patient-clinician relationship factors that were examined were perceptions of trust in the clinician (TPS scale), mistrust in health care organizations (MMI-7 scale), autonomy support received from the clinician (HCCQ-6 subscale), and strength of therapeutic working alliance with their clinician (WAI-GP). Scores from the TPS scale, MMI-7 scale, HCCQ-6 subscale, WAI-GP scale and API-DM6 subscale were analyzed using descriptive statistics. Relationships and associations among specified factors (i.e., patient, clinician, and patient-clinician relationship) and the outcome variable, SDM involvement (API-DM6 subscale), were analyzed using a correlational analysis, simple linear regression, an analysis of variance and covariance, and multiple linear regression.

A Spearman correlation analysis was conducted to examine relationships and estimate associations among patient age, patient education, clinician race, clinician gender, therapeutic working alliance (WAI-GP), trust in clinician (TPS), mistrust in health care organizations (MMI-7), autonomy support received from the clinician (HCCQ-6), and the outcome variable SDM involvement (API-DM6). Scores from each respective scale were analyzed using descriptive statistics (means, standard deviations, and means). Normality assumptions were met for all scale scores (i.e., WAI-GP, TPS, MMI-7, HCCQ-6 API-DM6). Cohen's standard was used to evaluate the strength of the relationships, where coefficients between .10 and .29 represent a small effect size, coefficients between .30 and .49 represent a moderate effect size, and coefficients above .50 indicate a large effect size (Cohen, 2013). The significance level was set at $\alpha = 0.05$ to determine statistical significance.

Simple linear regression analyses were conducted to assess the relationship between each independent variable individually, including patient age, patient education, clinician race, clinician gender, therapeutic working alliance (WAI-GP), trust in clinician (TPS), mistrust in health care organizations (MMI-7), and autonomy support received from the clinician (HCCQ-6 subscale) and the outcome variable, SDM involvement (API-DM6 subscale), using each respective scale score. Before conducting the analyses, assumptions such as linearity, independence of observations, homoscedasticity were assessed. The significance level was set at $\alpha = 0.05$ to determine statistical significance.

Analysis of variance (ANOVA) was conducted, using a significance level of $\alpha = 0.05$ to determine whether there were significant differences in SDM involvement across the categorical independent variables, consisting of clinician races (i.e., White, Black, or African American, Other) and clinician genders (i.e., male, female), for the dependent variable SDM involvement (API-DM6 subscale). Data assumptions of normality, homogeneity of variances, and independence were assessed. Post-hoc tests (i.e., Tukey's HSD t-test) were utilized for pairwise comparisons if the overall ANOVA results were significant.

Analysis of covariance (ANCOVA) was conducted to test for interaction effects of selected independent continuous variables (trust in clinician and therapeutic working alliance) and categorical variables (clinician gender or race) on the outcome variable, SDM involvement (API-DM6 subscale) using scores from TPS scale trust in clinician,

WAI-GP scale therapeutic working alliance. ANCOVA was employed to assess whether there were significant differences in SDM involvement across different clinician race and gender groups while controlling for the effects of selected independent variables (trust in clinician and scale therapeutic working alliance). Assumptions of normality, homoscedasticity, and homogeneity of variance were met.

Multiple regression analysis was conducted to determine what factors (patient, clinician, and patient-clinician relationship) may predict SDM involvement. After carefully examining previous analyses to estimate linear relationships between different independent variables and SDM involvement, selected variables (trust in clinicians and clinician gender) were put into the multiple regression analyses as possible predictors to determine how they might influence SDM involvement. The variables were selected based on their theoretical relevance and findings from previously conducted analyses. Before conducting the multiple regression analyses, tests for assumptions (i.e., normality, multicollinearity) were conducted to determine the appropriateness of variables included in the multiple regression models.

Ethical Considerations of Human Subjects

All research study components were conducted following the ethical guidelines governing research involving human subjects. This was done to guarantee that all the males recruited for the study who agreed to participate were safe and protected. The IRB at the UTHSC used an expedited assessment process to review and approve the study methods.

The informed consent processes ensured that the participants could exercise their right to make well-informed judgments. The procedure of providing informed consent involved the creation of an electronic consent document. The study's principal investigator drafted a document for informed consent that outlined the research study's objectives, the type of data collected (individual semi-structured interviews and an online survey), procedures, and time commitments, as well as potential risks and benefits, voluntary consent, and the right to withdraw from the study and withhold information without incurring any penalties. In addition, the study's principal investigator responded to any questions that participants had concerning the study before, during, and after the processes for obtaining consent and conducting the study were carried out. The study's principal investigator informed research participants of their right not to answer questions, move to another set of questions during the individual interviews, and withdraw participation at any point without penalty. This was done to minimize the psychological risk associated with discussing sensitive topics (discrimination in health care, sexual side-effects of antihypertensive medications), which the study's principal investigator felt was necessary. During the processes for the study, every effort was made to guarantee that the rights of all potential participants and participants who had previously agreed to participate in the study were protected.

Strict confidentiality was maintained throughout the entire recruitment and data collection processes (individual semi-structured interviews and an online survey). The following measures were taken to protect the participant's right to privacy: Participants were given a number that served as their identifier and was attached to their data in place of personally identifying information. On a strictly need-to-know basis, members of the research team were given access to deidentified data for the sole purpose of conducting data analysis. The study's principal investigator of the project was the only person with access to the research records, all kept on a computer that required a password entry. The study's principal investigator conducted semi-structured interviews in a discrete location via Zoom and the telephone. Before the interview, the study's principal investigator asked respondents whether they would like to transfer to a private place. This was done to guarantee that the interviewees were in a private setting before discussing the interview topics. The data analysis methods were carried out discretely to reduce the likelihood of sensitive data being viewed by those not part of the study team.

CHAPTER 4. RESULTS

Phase 1: Qualitative Exploration of SDM Preferences of Black Men with HTN in the U.S. Mid-South

As a young Black woman, nurse, and researcher, I approached this study on Black men with HTN and their decision-making in navigating treatment options with an acute awareness of the multi-dimensional lens through which I conducted it. My professional background as a nurse equipped me with valuable insights into the healthcare system, but I also recognized the privilege it afforded me in accessing and understanding medical information. This background influenced the framing of my research questions. Simultaneously, my dual role as a researcher studying Black men with HTN felt profoundly personal. Many participants mirrored the experiences of my loved ones, including my husband and father. This personal connection, while providing me with an empathetic understanding, also required a conscious effort to prevent potential bias. Throughout the research process, I engaged in continuous self-reflection and dialogues with healthcare colleagues and research team members to ensure that my positionality as a healthcare professional and someone deeply connected to this community did not unduly shape the research outcomes.

In this study, I employed various reflexive practices to enhance the rigor and depth of my investigation. One crucial aspect of this self-reflective approach was journaling. I meticulously documented my thoughts, feelings, and biases throughout the research process, before and after each in-depth interview. This journaling practice enabled me to acknowledge and address any preconceived notions or personal biases that may have influenced my data collection and analysis. For example, there were instances where I had to set aside my nursing perspective when participants described their experiences of non-adherence to medication regimens. In those moments, I deliberately adopted the role of an impartial observer to understand the participants' viewpoints better. I consistently engaged in self-reflection, ensuring that my positionality, encompassing healthcare expertise and a deep connection to the community, did not unduly shape the research outcomes. Regular peer debriefing sessions also played a significant role in critically examining and refining my interpretations, with team discussions revealing potential biases, assumptions, and novel insights. For example, challenges in the interview process were presented when inquiring about participants' experiences with the sexual side effects of antihypertensive medications. It's important to acknowledge that some male participants may have exhibited reluctance in discussing this component of HTN treatment, which could potentially be influenced by various factors, including the interviewer's gender. During these discussions, I also acknowledged the power hierarchies inherent in my healthcare expertise compared to my participants, adding depth to the interpretation of health communication challenges between patients and healthcare clinicians. Furthermore, it is important to note that some participants shared geographical origins with me. Given my intimate familiarity with the sociocultural context and the challenges many participants face, this shared geographical background brought an added layer of understanding of Black men's challenges when

navigating healthcare organizations. By addressing these dynamics, I aimed to contribute to a more nuanced understanding of the experiences of Black men with HTN and the factors that influence their involvement in SDM for HTN treatment.

Participant Characteristics

Table 4-1 describes the characteristics of the 16 Black men who participated in individual semi-structured interviews for the qualitative phase. Their clinician's characteristics are also reported. Most participants earned an advanced education degree, half reporting some graduate school or more (50%, $n = 8$). Most participants were married (56.25%, $n = 9$). The distribution of income among the participants demonstrated economic diversity. Specifically, a quarter of the participants reported annual incomes of less than \$20,000 and greater than \$100,000 (25%, $n = 4$ each). Most participants reported having medical insurance (93.75%, $n = 15$). Participants frequently reported having had HTN for 1 to 5 years. (31.25%, $n = 5$) with most prescribed 1-2 blood pressure medications (75%, $n = 12$) for HTN management. Regarding clinician characteristics, participants frequently reported that their clinicians were Black or African American (75%, $n = 12$) and male (62.50%, $n = 10$).

The subsequent sections identify key themes concerning patients, clinicians, and the SDM environment. Specifically, we explore the factors that act as barriers and facilitators, influencing participants' engagement in the SDM process for HTN treatment and management.

Patient-Related Factors Influencing Involvement in SDM

Participants expressed thoughts regarding how cultural norms impact their communication with their clinicians, self-perceptions of power and the ability to advocate for treatment preferences and expectations regarding their clinician's role in developing the HTN treatment and management plan as relevant factors to active engagement in the SDM process **Table 4-2**.

Race Congruence/Cultural Congruence

Participants expressed that having a Black doctor with whom they share cultural experiences made it easier for them to communicate openly and feel less judged based on their behavioral choices that impact blood pressure management. For example, one participant mentioned that he didn't grow up with other races, and it set his expectations and preferences for the kind of doctor he wanted, a Black male doctor, because of his ability to understand and relate to the Black experience:

Table 4-1. Characteristics of Qualitative Interview Participants.¹

Variable	<i>n</i>	%
Highest education level		
8th grade or less	2	12.50
High school graduate/ GED	3	18.75
Some college or 2-year degree	2	12.50
4-year college degree	1	6.25
Some graduate school or more	8	50.00
Annual income		
Less than \$20,000	4	25.00
\$20,001 - \$40,000	1	6.25
\$40,001 - \$60,000	2	12.50
\$60,001 - \$80,000	3	18.75
\$80,001 - \$100,000	2	12.50
\$greater than \$100,000	4	25.00
Relationship/ partnership status		
Single	6	37.50
Divorced	1	6.25
Married	9	56.25
Health insurance status		
Yes	15	93.75
No	1	6.25
HTN diagnosis (years) ²		
Less than or = 5 years	5	31.25
> 5 years or = 10 years	3	18.75
> 10 years or = 15 years	4	25.00
> 15 years or = 30 years	4	25.00
Number of blood pressure medications ³		
1–2 medications	12	75.00
3 or more medications	4	25.00
Clinician race/ ethnicity		
Black or African American	12	75.00
White	2	12.50
Other	2	12.50
Clinician Gender		
Male	10	62.50
Female	6	37.50

¹Black men with hypertension (HTN) in the Mid-South who participated in individual semi-structured interviews (N=16). Participants were on average 50.9 years old (*SD*=12.87; Min 34 years to Max 74 years). ² Based on participant self-report. ³ Based on participant self-report.

Table 4-2. Patient-Related Factors.¹

Patient-related factors influencing involvement in SDM	Example quotes
Cultural congruence between Black men and their clinicians influences their involvement in SDM racial and cultural congruence	“I didn’t grow up around other races, white, Black and definitely not Asian, So my social norms were all Black. The way we interacted with each other, certain slang and verbiage, or whatever. So that gives a different dynamic. I think maybe for maybe a Black doctor who grew up in Connecticut or Vermont, or whatever, their experience would be different than a Black guy who grew up in Mississippi or Tennessee. So they may come in with certain biases, not purposely, but just because they don’t know. Like, honestly, what’s the likelihood of anybody in Vermont unless they were raised in the south having greens and ham hocks and fried catfish at Thanksgiving Dinner?” (P11, 49 years)
Black male clinicians facilitate SDM involvement gender congruence	“If I have a Black male doctor, he may understand that my high blood pressure just isn’t the result of my diet or other things like that. I wasn’t really taking the medications like I should. After I started my treatments, he asked me how it was going. I was comfortable enough to have that conversation with him. I don’t know if I could talk like that to any other doctor and just tell him how I felt. Not definitely a female doctor, or probably not even a white man. Just to be honest, but that’s me. But I also think that’s probably how many Black men are.” (P7, 53 years)
Power negotiations between Black men and their clinicians influence their involvement in SDM	“And I guess, when it comes to me and my doctor. I give him complete control. It’s like I take all my thoughts about my health, pack them in my car, drive them over, and park them in his garage. I need to give myself more room for empowering myself” (P4, 59 years)
Stereotype threat influences Black men’s involvement in SDM with clinicians	“If my doctor says, Hey, I want you to take this medication and I say, No, I don’t want to take that, I don’t want that doctor or that nurse practitioner to view us and say, This cat doesn’t want to get better. I’m trying to give him a solution. He doesn’t want to comply with the treatment options that I’m giving him.” (P15, 44 years)

¹n=16 Black men who participated in individual semi-structured interviews. SDM= shared decision-making.

I didn't grow up around other races, white, Black, and definitely not Asian, So my social norms were all Black. The way we interacted with each other, certain slang and verbiage, or whatever. So that gives a different dynamic. I think maybe for maybe a Black doctor who grew up in Connecticut or Vermont, or whatever, their experience would be different than a Black guy who grew up in Mississippi or Tennessee. So, they may come in with certain biases, not purposely, but just because they don't know. Like, honestly, what's the likelihood of anybody in Vermont unless they were raised in the south having greens and ham hocks and fried catfish at Thanksgiving dinner? (P11, 49 years)

Additionally, some participants expressed thoughts that Black doctors possess a unique insight into the environmental stressors affecting Black men and understanding of the role it plays in their overall health. One participant reported,

They can really understand where the patients come from, as an African American, their environment... did they have a father in the home? Did they grow up in a violent atmosphere... that's trauma that could all lead to underlying stress that keep blood pressure up. They actually look at the whole picture, instead of it being a one stop shop for medicine. (P6, 39 years)

Most participants reported that having a Black doctor was not just a preference but a prerequisite for seeking medical care and developing a relationship due to the ease of communication relational nature of the relationship. Another participant candidly stated,

That was my desire to have a Black person. Just being honest, I probably wouldn't have given another person a chance." I don't think I could have had a relationship with nobody else. I like that my doctor is professional but also able to shoot it straight with me. We shoot the breeze a little bit before we start talking about health-related stuff, and with him, its relational and not transactional. It don't feel like he's trying to take my money. (P14, 36 years)

Gender Congruence

Many participants expressed their desire to have a Black man as their clinician. Specifically, participants expressed greater chances of their clinicians understanding their experiences of being a Black man outside of the patient-clinician context and the socio-cultural context impacting their blood pressure management, such as experiences of masculinity. Participants expressed that this made them feel comfortable openly discussing the impact of HTN treatment on their daily lives. One participant stated, "I'm more comfortable with a male doctor than I am with a female doctor. But I'm most comfortable with a Black male doctor" (P11, 49 years).

Another participant stated,

If I have a Black male doctor, he may understand that my high blood pressure just isn't the result of my diet or other things like that. I wasn't really taking the medications like I should. After I started my treatments, he asked me how it was going. I was comfortable enough to have that conversation with him. I don't know if I could talk like that to any other doctor and just tell him how I felt. Not definitely a female doctor, or probably not even a white man. Just to be honest, but that's me. But I also think that's probably how many Black men are." (P7, 53 years)

Many participants mentioned the expectations of Black men having to demonstrate strength all the time, and having a Black male doctor increases their likelihood of being vulnerable and open up with the information they share. One participant mentioned,

I think a lot of us are just always expected or believe that we are expected to always be strong. And so, we don't want to tell people when something is wrong with us, even physically. And then, admitting that there's something wrong is like admitting to us that we are weak and vulnerable. But we do have weaknesses like that something did penetrate our strength. I don't have to explain that to my doctor, he just lets me open up about how this impacts me. (P10, 55 years)

Patient Ability to Negotiate Power with Clinician

Participants described ongoing negotiations with their clinicians about HTN management, specifically blood pressure medications. Some participants, who perceived diminished power, compared to their clinicians in determining their HTN treatment, were hesitant to advocate for their HTN treatment preferences, avoided open and honest discussions about treatment, and passively agreed to treatment (i.e., blood pressure medications) with their clinicians during clinical encounters. For most participants failed power negotiations led to treatment nonadherence to regain power lost during failed SDM. One participant stated,

It's not exactly that they have more power than me. I think they can tell me what I can get, but they can't make me take nothing. It's about a balance of power. 'Cause then, you know I'll get home and I just won't take it. (P5, 34 years)

Another participant stated,

It's kind of a power struggle because, you know, that's kind of the reason why you're not honest with them. Because you'll be honest with somebody who you felt like was not as powerful as you or couldn't dictate what you do or something. (P11, 49 years)

Power negotiations differed for participants based on the duration of their relationships with their clinicians. Participants who had long-term relationships with their

clinicians were more likely to openly express their disagreement with plans for treatment options compared to participants with short-term relationships who were more likely to express a hesitancy to advocate for their preferences. One participant, who had a long-established relationship with his clinician, reported, I've known Dr. X for a long time. If I tell him something isn't going to work, he listens to me (P2, 60 years). Another participant added, "Well, I don't really advocate much because I haven't been with this doctor for long, and it's not like I can tell him I don't think he's right (P8, 58 years).

Another participant reflected on his passive interactions with his clinician and reported,

And I guess, when it comes to me and my doctor. I give him complete control. It's like I take all my thoughts about my health, pack them in my car, drive them over, and park them in his garage. I need to give myself more room for empowering myself. (P4, 59 years)

Participants reported thoughts that they should follow their clinician's recommendations and not disagree due to their clinician's expertise, for example, initiating blood pressure medications into the treatment plan.

Interviewer: Okay, your doctor started you on medicine. And you stated that you just went ahead and took it, even though you didn't want it. Do you know why you made the decision then to just go ahead and take it?

Resp: It was my doctor. When your doctor says do something, you typically just do it.

Some participants reported successful power negotiations with their clinicians regarding HTN treatment by promptly informing the clinician about experiences with medication side-effects, communicating openly with their clinicians about a desire for a change, and actively participating in the decision-making process to reach an alternative solution. One participant reported,

So, I instantly made him aware, I got side effects, I came in and told him that my ankle was swollen after taking the medicine. I don't like this; we need to change this. When we talked about it, he reduced what he was believing to be the cause of my ankles to swell. And then he gave me something else and I haven't had a problem since. (P6, 39 years)

This approach demonstrated patient's agency in communicating his needs to the clinician and resulted in a treatment plan that better suited the patients' needs.

Stereotype Threat

Most participants reported not openly sharing their opinions or thoughts about HTN treatment (i.e., blood pressure medications) with their clinicians. Participants expressed the effects of stereotype threat, particularly, a lack of desire to engage in deliberations about their HTN treatment plan, a key component of the SDM process. Some participants reported reasons for not sharing their opinions about treatment because they didn't want their clinicians to view them as non-compliant or rejecting better health. One participant stated,

If my doctor says, Hey, I want you to take this medication and I say, No, I don't want to take that, I don't want that doctor or that nurse practitioner to view us and say, This cat doesn't want to get better. I'm trying to give him a solution. He doesn't want to comply with the treatment options that I'm giving him." (P15, 44 years)

Participants expressed thoughts that if they spoke up or asked questions about recommendations, it would be confrontational or argumentative. For example, one participant stated,

I hate confrontation. I don't like confrontation, I don't like to put myself in situations where I'm going to argue, whatever the case may be, I try to stay mellow, I try to stay calm, I try to stay, I'm pretty much peaceful. That's who I am, and I think it shows up in my relationship with my doctor. (P12, 34 years)

Clinician-Related Factors Influencing Involvement in SDM

Key clinician-related factors that significantly influence Black male patients' involvement in SDM for HTN treatment and management encompass: clinicians' ability to relate to their Black male patients by disclosing their personal experience with managing HTN, depth of clinicians' investigations into root causes of their patients' high blood pressure, and clinicians' approaches to treatment **Table 4-3**.

Clinicians Disclosing Personal Experience with Blood Pressure Medications Influence Black Men's Involvement in SDM

Participants expressed that clinicians who demonstrated relatability in their experiences with HTN were empowered to communicate their hesitancy with starting blood pressure. One participant reported,

Although I was reluctant, initially, our conversation that he had with me as far as putting himself in the same category, and him being particularly on the same medicine that he prescribed to me, made my mind a little bit more at ease for me and of course, I asked for the side effects of that medicine. So what's the side effects? And he told me that the ones he prescribed were good for Black men. (P6, 39 years)

Table 4-3. Clinician-Related Factors.¹

Clinician-related factors to involvement in SDM	Example quote
Clinicians disclosing personal experience with blood pressure medications influence Black men's involvement in SDM.	"So, he put me a little bit at ease because he was like, Man, this is something that, I was diagnosed with high blood pressure when I was 33, as well, like young. And I was a little bit younger than 33 at the time. He was like, But I've been on this medicine." (P14, 36 years)
Clinicians' lack of investigation into the root cause of participants' high blood pressure negatively influenced their desire to engage in SDM.	"He just basically threw me out without discussing it with me, I need to know what exactly is causing this. Could it be stress? Could it be a whole plethora of things going on?" (P12, 34 years)
Clinicians' use of a "medication-heavy" approach to HTN treatment limit opportunities to discuss alternative treatment options with Black men patients.	"But my provider tends to be medication-heavy. I'm not a huge fan of taking medicine. I don't mind doing the blood pressure medication, but there are other things I would like to focus on and discuss, such as lifestyle and behavioral changes." (P15, 44 years).

¹n=16 Black men with a (HTN) hypertension diagnosis who participated in individual semi-structured interviews. SDM= shared decision-making.

Another participant described a situation in which his clinician made him comfortable discussing his HTN treatment due to the depth of conversation regarding HTN treatment, medication side effects, and his clinician disclosing that he was taking the same blood pressure medication and was diagnosed at the same age as the participant.

But he told me, he was just like, I'm going to give you a very small dose. So, he put me a little bit at ease because he was like, Man, this is something that, I was diagnosed with high blood pressure when I was 33, as well, like young. And I was a little bit younger than 33 at the time." He was like, "But I've been on this medicine. (P14, 36 years)

Clinicians' Lack of Investigation into the Root Cause of Participants' High Blood Pressure Negatively Influenced Their Desire to Engage in SDM

Participants reported that their clinicians did not attempt to understand the root cause of their high blood pressure. Participants expressed a desire for their clinicians to determine the root cause of their high blood pressure, emphasizing the need for clinicians to explore potential contributing factors (i.e., poor diet and stress) and tailor the plan accordingly. One participant reported that the lack of investigation limited opportunities to discuss his HTN diagnosis with his clinician. "He just basically threw me out without discussing it with me, I need to know what exactly is causing this? Could it be stress? Could it be a whole plethora of things going on?" (P12, 34 years). Participants said their clinicians consistently prescribe additional medications during medical visits without addressing the underlying cause. For example, one participant mentioned that his clinician continued to "add medication instead of trying to get to the root of the problem." (P8, 58 years)

Clinicians' Use of a "Medication-Heavy" Approach to HTN Treatment Limit Opportunities to Discuss Alternative Treatment Options with Black Men Patients

Participants reported that clinicians who use a "medication-heavy" approach to HTN treatment limit opportunities to discuss alternative treatment options. Participants expressed aversion to taking medications due to concerns about becoming dependent on medications. "I just didn't want the medications because eventually your body will become dependent on those drugs, and you will not be able to come off those drugs no matter what you do" (P12, 34 years). Participants reported wanting more balanced discussions regarding treatment strategies, including behavioral and lifestyle approaches such as stress reduction, diet, and exercise. For example, one participant stated,

But my provider tends to be medication heavy. I'm not a huge fan of taking medicine. I don't mind doing the blood pressure medication, but there are other things I would like to focus on and discuss, such as lifestyle and behavioral changes. (P15, 44 years)

Participants reported wanting their clinicians to focus on behavioral and lifestyle modifications first before prescribing blood pressure medications, as stated by (P5, 35 years),

Their first solution is let's get you on blood pressure medicine, instead of it being, Let's get you on a workout, a diet plan..., let's come up with a strategy or a solution to help fix it before we prescribe these drugs to you.

Additionally, participants associated clinicians' biases about Black patients with HTN as the underlying cause for them prescribing medications first without having in-depth discussions about other treatment options. For example, one participant stated,

I think there's stigma, a stereotype. It's an assumption based on us being African American... they're more likely to have high blood pressure than their white counterparts, and based on that, let's go ahead, knock it out, and make it a quick fix. A quick fix is not always a solution. (P12, 34 years)

Characteristics of an Optimal SDM Environment for Black Men with HTN

The social interactions between participants and their clinicians emerged as pivotal factors driving SDM involvement. Participants identified these interactions as integral aspects of the patient-clinician relationship that cultivated collaboration and patient-centered approaches to HTN treatment and management. Key characteristics of patient-clinician relationships comprised therapeutic working alliances, autonomy support, and trust **Table 4-4**.

Therapeutic Working Alliance

For Black men in this study, a working alliance with their clinician was characterized by communication strategies facilitating open discussions about HTN treatment and management goals, willingness to delay blood pressure medications, and active listening. Participants reported that their clinicians' informal and relatable communication style creates a comfortable and engaging environment for open discussions. For instance, one participant shared how being addressed as 'boss' by his doctor contributed to a relaxed and open atmosphere, stating,

He doesn't call me Mr. X. It may be a generic term, but he refers to me as boss, like, "How's it going today, boss? Everything okay today, boss?" You may say that to 75 other patients, but it's the informality of it that makes me comfortable to open up. (P14, 34 years).

Another participant expressed similar thoughts regarding their clinician's informal communication style by stating,

Table 4-4. Findings from Thematic Analyses with Supporting Quotes.¹

Characteristics of an optimal SDM environment for Black men with HTN	Example quotes
Therapeutic working alliance	<p>“I’ve discussed my desire to discontinue the medication with my doctor, and he’s not entirely opposed to the idea. He doesn’t insist that I must take it for the rest of my life. Instead, he suggests we monitor the situation, and if he observes consistent improvements, he’ll consider reducing the medication dosage or discontinuing it altogether” (P6, 39 years)</p>
Respect for patients decision-making autonomy in HTN management	<p>“I explained that I could muster the motivation to exercise consistently for about a week, but after that, I’d lose patience because I often expect instant results. I also mentioned my time constraints, as my mornings are tightly scheduled, leaving me with just 45 minutes to prepare and head to work. So he focused on helping me to focus on diet instead.” (P14, 35 years)</p>
Trusting patient-clinician relationships influences SDM Involvement	<p>“I’ve been knowing him for over 20 years, and I trust him. It’s the trusting relationship that we have. The rapport. That’s what empowers me to continue to let him take care of me, that trust.” (P3, 73 years)</p>

¹n=16 Black men who participated in individual semi-structured interviews. SDM= shared decision-making.

And so, if I'm in an environment where I feel I can't be loose and relaxed, I won't open up. And with him, I can tell he purposely creates that environment. We have personal conversations where he asks me about my job and how that's going. We may even talk about sports. That helps me to open up and allows me to be involved. (P6, 39 years)

Black men in this study expressed beliefs that clinicians who take the initiative to get to know them beyond the information available in their medical charts convey to participants that they share a common understanding when defining HTN treatment goals. This becomes particularly evident in the decision-making process of initiating blood pressure medications. Participants described an alliance with clinicians who invested the time to understand them on a personal level, aligning treatment goals with their individual preferences. Some participants highlighted specific clinician behaviors that exemplified this alliance, such as a clinician's willingness to delay prescribing blood pressure medications. One participant shared their experience, stating,

Before my doctor prescribes any medication, we discuss whether it's the best choice for me, or if it is even necessary. Looking back to around 2006 when another doctor initially prescribed blood pressure medication for me, maybe I eventually needed it, but I didn't feel it was necessary then. However, my doctor at the time simply instructed me to take it, and I did. (P9, 47 years)

Another participant shared the same thoughts,

I've discussed my desire to discontinue the medication with my doctor, and he's not entirely opposed to the idea. He doesn't insist that I must take it for the rest of my life. Instead, he suggests we monitor the situation, and if he observes consistent improvements, he'll consider reducing the medication dosage or discontinuing it altogether. (P6, 39 years)

Participants emphasized that clinicians who exhibit genuine interest by actively listening and providing the necessary time to process information enhance their sense of involvement in their HTN treatment plan, thus fostering open and effective communication. One participant summarized this by stating,

I genuinely believe my doctor has my best interests at heart, particularly my health. As a result, I feel comfortable discussing any concerns with him. If something isn't working, he's open to making adjustments. While I may be stubborn, he respects that I will eventually recognize the benefits of considering his recommendations, and he allows me the necessary time to adapt. (P14, 35 years)

Respect for Patients' Decision-Making Autonomy in HTN Management

Participants defined autonomy support as the clinician involving the participant in antihypertensive treatment decisions, especially antihypertensive medication. Participants

expressed a desire for autonomy regarding when to initiate blood pressure medication, reduce the number of prescribed medications, or stop taking blood pressure medications altogether. Participants often reported preferences for HTN treatment plans focused on behavioral and lifestyle modifications such as controlling stress, improving quality of sleep and rest, managing anxiety, changing diets by reducing sodium intake, and incorporating more exercise.

For instance, one participant said, “The only decisions or issues I have with my doctor is,... I wish that I could reduce the number of medications I’m taking... I wanted something that I could work with my own lifestyle” (P16, 73-years). The clinician’s role in empowering patients through unwavering support for their autonomy cultivates a patient-centered approach to HTN care that respects patient’s decision-making autonomy and self-management. Examples include not imposing treatment recommendations that do not align with the patient’s lifestyle. For example, a younger participant, reported,

I told him, it’s going to be tough for me to commit to regular exercise. I’m sorry.’ I explained that I could muster the motivation to exercise consistently for about a week, but after that, I’d lose patience because I often expect instant results. I also mentioned my time constraints, as my mornings are tightly scheduled, leaving me with just 45 minutes to prepare and head to work. So, he focused on helping me to focus on diet instead. (P14, 35 years)

Trusting Patient-Clinician Relationships

Participants’ desire for trust was expressed when discussing their trust in their clinician and their perceptions of the relationship. For Black men in this study, men reported that trust was necessary in the patient-clinician relationship, especially regarding the HTN treatment plan. Trust is established when the patient believes the clinician prioritizes the patient’s best interest when deciding HTN management options. Participants reported trust in clinicians based on the duration of the relationship and depth of discussions surrounding HTN benefits and consequences (i.e., medication side effects). For instance, one participant stated, “I’ve been knowing him for over 20 years, and I trust him. It’s the trusting relationship that we have. The rapport. That’s what empowers me to continue to let him take care of me, that trust” (P3, 73 years). Yet, participants reported distrustful relationships with their clinician due to a lack of detailed discussions about medication side effects (i.e., frequent or persistent headaches, sexual dysfunction) ($n=7$), clinician disregard of patient intolerance to medication side effects ($n=8$), frequent medication adjustments without explanation ($n=7$), and beliefs that the clinician was prescribing blood pressure medication(s) for financial gain ($n=5$). One participant stated,

But, as far as like, they can prescribe you something you may not need. It’s like a triple benefit to get you back in there. Not necessarily to get you better, but to get you okay enough just to come back in there. (P1, 39 years)

Furthermore, participants also reported their beliefs that clinicians' biases and prejudices about Black men substantially impacted their healthcare experiences, leading to shorter time spent in medical encounters and fewer treatment recommendations, which in turn contributed to their growing distrust. For instance, a younger participant reported, "We have a stigma on African Americans as us being lazy, we always have, because that was the way society depicted us, that's probably why he automatically assumed medication was the only option that would work for me" (P12, 34 years).

Phase 2: Quantitative Examination of Factors Influencing SDM Involvement Among Black Men with HTN In The U.S. Mid-South

Descriptive Statistics of Quantitative Participants

Out of 155 survey responses received, 105 were eligible for analysis. Seventeen were incomplete or non-responses, 15 failed pre-screens, and eighteen responses were flagged as bots by Qualtrics software and removed due to potential data compromise. Attempts to contact these participants were unsuccessful. The exclusion of bots was crucial to maintaining data integrity. There were 17 incomplete or non-responses, meaning that participants opened and closed the survey without reading past the first page of the online survey. As defined in this study, incomplete surveys encompassed over ten missing items from the scales used to measure the primary study variables (API-DM-6, TPS, MMI-7, HCCQ-6, and WAI-GP scale). After seven days of survey inactivity, the study's principal investigator sent a follow-up email to participants who provided contact details and allowed 3 weeks for completion. Individuals who did not respond after the 3-week period were not contacted again.

Fifteen respondents failed the pre-screening, as indicated by responding "no" to having HTN. Lastly, 18 responses were excluded from the data analysis because they were identified as bots by the Qualtrics software. The automated bot detection system eliminated responses with a reCAPTCHA score below 0.5 (Qualtrics, 2023). A manual examination of each response revealed a reCAPTCHA score of 0.2, redundant IP and email addresses, and less than 5 minutes to answer questions in the survey. The survey response time was shorter than the response time that it took pilot participants to take the survey (i.e., 23–53 minutes). An attempt to call and email the participants to corroborate their identities revealed no response. To ensure accurate results, the bots were eliminated from the analysis (**Figure 4-1**).

Characteristics of Quantitative Participants

This section provides an overview of the demographic and patient characteristics of the 105 Black men who responded to the online web survey about SDM involvement for HTN treatment and management. Participants' HTN treatment and clinicians' are also reported.

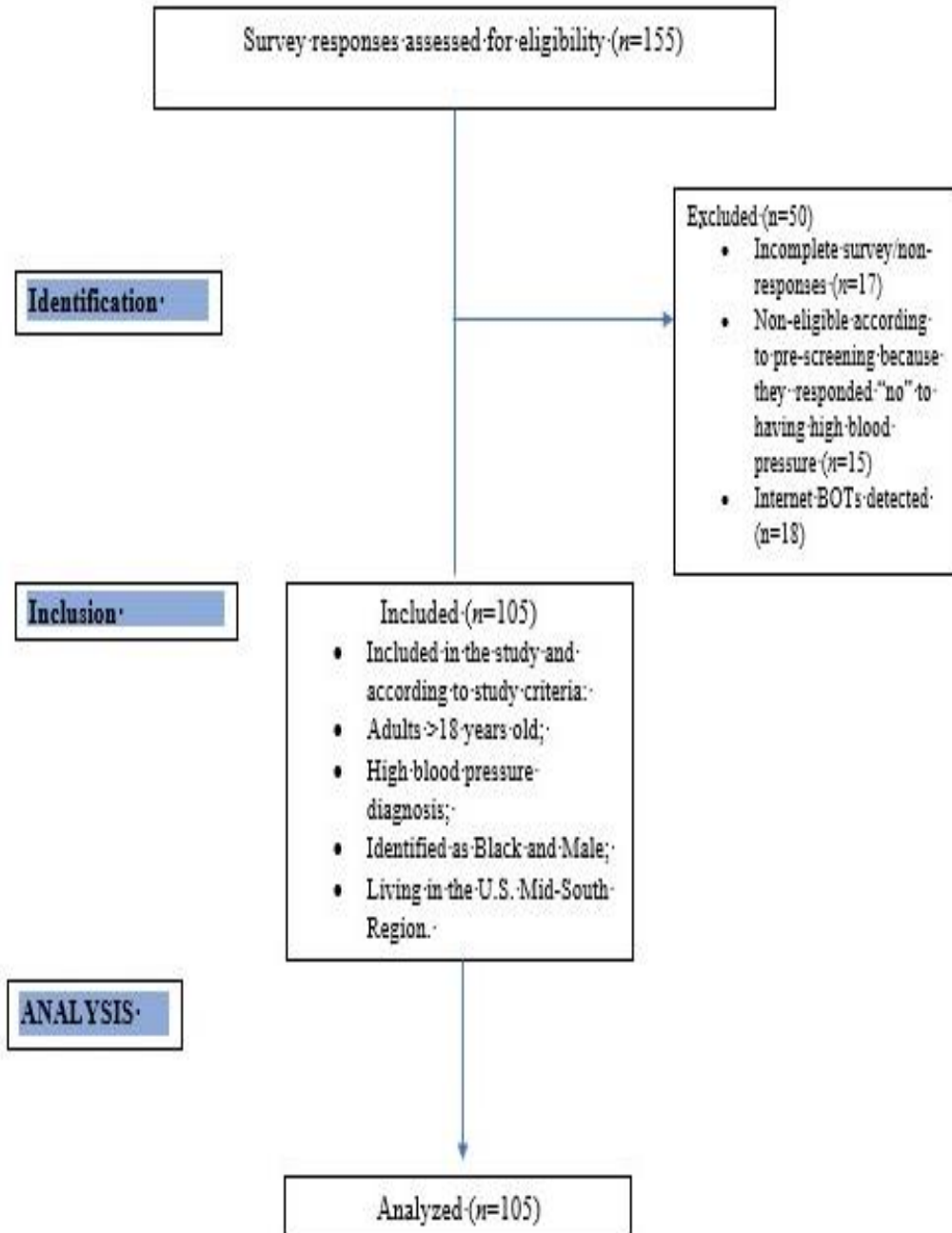


Figure 4-1. Flow Diagram of Survey Participants Included in Analyses.

Participants were between 40 and 49 years of age, and 35.24% held at least a 4-year college degree ($n = 37$). Most participants reported being married (65.71%, $n = 69$), having health insurance coverage (48%, $n = 95$), with an annual income ranging between \$60,000 - \$79,999 (31.43%, $n = 33$).

Participants frequently reported being diagnosed with HTN at 40–49 years (31.43%, $n = 33$) and taking at least one blood pressure medication for HTN treatment (45.71%, $n = 48$). Participants often reported that their clinicians who managed their HTN identified as Black or African American (63.81%; $n = 67$) and male (79.05%, $n = 83$). Participants reported being seen by their clinician for at least three years (29.52%, $n = 31$). Percentages and frequencies are reported in **Table 4-5**.

Descriptive Statistics of Study Scales

Scales employed in this study and their descriptive statistics are presented in this section. The summary statistics for these scales can be found in **Table 4-6**, and the reported reliability for each scale is presented in **Table 4-7**. The Working Alliance scale was used to measure the quality of collaboration between participants and their healthcare clinicians, yielding an average score of 49.68 ($SD = 8.36$), indicating a high level of perception of collaboration with their clinicians. The scores ranged from a minimum of 14.00 to a maximum of 60.00, with a median score of 49.00. Participants' perception of autonomy support received from healthcare clinicians for HTN treatment and management yielded an average score of 35.54 ($SD = 6.92$), indicating a high level of support from their clinicians. Participant scores on this scale varied between 12.00 and 42.00; the median was 37.00.

Participants' perception of medical mistrust yielded an average score of 19.95 ($SD = 3.77$), indicating a low level of mistrust of health care settings. Scores on this scale ranged from a minimum of 7.00 to a maximum of 28.00, with a median score of 20.00. Participants' perception of trust in their healthcare clinician yielded an average score of 36.41 ($SD = 4.83$), indicating a relatively low perception of trust in their clinician. Participants' scores on this scale ranged from 23.00 to 53.00, with a median of 36.00.

Participants' desire to be involved in their HTN treatment and management produced an average score of 51.63 ($SD = 12.94$), indicating a high level of desire to be involved in HTN treatment and management decisions. Scores on this scale had a wide range, spanning from 16.67 to 75.00, with a median score of 50.00.

Reliability of Study Scales

A Cronbach alpha coefficient was estimated for the TPS scale, which consisted of 11 items measuring the degree to which patients trusted their clinician. The items measuring Trust (Clinician) had a Cronbach's alpha coefficient of 0.87, indicating good

Table 4-5. Characteristics of Quantitative Participants.¹

Variable	<i>n</i>	%
Highest education level		
8th grade or less	2	1.90
High school graduate/ GED	17	16.19
Some college or 2-year degree	27	25.71
4-year college degree	37	35.24
Some graduate school or more	22	20.95
Age		
20–29 years	9	8.57
30–39 years	15	14.29
40–49 years	35	33.33
50–59 years	26	24.76
60–69 years	18	17.14
70 years and older	2	1.90
Annual income		
Less than \$20,000	6	5.71
\$20,000–\$39,999	2	1.90
\$40,000–\$59,999	9	8.57
\$60,000–\$79,999	33	31.43
\$80,000–\$100,000	25	23.81
More than \$100,000	30	28.57
Relationship/ partnership status		
Single	33	31.43
Engaged	3	2.86
Married	69	65.71
Health insurance status		
Yes	95	90.48
No	10	9.52
Age at HTN onset (years) ³		
18–29 years old	31	29.52
30–39 years old	30	28.57
40–49 years old	33	31.43
50–59 years old	10	9.52
Number of blood pressure medications ⁴		
0	1	0.95
1	48	45.71
2	20	19.05
3	9	8.57
4 or more	7	6.67
I don't know/remember	1	0.95
Clinician-patient relationship (months/years)		
0–12 months	26	24.76
1–2 years	20	19.05
3–5 years	31	29.52
More than 5 years	28	26.67
Clinician's race/ethnicity		
Black or African American	67	63.81
White	26	24.76
Other	12	11.43
Clinician's gender		
Male	83	79.05
Female	22	20.95

¹Black men with hypertension (HTN) in the Mid-South who completed the quantitative survey (*n*=105). Participants' clinician characteristics are also reported.

Table 4-6. Descriptive Statistics of Study Scale Scores.

Variable	<i>M</i>	<i>SD</i>	Min	Max
Working alliance ¹	49.68	8.36	14.00	60.00
Autonomy support ²	35.54	6.92	12.00	42.00
Medical mistrust ³	19.95	3.77	7.00	28.00
Trust ⁴	36.41	4.83	23.00	53.00
Decision-making involvement ⁵	51.63	12.94	16.67	75.00

(*M*-Mean; *SD*=Standard Deviation; Min=minimum; Max=maximum.) ¹WAI-GP ²Health Care Climate Questionnaire-HCCQ6 ³MMI-7 ⁴TPS ⁵API-Decision Making.

Table 4-7. Reliability of Study Scales.

Scale	Number of items	α	Lower bound	Upper bound
Trust-TPS	11	.87	.84	.90
Medical Mistrust-MMI-7	7	.86	.82	.89
Autonomy Support-HCCQ-6	6	.91	.89	.93
Working Alliance-WAI GP	12	.96	.95	.97
Decision-Making Involvement-API DM-6	6	.70	.61	.75

The lower and upper bounds of Cronbach's α were calculated as 95% confidence intervals. The Cronbach's alpha coefficients were evaluated using the guidelines suggested by George and Mallery (2016) where $>.9$ implies excellent, $>.8$ good, $>.7$ acceptable, $>.6$ questionable, $>.5$ poor, and $\leq.5$ unacceptable.

reliability. A Cronbach alpha coefficient was estimated for the MMI-7 scale, which consisted of six items measuring the degree to which patients felt they trusted the healthcare organization. The items measuring medical mistrust had a Cronbach's alpha coefficient of 0.86, indicating good reliability. A Cronbach alpha coefficient was estimated for the HCCQ-6 scale, which consisted of six items measuring the degree to which patients felt they had autonomy support from their clinicians. The items measuring autonomy support had a Cronbach's alpha coefficient of 0.91, indicating excellent reliability. A Cronbach alpha coefficient was estimated for the WAI-GP scale, which consisted of 12 items measuring the degree to which patients felt they had a working alliance or collaborative relationship to reach an agreement in health care decisions. The items measuring working alliance had a Cronbach's alpha coefficient of 0.96, indicating excellent reliability. A Cronbach alpha coefficient was estimated for the API-DM-6 scale, which consisted of six items measuring the degree to which patients desired involvement in decision-making. The items measuring decision-making involvement had a Cronbach's alpha coefficient of 0.70, indicating acceptable reliability. **Table 4-7** presents the results of the reliability analysis.

Quantitative Research Phase: Findings

In the quantitative phase of this mixed methods study, the primary goal was to identify selected patient, clinician, and patient-clinician relationship domains that influence the involvement in the SDM process among Black men with HTN in the U.S. Mid-South. We explored patient factors (such as patient age and education), clinician factors (such as clinician's race and gender), and perceptions of the men's relationships with their clinicians (such as working alliance, trust, and autonomy support) and examined the impact of these factors on desired levels of SDM involvement. Findings from statistical analyses (Spearman correlation, simple linear regression, ANOVA, ANCOVA, and multiple linear regression) are reported.

Relationships and Associations Among Decision-Making Involvement, Patient (Age and Education), Clinician (Gender and Race) and Relationship Factors (Trust, Autonomy Support, Working Alliance)

Spearman correlation analysis conducted among decision-making, patient age and education, clinician race and gender, trust, autonomy support, and working alliance. Cohen's standard was used to evaluate the strength of the relationships, where coefficients between .10 and .29 represent a small effect size, coefficients between .30 and .49 represent a moderate effect size, and coefficients above .50 indicate a large effect size (Cohen, 1988).

Findings from Correlation Analysis

The result of the correlations was examined using the Holm correction to adjust for multiple comparisons based on an alpha value of 0.05. A significant positive correlation was observed between the desire for Decision-Making Involvement and Clinician Gender, with a correlation of 0.31, indicating a moderate effect size ($p = .038$, 95% CI = [.13,.48]). A significant positive correlation was observed between Autonomy Support and Working Alliance, with a correlation of 0.74, indicating a large effect size ($p < .001$, 95.00% CI = [.63,.81]). This suggests that as autonomy support increases, the working alliance increases. A significant positive correlation was observed between Autonomy Support and Trust in Clinicians, with a correlation of 0.33, indicating a moderate effect size ($p = .023$, 95.00% CI = [.14,.49]). This suggests that trust in the clinician tends to increase as Autonomy Support increases. A significant positive correlation was observed between Working Alliance and Trust in Clinicians, with a correlation of 0.37, indicating a moderate effect size ($p = .004$, 95.00% CI = [.19,.52]). This suggests that trust in the clinician increases as the working alliance increases. No other significant correlations were found. **Table 4-8** presents the results of the correlations.

Findings from Simple Linear Regression Analysis

Simple linear regression analysis investigated whether a linear relationship existed between decision-making involvement and each independent study variable (patient age and education, clinician race and gender, trust, autonomy support, and working alliance). The analysis yielded no significant relationships with patient age and education, clinician race, working alliance, medical mistrust, or autonomy support. However, significant relationships existed for decision-making involvement with clinician gender and trust.

Specifically, the analysis revealed a statistically significant positive relationship between clinician gender, particularly female clinicians, and a greater desire for involvement in decision-making. This implies that individuals in the study expressed a stronger preference for participating in the decision-making process when interacting with female clinicians.

Additionally, a significant negative relationship between trust in clinicians and the level of involvement in SDM was observed. Specifically, when participants reported higher levels of trust in their clinicians, their preference for SDM involvement tended to be lower. Conversely, participants who reported lower levels of trust in clinicians were more likely to express a greater desire for involvement in SDM. This suggests an inverse relationship between trust in clinicians and the desire for SDM involvement. Summary findings for each variable are presented in **Tables 4-9** and **4-10**.

Table 4-8. Spearman Correlation Matrix Among Key Study Variables.¹

Variable	1	2	3	4	5	6	7	8	9
Age	-								
Education	-.18	-							
Decision making involvement	.09	-.01	-						
Clinician race	.07	-.08	.20	-					
Clinician gender	-.22	.14	.31*	-.07	-				
Medical mistrust	-.04	-.01	-.01	-.04	-.04	-			
Autonomy support	.10	-.05	.03	.10	-.14	-.29	-		
Working alliance	-.05	.08	-.03	.04	.10	-.30	.74*	-	
Trust in clinician	-.24	-.03	-.09	.02	-.10	-.03	.33*	.37*	-

* $p < .05$. In this study, Clinician's race was coded as follows: Black or African American=1; White=2; Other =3. Clinician's gender was coded as follows: Male=1; Female=2. ¹patient's age, education, decision-making involvement, medical mistrust, autonomy support, working alliance, and trust in their clinician and their clinician's race and gender.

Table 4-9. Simple Linear Regression with Clinicians' Gender.¹

Variable	B	SE	t	p	95% CI
(Intercept)	49.60	1.36	36.50	< .001	[46.90,52.29]
Clinician gender-female	9.68	2.97	3.26	.002	[3.79, 15.57]

Results: $F(1,103) = 10.64$; $p = <.001$, $R^2 = .09$. ¹Predicting decision-making involvement.

Table 4-10. Simple Linear Regression with Trust.¹

Variable	B	SE	t	p	95%CI
(Intercept)	71.15	9.50	7.49	<.001	[52.30,89.99]
Trust in clinician	-0.54	0.26	-2.07	.041	[-1.05,-0.02]

Results: $F(1,103) = 4.29$; $p = .041$; $R^2 = .04$. ¹Predicting decision-making involvement.

Subsequently, an analysis was conducted to determine whether there was a significant interaction effect between trust and clinician's gender among Black men's decision-making involvement. The test for the interaction was not significant, $F(3, 102) = 1.566$; $p = .214$, indicating there was not a significant interaction effect of trust with clinician's gender. Therefore, the slopes of the regression of decision-making involvement on trust were the same for male and female clinicians.

Predictors of SDM Involvement Among Black Men with HTN

A multiple linear regression analysis investigated whether both trust in clinicians and the clinician's gender significantly predicted involvement in decision-making. The linear regression model was statistically significant ($F(2,102) = 7.05$; $p = .001$), indicating that approximately 12.14% of the variance in decision-making involvement can be explained by trust in clinicians and the clinician's gender. However, trust in clinicians did not emerge as a significant independent predictor of decision-making involvement ($b = -0.45$; $t(102) = -1.80$; $p = .075$) with clinician gender in the statistical model. Specifically, having a female clinician was a significant independent predictor of decision-making involvement ($b = 9.09$; $t(102) = 3.07$; $p = .003$). According to the findings from this sample, engaging in the SDM process with a female clinician increased the desired level of decision-making involvement for HTN treatment and management by about nine points. The multiple regression model can be found in **Table 4-11**.

Summary of Quantitative Findings

Findings from the quantitative phase of this study show that the only statistically significant predictor of involvement in SDM involvement among Black men with HTN was the clinician's gender. Findings from the quantitative phase of this study will be integrated with qualitative results to draw inferences.

Phase 3: Integration of Qualitative and Quantitative Results Mixed Methods Results

In this study, mixed methods integration occurred across three stages: the study design stage, the methods stage, and the analysis and interpretation of qualitative and quantitative results. At the design and methodological stage (i.e., exploratory sequential design), qualitative themes from semi-structured interviews informed the selection of key concepts related to SDM among Black men with HTN. These themes, such as race congruence, gender congruence, and trusting clinician relationships, for example, were identified as precursors to Black men's desire for involvement in the SDM process for HTN treatment. These themes were turned into measurable concepts using existing scales for further exploration in the study's quantitative online survey.

Table 4-11. Trust and Clinicians' Gender.¹

Effect	Estimate	SE	95% CI		p
			LL	UL	
Fixed effects					
Intercept	66.10	9.28	47.69	84.51	<.001
Trust in clinician	-0.45	0.25	-0.95	0.05	.075
Clinician gender-female	9.09	2.96	3.22	14.95	.003

Results: $F(2,102) = 7.05$; $p = .001$; $R^2 = .12$. CI = confidence interval; LL = lower limit; UL = upper limit. SE = standard error. ¹ Prediction of decision-making involvement.

The quantitative investigation described the relationships among factors influencing SDM involvement. Lastly, integration occurred at the analysis stage to determine if qualitative and quantitative findings showed differences (divergence), alignments (convergence), or combined findings (mixed) regarding factors related to preferences for SDM involvement among Black men with HTN **Table 4- 12**.

Qualitative participants emphasized a preference for discussing HTN treatment with Black clinicians, citing the importance of racial congruence for open and honest conversations. However, the quantitative analysis found no significant correlations, indicating a divergence in perceptions with quantitative participants. This suggests that, although qualitative participants stressed the important of having a Black clinician, this factor did not align with quantitative survey responses on its role in SDM involvement. This finding suggests that while racial congruence may be important among Black men in this study, this factor may not directly translate into quantifiable measures of SDM involvement. Findings converged regarding clinician gender, suggests that gender dynamics may play an underlying role in shaping healthcare interactions for Black men in this context. Qualitative participants expressed preferences for male clinicians, particularly Black male clinicians, while the regression analysis showed that having a female clinician was the only significant predictor of preference for decision-making involvement, showed that engaging in the SDM process with female clinicians increased the desired level of involvement for HTN treatment.

The qualitative and quantitative findings regarding trust in the context of SDM among Black men with HTN diverged. Qualitative participants emphasized trust as necessary factor for SDM involvement, emphasizing the importance of trust in the patient-clinician relationship. Contrastingly, the quantitative analysis revealed an unexpected result—participants were less likely to express a desire for SDM involvement when they reported higher levels of trust in their clinicians. These findings highlight the multifaceted nature of how trust is perceived in patient-clinician relationships among Black men. The scale measuring trust in the quantitative phase specifically measured interpersonal trust with the clinicians, focusing on a narrower dimension than the qualitative interviews, which explored trust within the broader patient-clinician relationship. The scale’s emphasis on trust in their clinicians may not have fully captured the nuanced dimensions of trust as described by participants in the qualitative phase.

Furthermore, participants highlighted the importance of a therapeutic working alliance and autonomy support in facilitating SDM involvement in qualitative responses. However, quantitative analysis did not reveal significant relationships between therapeutic working alliance, autonomy support, and decision-making involvement, indicating a divergence between how Black men in this study perceived these concepts in relationship to how concepts were measured in the quantitative scales. In conclusion, integrating qualitative and quantitative data provides a nuanced understanding of the factors influencing SDM preferences among Black men with HTN, revealing both converging and diverging results across different themes.

Table 4-12. Integrated Findings for Shared Decision-Making.¹

Qualitative themes and codes	Example quote	Quantitative results	Do results diverge or mix?
<p>Theme: Racial/cultural congruence</p> <p>Codes: Black doctor, being taken care of by my own, If I go to the doctor I will be looking for an African American doctor</p>	<p>“I feel more comfortable discussing my health with a Black male doctor.., he may understand that my high blood pressure just isn’t the result of my diet or other things that. I like how he handles things.</p>	<p>Clinician race</p> <p>$r = .20, p = 1.00$</p>	Diverge
<p>Theme: Gender congruence</p> <p>Codes: Most men I know don’t want a woman doctor; won’t be able to talk like that to a female doctor</p>	<p>“I kind of have a ranking in my mind, I’m more comfortable with a male doctor than I am a female doctor. But I’m most comfortable with a Black male doctor.”</p>	<p>Clinician gender</p> <p>$b = 9.68; t = 3.26; *p = .002$</p> <p>Gender</p> <p>*(Having a female) clinician was a significant predictor of preference for decision-making involvement</p>	Converge
<p>Theme: Therapeutic working alliance</p> <p>Codes: Ways to achieve agreement about HTN treatment plan; Work with me at my level</p>	<p>“I’ve discussed my desire to discontinue the medication with my doctor, and he’s not entirely opposed to the idea. He doesn’t insist that I must take it for the rest of my life. Instead, he suggests we monitor the situation, and if he observes consistent improvements, he’ll consider reducing the medication dosage or discontinuing it altogether.”</p>	<p>therapeutic working alliance</p> <p>$r = -0.3, p = 1.00$</p>	Diverge
<p>Theme: Trusting patient-clinician relationships</p> <p>Codes: Rapport; knowing him; That’s what empowers me to let him take care of me, that trust.</p>	<p>“When you’re speaking with your healthcare provider, whether it’s related to blood pressure or something more serious, it’s a matter of utmost confidentiality. So, I think the primary reason someone might avoid talking to a provider is a lack of trust.”</p>	<p>Trust in clinicians</p> <p>$B = -0.45, t(102) = -1.80, p = .075$.</p>	Diverge
<p>Theme: Respect for patients’ decision-making autonomy</p>	<p>“So, he focused on helping me with my diet instead.”</p>	<p>Autonomy support</p> <p>$r = 0.3, p = 1.00$</p>	Diverge

¹SDM. We combined qualitative data (interviews with Black men with HTN= hypertension) and quantitative data (a web survey examining patient clinician factors) to gain a comprehensive understanding of factors influencing their preferences for involvement in SDM with clinicians for hypertension treatment.

CHAPTER 5. DISCUSSION

This exploratory sequential MMR study aimed to identify factors that impact Black adult men's preferences for involvement in the SDM process with their clinician regarding HTN treatment and management decisions. This two-phase study employed a qualitative phase in which individual, semi-structured interviews were conducted to inform the selections of factors to examine in a quantitative survey-based study with a separate sample of Black adult men with HTN. This study was informed by previous studies that suggest that adult Black men want SDM in their medical encounters (George et al., 2020; Hart et al., 2009; Mhaimed et al., 2023). Yet, little is known about unique SDM preferences among adult Black men with HTN who live in the U.S. Mid-South region. This study found that SDM preferences go beyond simply determining who should make the decision: the patient or the clinician (Edwards & Elwyn, 2006). As such, we have identified key factors that contribute to shaping an optimal environment for SDM interactions between Black men and their healthcare clinicians.

The qualitative thematic analysis reveals several nuanced patient and clinician factors that Black men consider that describe the optimal SDM environment for HTN treatment and management. Patient-related factors include racial and cultural congruence with clinicians. Culture congruence facilitated open communication and understanding for participants, particularly regarding cultural factors affecting HTN control. Participants felt more comfortable discussing the impact of HTN treatment on their daily lives with Black male clinicians who can relate to their experiences and understand the sociocultural context impacting their blood pressure management. For example, participants were more willing to openly communicate with their clinicians about non-adherent behaviors, such as eating foods outside the prescribed treatment recommendations for blood pressure control.

Black men's experiences of power negotiations and stereotype threats also play a role in SDM involvement. Black men's experiences negotiating their decision-making power with clinicians in deciding HTN treatment and management plans were a common theme, especially with some participants who perceived having a lower decision-making power than their doctor. These participants were hesitant to advocate for their treatment preferences. This finding is consistent with prior studies indicating that Black men's health perspectives are shaped by historical and sociopolitical factors, which in turn affect various aspects of disease self-management, notably resulting in a perception of diminished control over their health (Long et al., 2017; Powell et al., 2019). Participants avoided openly sharing their opinions or thoughts about treatment with their clinicians to avoid being viewed as non-compliant, confrontational, or conforming to a typical stereotype of Black men. This finding aligns with previous research that discussed the impact of stereotype threat on health disparities (Burgess et al., 2010; Eaton et al., 2015), specifically, its impact on patient communication (Levinson et al., 2008), or patients being less participatory in their care (Wilson et al., 2021).

Clinicians' disclosure of personal experience with blood pressure medications, lack of investigation into the root cause of high blood pressure, and medication-centered approach to HTN treatment negatively affect participants' desire to engage in SDM. This finding aligns with previous studies that have reported that clinicians' self-disclosure about their life experiences is a positive feature of patient-clinician relationships (Arroll & Allen, 2015), especially among marginalized groups (Nazione et al., 2019). Furthermore, Nazione et al. (2019) found that providers' self-disclosure about personal experiences led to higher levels of trust, rapport, and honest disclosure for patients about treatment. Similarly, Dangerfield et al. (2022) found that clinicians' self-disclosure about using HIV pre-exposure prophylaxis (PrEP) helps lessen the burden of vulnerability of Black male patients when discussing sensitive topics about care (i.e., symptom management, PrEP use disclosure with romantic/sexual partners). Our finding that clinician disclosure of hypertensive medication use is influential in SDM may help explain why race and trust alone do not conclusively explain Black men's involvement in SDM.

The interaction between clinicians and patients is multifaceted, extending beyond racial considerations. The trust in this relationship is influenced by personal factors, including the communication strategies employed by clinicians (Asan et al., 2021). Participants expressed reservations about relying on medications and have expressed a desire for more balanced discussions that encompass alternative treatment options, such as behavioral and lifestyle approaches. This echoes findings from previous studies where individuals with HTN voiced concerns about the potential long-term effects of medications (Benson & Britten, 2002; Hamrahian et al., 2022; Khan et al., 2014). Participants in the study also indicated a perception that clinicians may have biases and stereotypes about Black patients with HTN, such as associating them with laziness. This perception contributes to a medication-centered approach to HTN management. There is a belief that clinicians might be more inclined to prescribe medications without thoroughly discussing alternative treatment options due to these underlying biases. Existing literature supports the idea that clinicians' implicit biases, particularly regarding patients' adherence to treatment, can influence treatment decisions (Blair et al., 2014; Lauffenburger et al., 2023; van Ryn et al., 2006). This emphasizes the need for awareness and sensitivity to potential biases that could affect the doctor-patient relationship, particularly in the context of chronic conditions like HTN. Additionally, it underscores the importance of fostering open and comprehensive discussions about treatment options.

In the qualitative phase, found that Black men with HTN reported their relationships with their clinicians centered around creating optimal SDM environments. Key characteristics of patient-clinician relationships include therapeutic working alliances, clinicians' respect for Black men's decision-making autonomy, and trust. Participants described a therapeutic working alliance as clinicians taking the time to understand participants personally and align treatment goals with their preferences. Participants emphasized the importance of their clinicians' informal and relatable communication style, which created a comfortable and engaging environment for open discussions about HTN treatment and management. Clinicians who took the time to understand participants personally and aligned treatment goals with their individual

preferences fostered a strong therapeutic alliance. Participants expressed satisfaction with clinicians who actively listened to their concerns about treatment and were willing to delay prescribing blood pressure medications.

Trust in the patient-clinician relationship was crucial for participants. Trust was established when participants believed that clinicians prioritized their best interests when deciding on HTN management options. Trust was built over time through the duration of the relationship, and clinicians having detailed discussions about the benefits and consequences of HTN treatment. However, participants reported distrust when there was a lack of detailed discussions about medication side effects, clinician disregard of patient intolerance to side effects, frequent medication adjustments without explanation, and beliefs that clinicians were prescribing medications for financial gain. This finding aligns with prior research by Kaplan et al. (2006), Alpers (2016), and Adams & Craddock (2023), all of whom found that poor communication with clinicians exacerbated the lack of trust in the healthcare system. Participants also reported that clinicians' implicit biases and prejudices about Black men impacted their healthcare experiences and contributed to their growing distrust. Findings suggest the need for more implication for more patient-centered care to reduce the effects of medical mistrust (Cuevas et al., 2019; Jaiswal, 2019).

Among Black male participants in the quantitative survey phase of this study, we found that most findings diverged from qualitative findings regarding key factors influencing SDM preferences. Findings from regression analyses suggest trust and clinician gender are the only predictors of SDM involvement among Black men in the quantitative sample. Surprisingly, among Black men in the quantitative sample, having a Black clinician, therapeutic working alliance, and autonomy support did not predict Black men's desire to participate in the SDM process. Li (2024) reported similar findings that race concordance had no statistically significant effect on SDM or working alliance among Black patients.

In prior studies, researchers have highlighted the significance of race or ethnic concordance between clinicians and patients as a factor within the patient-clinician relationship that can influence outcomes for marginalized groups (Bayne, 2023; Otte, 2022; Shen et al., 2018). These outcomes include patient satisfaction within healthcare systems (Takeshita et al., 2020) and decision-making (Saha & Beach, 2020). Preference for race-concordant patient-clinician relationships among Black male participants in the qualitative phase is similar to the findings of previous studies. Cuevas et al (2019) found that participants preferred Black doctors, believing that Black doctors were better communicators and more empathetic, fostering trust and contributing to positive healthcare experiences, similar to those in survey research studies examining the impact of race on decision-making (Chung et al., 2020) and satisfaction with patient-provider communication (Assari, 2019).

However, over the past two decades, research findings have yielded inconclusive, contradictory results regarding the influence of race concordance on health outcomes (Cooper et al., 2003; Franks & Bertakis, 2003; Miller et al., 2023; Peek et al., 2010; Shen

et al., 2018). The authors highlighted several reasons for discrepancies among studies, including oversimplification of ethnic and cultural experiences, inconsistent operationalization of communication variables, and a poorly conceptualized patient-clinician relationship. This finding is similar to our study, where Black men in the qualitative phase expressed the desire for Black male clinicians to engage in SDM. However, the findings from the quantitative sample revealed that race was not associated with SDM. For example, Peek et al. (2010) found in a study exploring the impact of race on SDM that most interview participants reported that race was not an essential factor in communicating with their clinicians; however, patients valued cultural humility, empathy, and collaborative decision-making.

The divergence among men in the study may be attributed to a complex interplay of factors such as individual preferences, cultural nuances, and variations in healthcare experiences. The mixed results suggest that Black men, particularly in the Southern context, exhibit diverse preferences in SDM involvement, challenging any simplistic generalizations. These findings shed light on the heterogeneity within the Black male population, emphasizing the importance of recognizing individual preferences and not assuming a one-size-fits-all approach to SDM. Personal experiences may contribute to the observed divergence, highlighting the need for a nuanced understanding of healthcare preferences among Black men in this context. Additionally, the mixed results may indicate that factors beyond demographics, play pivotal roles in shaping preferences for SDM among Black men. The study's complexity underscores the need for healthcare providers to approach SDM with cultural sensitivity and a tailored approach that respects the individuality of Black men in the South, recognizing and addressing their unique healthcare needs and preferences.

Similarly, the influence of gender on SDM processes among Black men with HTN were prominent in this study. Black men in the quantitative sample desired more SDM with women clinicians, compared to qualitative participants who more often expressed preferences discussing their HTN treatment with Black male clinicians. Authors who conducted a randomized control trial regarding SDM preferences found that both men and women participants displaying gender role prejudices and were more inclined to prefer active roles in treatment decisions with female clinicians rather than male clinicians (Monzani et al., 2020). This aligns with our study's findings and suggests that pre-existing biases about gender roles may contribute to preferences for increased involvement in decision-making interactions. The reasons for this preference in our study stemmed from participants' perceptions of Black male clinicians' unique ability to relate to cultural norms, their heightened understanding of the challenges faced by Black men, and the ease of communication they experienced in these interactions. This finding aligns with previous research that underscores the interplay between power, social identity, and masculinity, and the significant roles in men's health behaviors (Courtenay, 2000; Edley & Wetherell, 1996; van Wees et al., 2023). Ideas of masculinity and manhood significantly influence men's health-related choices and are the most influential factors in predicting individual risk behaviors throughout their lives (Evans et al., 2011; Garfield et al., 2008). Men's unhealthy behaviors, such as suppressing their health needs and refusing to acknowledge their pain (Courtenay, 2000), often stem from reinforcing

cultural beliefs surrounding notions of masculinity and power (Gilbert et al., 2016; Griffith et al., 2011). When a man experiences illness or disability, it carries profound gender implications (Courtenay, 2000). It can diminish his status within masculine hierarchies, alter power dynamics about women, and trigger self-doubts about his masculinity. Men's embodied notions of manhood may be questioned during significant life transitions, such as age milestones, chronic disease, and sexual dysfunction (de Visser & McDonnell, 2013; Liburd et al., 2004). This interaction may be further complicated when a man assumes the role of a patient. Thus, during the clinical interactions, his objective may be to maintain a sense of empowerment power, as it may serve as an underlying component of his gender identity (Griffith, 2016). Additionally, it is reported that patients express greater satisfaction when their physicians allocate more time for them during medical appointments (Martinez et al., 2018). Notably, women physicians have been observed to spend more time with patients than their male colleagues, as evidenced in studies by (Ganguli et al., 2020; Ong et al., 2000; Roter et al., 2002).

The observed preference among men in our study for SDM with women clinicians could be elucidated by considering existing research findings. Studies suggest that women clinicians, in comparison to their male counterparts, tend to exhibit behaviors such as greater adherence to clinical guidelines (Baumhäkel et al., 2009; Kim et al., 2005), the provision of more preventive care, utilization of patient-centered communication strategies (Roter & Hall, 2002), and offering more psychosocial counseling (Tsugawa et al., 2017). This body of evidence proposes a plausible explanation for our study's results, indicating that men's preference for involvement in SDM may be influenced by the healthcare environment created by women clinicians. The qualities associated with women clinicians may potentially contribute to establishing an atmosphere conducive to active participation in treatment decision-making. Understanding and recognizing these tendencies could inform healthcare providers, particularly in our study context of Black men in the South, to tailor their approaches to foster effective SDM. This insight underscores the importance of considering clinician characteristics and communication styles in promoting patient engagement and satisfaction, aligning healthcare practices with the preferences of diverse patient populations.

This study presented divergent findings regarding the patient-clinician relationship among Black men. While trust emerged as a central theme among interview participants, similar to findings from (Whitney et al., 2021), quantitative analysis did not find it a significant predictor of the desired level of SDM involvement. This finding aligns with a relatively recent study that reported trust impaired Black participants involvement in SDM for men in primary care (Pokhilenko et al., 2021). Mixed findings between the qualitative and quantitative samples could be attributed to the nuanced role of trust in SDM involvement. Some studies suggest that excessive clinician trust can limit SDM involvement, as patients may overly rely on clinicians to make decisions (Engelhardt et al., 2020; Pokhilenko et al., 2021; Yeh, 2018). Conversely, trust has also been found to facilitate SDM (Peek et al., 2013). Among Black men in the qualitative sample, distrust in their clinicians was prominent, particularly when clinicians prescribed

multiple medications without providing comprehensive information. This finding is similar to (Zisman-Ilani et al., 2023), who reported similar results regarding clinicians' lack of communication negatively influencing SDM involvement among Black adult patients with diabetes. For some participants, these practices led to suspicions about clinicians' intentions, including the belief that prescribing multiple medications was more about financial gain than genuine patient need. In some cases, these beliefs drove patients to seek advice from relatives or friends instead of consulting or deliberating with their clinicians regarding HTN medication. Clinicians can leverage this insight to establish trust and promote SDM. By inquiring about the information patients have gathered from external sources and considering it in the care plan. This approach validates the patient's agency in their healthcare decisions and enhances trust by demonstrating a willingness to consider the patient's perspective.

Our study adopted Peek et al.'s (2016) conceptual model for SDM as the guiding framework. Like Peek's model, our study identified patient and clinician intersectional identities, such as gender and race, as prominent factors influencing involvement in the SDM process among Black men with HTN in the South. Understanding the underlying perceptions of these identities and how they affected the patient-clinician relationship was essential to fully grasping SDM preferences. Clinician's gender stood out as a predicted factor in SDM involvement among Black men. Clinician's gender may have been an underlying source of empowerment in the patient-clinician relationships. Building upon Peek's model, our study extended the conceptualization of SDM preferences. While Peek et al. (2016) defined *SDM preference* as the patient's desire for this approach to medical decision-making, our study clarifies that decision-making preferences refer to the desire for a level of involvement in the decision-making process. This distinction emphasizes clearly defining SDM preferences in research studies. Our study further clarified the characteristics of the patient-clinician relationship that may be relevant to Black men by considering factors such as the degree of therapeutic working alliance and clinician autonomy support., offering a more comprehensive understanding of characteristics of the patient-clinician relationships that may be particularly relevant to Black men deciding to engage in the SDM process in the HTN treatment context. These findings contribute to a richer understanding of the complexities surrounding SDM in healthcare interactions, particularly among Black men, and set the precedence for future exploration of these concepts.

As mentioned previously, gender was a significant predictor of SDM among Black men in this study. Nurses, as a predominantly female profession (Woo et al., 2022), may help foster an environment for male patients to participate in decision-making actively (Inagaki et al., 2023). Future studies should explore in more depth the interactions between Black male patients and clinicians by gender to compare behaviors during these encounters. Specifically, studies might compare the impact of clinician characteristics, such as race and gender, on SDM preferences among diverse patient populations. This comparative analysis could reveal whether specific characteristics have universal effects or if preferences are context-specific, providing insights for tailoring healthcare practices to different demographic groups.

Limitations

While interpreting the findings of this study, it is crucial to acknowledge the strengths and limitations inherent in the research design. The study's sample included a relatively high SES. This characteristic may limit the generalizability of the study's findings to Black men with HTN from lower SES backgrounds who might face different healthcare access barriers and treatment options. Another limitation arises from the geographical specificity of the sample. The study collected data exclusively from the southern region of the United States. The regional variations in healthcare access, cultural norms, and healthcare provider-patient interactions may differ from other regions of the country. Therefore, the findings may not directly apply to Black men living in other geographical areas with HTN.

Cross-sectional data inherently restrict the ability to establish causal relationships since each subject is their own control, preventing the testing of variables under different circumstances. Furthermore, participants in the quantitative phase had to rely on their own memory when responding to research questions, which can introduce recall bias and affect the accuracy of the data collected. The utilization of an exploratory sequential mixed methods approach aimed to mitigate certain limitations associated with both qualitative and quantitative methodologies. These limitations should be considered when interpreting and generalizing the study's findings, and future research may address these issues to enhance the robustness of the results.

However, a notable strength of this study is its integration of qualitative and quantitative data, addressing a common gap in mixed methods research. Moreover, the qualitative findings from Black men themselves bolster the reliability of the study's conclusions. Additionally, the study's clarification of SDM preferences, specifically regarding role preference and behavioral involvement, provides conceptual clarity often lacking in SDM literature. This study fills a crucial gap in scholarship and research by offering empirical data on Black men's SDM preferences in HTN treatment.

Conclusion

The findings from this study shed light on the complex interplay between clinician gender, trust, and Black men's preferences for shared decision-making SDM involvement in hypertension treatment. The discussion reveals two primary themes: the role of trust and the influence of clinician gender on SDM preferences. The complexity of patient preferences for SDM among Black men with HTN necessitates a nuanced approach to fostering SDM implementation. Our study has revealed a divergence between qualitative and quantitative findings, underscoring the multifaceted nature of these preferences. Clinicians must recognize that each patient brings unique factors and experiences that shape their approach to healthcare decisions making SDM contextual (Gartlehner & Matyas, 2016). Firstly, trust emerges as a pivotal factor influencing Black men's engagement in SDM. Both qualitative and quantitative findings underscore the

significance of trust in shaping patients' desire for involvement in their healthcare decisions. While qualitative data highlight trust as a necessary component for SDM engagement, quantitative results reveal a nuanced relationship wherein high levels of trust correlate with reduced SDM involvement. In contrast, low trust prompts a desire for increased involvement. This contradiction underscores the multifaceted nature of trust, encompassing past experiences and expectations of discussing care with male clinicians, significantly impacting Black men's trust in healthcare providers.

Secondly, clinician gender emerges as another significant determinant of SDM preferences among Black men in this study. Qualitative data indicate that Black men express a preference for discussing treatment with male clinicians, citing greater comfort and perceived understanding. Conversely, having a female clinician is associated with a higher preference for SDM involvement. The gender of the clinician moderates this relationship, with Black men demonstrating differing preferences based on the gender concordance with their provider.

These findings prompt critical reflections on assumptions about patient preferences for SDM and highlight the need for culturally responsive approaches in healthcare research and practice. Therefore, a one-size-fits-all approach is inadequate in SDM implementation. Instead, clinicians should prioritize patient-centered care, acknowledging individual differences and preferences in decision-making (Elwyn et al., 2017). Furthermore, the study suggests that clinicians' gender plays a significant role in patients' preferences for SDM.

Stereotype threats, as our study reveals, can discourage Black men from openly discussing their treatment preferences, fearing they might be perceived as non-compliant or confrontational. To counteract this, healthcare providers and institutions must acknowledge and actively work to mitigate these threats. A crucial step involves incorporating cultural competence training for healthcare professionals (Brown et al., 2016), to include discussions about stereotype threats and biases. This training can help create a more supportive and non-judgmental environment for SDM. Additionally, encouraging patients to voice their preferences and concerns becomes pivotal in empowering them to overcome stereotype threats. Such encouragement fosters an environment where patients feel valued, respected, and in control of their healthcare decisions (Brown et al., 2016).

Power negotiations, another key aspect influencing patients' engagement in SDM, call for attention and action from healthcare providers. Achieving a balanced and collaborative approach to decision-making is essential to address patient empowerment effectively (Beyene et al., 2018). This implies a need for SDM models emphasizing patient empowerment and the role that power plays in SDM. Effective communication skills, including active listening and empathy, facilitate these negotiations by building trust and rapport (Asan et al., 2021). These skills empower patients to assert their preferences and participate in SDM (Minheere et al., 2023). Integrating strategies to address stereotype threats and power negotiations into healthcare practice may promote a more patient-centered, equitable, and effective SDM facilitation for Black men.

Qualitative insights emphasize the significance of cultural congruence and trust in healthcare relationships. To foster SDM effectively, clinicians should prioritize cultural sensitivity, adapting their communication styles to meet patients where they are (Chevalier et al., 2016). Furthermore, trust-building is essential and may require time and effort from clinicians (Crits-Christoph et al., 2019), which can be facilitated by transparent communication (Gregory & Austin, 2021), such as addressing concerns about medication side effects and giving patients more time to adjust to taking medications. To ensure equitable healthcare, clinicians must also be vigilant in addressing biases and stereotypes that may influence their interactions with Black male patients.

Looking ahead, future research should expand its focus to include the perspectives of clinicians regarding shared decision-making (SDM) in healthcare interactions, providing insights into their preferences and experiences in gender-discordant relationships. This exploration could involve more targeted inquiries to understand the specific aspects of trust that impact clinician involvement in such relationships, thus informing strategies to enhance patient-clinician communication and collaboration. As the trajectory of scholarship in this domain unfolds, there is an opportunity to leverage years of research in the SDM domain to develop clinical behavior and multilevel interventions. Specifically, efforts can be directed towards spearheading the development of SDM tools or aids tailored to assist men in preparing for conversations with their clinicians, empowering them to engage in their healthcare decisions actively. Additionally, there is a pressing need to develop more culturally responsive instruments that authentically capture the patient experience, ensuring that research efforts are inclusive and representative. Moreover, updating guidelines regarding SDM implementation, with a specific focus on improving the SDM experience for Black men with hypertension, is paramount for promoting equitable healthcare delivery and improving health outcomes within this population.

LIST OF REFERENCES

- Abrahamowicz, A. A., Ebinger, J., Whelton, S. P., Commodore-Mensah, Y., & Yang, E. (2023). Racial and ethnic disparities in hypertension: Barriers and opportunities to improve blood pressure control. *Current Cardiology Reports*, 25(1), 17–27. <https://doi.org/10.1007/s11886-022-01826-x>
- Adams, V., & Craddock, J. (2023). Patient-provider communication quality as a predictor of medical mistrust among young Black women. *Social Work in Public Health*, 38(4), 334–343. <https://doi.org/10.1080/19371918.2023.2177225>
- Ahmad, M., Abu Tabar, N., Othman, E. H., & Abdelrahim, Z. (2020). Shared decision-making measures: A systematic review. *Quality Management in Health Care*, 29(2), 54–66. <https://doi.org/10.1097/QMH.0000000000000250>
- Ajiboye, W., Nelson, L., Odhiambo, A., Yusuf, A., Djiadeu, P., Turner, D. A., Abubakari, M., Pedersen, C., Brown, R., Ni, Z., Guillaume, G., Lofters, A., & Williams, G. (2022). Decision conflict and the decision support needs of HIV PrEP-eligible Black patients in Toronto regarding the adoption of PrEP for HIV prevention. *Journal of the International Association of Providers of AIDS Care*, 21. <https://doi.org/10.1177/23259582211073399>
- Akpa, O. M., Made, F., Ojo, A., Ovbiagele, B., Adu, D., Motala, A. A., Mayosi, B. M., Adebamowo, S. N., Engel, M. E., Tayo, B., Rotimi, C., Salako, B., Akinyemi, R., Gebregziabher, M., Sarfo, F., Wahab, K., Agongo, G., Alberts, M., Ali, S. A., ... Owolabi, M. O. (2020). Regional patterns and association between obesity and hypertension in Africa: Evidence From the H3Africa CHAIR Study. *Hypertension*, 75(5), 1167–1178. <https://doi.org/10.1161/HYPERTENSIONAHA.119.14147>
- Al Khaja, K. A. J., Sequeira, R. P., Alkhaja, A. K., & Damanhori, A. H. H. (2016). Antihypertensive drugs and male sexual dysfunction: A review of adult hypertension guideline recommendations. *Journal of Cardiovascular Pharmacology and Therapeutics*, 21(3), 233–244. <https://doi.org/10.1177/1074248415598321>
- Allen, J. D., Akinyemi, I. C., Reich, A., Fleary, S., Tendulkar, S., & Lamour, N. (2018). African American women’s involvement in promoting informed decision-making for prostate cancer screening among their partners/spouses. *American Journal of Men’s Health*, 12(4), 884–893. <https://doi.org/10.1177/1557988317742257>
- Allen, J. D., Porteny, T., Kaplan, A., Ladin, K., Monahan, K., & Berry, D. L. (2022). Does shared decision-making for prostate cancer screening among African American men happen? It depends on who you ask. *Journal of Racial and Ethnic Health Disparities*, 9(4), 1225–1233. <https://doi.org/10.1007/s40615-021-01064-x>
- Al-Makki, A., DiPette, D., Whelton, P. K., Murad, M. H., Mustafa, R. A., Acharya, S., Beheiry, H. M., Champagne, B., Connell, K., Cooney, M. T., Ezeigwe, N., Gaziano, T. A., Gidio, A., Lopez-Jaramillo, P., Khan, U. I., Kumarapeli, V., Moran, A. E., Silwimba, M. M., Rayner, B., ... Khan, T. (2022). Hypertension pharmacological treatment in adults: A World Health Organization guideline executive summary. *Hypertension*, 79(1), 293–301. <https://doi.org/10.1161/HYPERTENSIONAHA.121.18192>

- Alpers, L.-M. (2016). Distrust and patients in intercultural healthcare: A qualitative interview study. *Nursing Ethics*, 25. <https://doi.org/10.1177/0969733016652449>
- Alsan, M., Garrick, O., & Graziani, G. (2019). Does diversity matter for health? Experimental evidence from Oakland. *American Economic Review*, 109(12), 4071–4111. <https://doi.org/10.3386/w24787>
- Alsan, M., & Wanamaker, M. (2018). Tuskegee and the health of Black men. *The Quarterly Journal of Economics*, 133(1), 407–455. <https://doi.org/10.1093/qje/qjx029>
- American Heart Association. (2021, April 15). *The link between structural racism, high blood pressure and Black people's health*. Heart. <https://www.heart.org/en/news/2021/04/15/the-link-between-structural-racism-high-blood-pressure-and-Black-peoples-health>
- American Heart Association. (2023). *High blood pressure among Black people*. Heart. <https://www.heart.org/en/health-topics/high-blood-pressure/why-high-blood-pressure-is-a-silent-killer/high-blood-pressure-and-african-americans>
- Anderson, L. A., & Dedrick, R. F. (1990). Development of the Trust in Physician Scale: A measure to assess interpersonal trust in patient-physician relationships. *Psychological Reports*, 67(3_suppl), 1091–1100. <https://doi.org/10.2466/pr0.1990.67.3f.1091>
- Arnett, M. J., Thorpe, R. J., Gaskin, D. J., Bowie, J. V., & LaVeist, T. A. (2016). Race, medical mistrust, and segregation in primary care as usual source of care: Findings from the exploring health disparities in integrated communities study. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 93(3), 456–467. <https://doi.org/10.1007/s11524-016-0054-9>
- Arroll, B., & Allen, E.-C. F. (2015). To self-disclose or not self-disclose? A systematic review of clinical self-disclosure in primary care. *British Journal of General Practice*, 65(638), e609–e616. <https://doi.org/10.3399/bjgp15X686533>
- Asan, O., Yu, Z., & Crotty, B. H. (2021). How clinician-patient communication affects trust in health information sources: Temporal trends from a national cross-sectional survey. *PloS One*, 16(2), Article e0247583. <https://doi.org/10.1371/journal.pone.0247583>
- Assari, S. (2019). Psychosocial determinants of communication satisfaction in racially concordant and discordant patient-physician interactions. *Journal of Medical Research and Innovation*, 3(2), Article 165. <https://jmrionline.com/jmri/article/view/165>
- Baah, F. O., Teitelman, A. M., & Riegel, B. (2019). Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health – An integrative review. *Nursing Inquiry*, 26(1), Article e12268. <https://doi.org/10.1111/nin.12268>
- Bager, J.-E., Manhem, K., Andersson, T., Hjerpe, P., Bengtsson-Boström, K., Ljungman, C., & Mourtzinis, G. (2023). Hypertension: Sex-related differences in drug treatment, prevalence and blood pressure control in primary care. *Journal of Human Hypertension*, 37(8), Article 8. <https://doi.org/10.1038/s41371-023-00801-5>

- Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*, 389(10077), 1453–1463. [https://doi.org/10.1016/S0140-6736\(17\)30569-X](https://doi.org/10.1016/S0140-6736(17)30569-X)
- Bailo, L., Vergani, L., & Pravettoni, G. (2019). Patient preferences as guidance for information framing in a medical shared decision-making approach: The Bridge between nudging and patient preferences. *Patient Preference and Adherence*, 13, 2225–2231. <https://doi.org/10.2147/PPA.S205819>
- Barnes, V., Schneider, R., Alexander, C., & Staggers, F. (1997). Stress, stress reduction, and hypertension in African Americans: An updated review. *Journal of the National Medical Association*, 89(7), 464–476. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2568086/pdf/jnma00162-0042.pdf>
- Baumhäkel, M., Müller, U., & Böhm, M. (2009). Influence of gender of physicians and patients on guideline-recommended treatment of chronic heart failure in a cross-sectional study. *European Journal of Heart Failure*, 11(3), 299–303. <https://doi.org/10.1093/eurjhf/hfn041>
- Bayne, C. O. (2023). The value of diversity, equity, and inclusion. *Hand Clinics*, 39(1), 9–15. <https://doi.org/10.1016/j.hcl.2022.08.001>
- Bell, C. N., Thorpe, R. J., & LaVeist, T. A. (2010). Race/ethnicity and hypertension: The role of social support. *American Journal of Hypertension*, 23(5), 534–540. <https://doi.org/10.1038/ajh.2010.28>
- Bellows, B. K., Ruiz-Negrón, N., Bibbins-Domingo, K., King, J. B., Pletcher, M. J., Moran, A. E., & Fontil, V. (2019). Clinic-based strategies to reach United States Million Hearts 2022 Blood Pressure Control Goals. *Circulation. Cardiovascular Quality and Outcomes*, 12(6), Article e005624. <https://doi.org/10.1161/CIRCOUTCOMES.118.005624>
- Benjamin, E. J., Muntner, P., Alonso, A., Bittencourt, M. S., Callaway, C. W., Carson, A. P., Chamberlain, A. M., Chang, A. R., Cheng, S., Das, S. R., Delling, F. N., Djousse, L., Elkind, M. S. V., Ferguson, J. F., Fornage, M., Jordan, L. C., Khan, S. S., Kissela, B. M., Knutson, K. L., ... On behalf of the American Heart Association Council on Epidemiology and Prevention Statistics Committee and Stroke Statistics Subcommittee. (2019). Heart Disease and Stroke Statistics—2019 update: A report from the American Heart Association. *Circulation*, 139(10). <https://doi.org/10.1161/CIR.0000000000000659>
- Benson, J., & Britten, N. (2002). Patients' decisions about whether or not to take antihypertensive drugs: Qualitative study. *BMJ (Clinical Research Ed.)*, 325(7369), Article 873. <https://doi.org/10.1136/bmj.325.7369.873>
- Beyene, L. S., Severinsson, E., Hansen, B. S., & Rørtveit, K. (2018). Shared Decision-Making-Balancing Between Power and Responsibility as Mental Health-Care Professionals in a Therapeutic Milieu. *SAGE Open Nursing*, 4, 2377960817752159. <https://doi.org/10.1177/2377960817752159>
- Blair, I. V., Steiner, J. F., Hanratty, R., Price, D. W., Fairclough, D. L., Daugherty, S. L., Bronsert, M., Magid, D. J., & Havranek, E. P. (2014). An investigation of associations between clinicians' ethnic or racial bias and hypertension treatment,

- medication adherence and blood pressure control. *Journal of General Internal Medicine*, 29(7), 987–995. <https://doi.org/10.1007/s11606-014-2795-z>
- Blasi, Z. D., Harkness, E., Ernst, E., Georgiou, A., & Kleijnen, J. (2001). Influence of context effects on health outcomes: A systematic review. *The Lancet*, 357(9258), 757–762. [https://doi.org/10.1016/S0140-6736\(00\)04169-6](https://doi.org/10.1016/S0140-6736(00)04169-6)
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252–260. <https://doi.org/10.1037/h0085885>
- Bosworth, H. B., Powers, B. J., & Oddone, E. Z. (2010). Patient self-management support: Novel strategies in hypertension and heart disease. *Cardiology Clinics*, 28(4), 655–663. <https://doi.org/10.1016/j.ccl.2010.07.003>
- Bragard, E., Fisher, C. B., & Curtis, B. L. (2020). “They know what they are getting into:” Researchers confront the benefits and challenges of online recruitment for HIV research. *Ethics & Behavior*, 30(7), 481–495. <https://doi.org/10.1080/10508422.2019.1692663>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589–597. <https://doi.org/10.1080/2159676X.2019.1628806>
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.
- Braveman, P. A., Arkin, E., Proctor, D., Kauh, T., & Holm, N. (2022). Systemic and structural racism: Definitions, examples, health damages, and approaches to dismantling: Study examines definitions, examples, health damages, and dismantling systemic and structural racism. *Health Affairs*, 41(2), 171–178. <https://doi.org/10.1377/hlthaff.2021.01394>
- Brewster, L. M., & Seedat, Y. K. (2013). Why do hypertensive patients of African ancestry respond better to calcium blockers and diuretics than to ACE inhibitors and β -adrenergic blockers? A systematic review. *BMC Medicine*, 11, Article 141. <https://doi.org/10.1186/1741-7015-11-141>
- Brondolo, E., Kaur, A., & Flores, M. (2023). Structural racism and health in the age of COVID-19: A selective review with policy implications. *Social Issues and Policy Review*, 17(1), 34–61. <https://doi.org/10.1111/sipr.12095>
- Brondolo, E., Love, E. E., Pencille, M., Schoenthaler, A., & Ogedegbe, G. (2011). Racism and hypertension: A review of the empirical evidence and implications for clinical practice. *American Journal of Hypertension*, 24(5), 518–529. <https://doi.org/10.1038/ajh.2011.9>
- Brown, C. E., Marshall, A. R., Snyder, C. R., Cueva, K. L., Pytel, C. C., Jackson, S. Y., Golden, S. H., Campelia, G. D., Horne, D. J., Doll, K. M., Curtis, J. R., & Young, B. A. (2023). Perspectives about racism and patient-clinician communication among Black adults with serious illness. *JAMA Network Open*, 6(7), Article e2321746. <https://doi.org/10.1001/jamanetworkopen.2023.21746>
- Brown, E. A., Bekker, H. L., Davison, S. N., Koffman, J., & Schell, J. O. (2016). Supportive care: Communication strategies to improve cultural competence in

- shared decision making. *Clinical Journal of the American Society of Nephrology*, 11(10), 1902–1908. <https://doi.org/10.2215/CJN.13661215>
- Brown, L. E., Burton, R., Hixon, B., Kakade, M., Bhagalia, P., Vick, C., Edwards, A., & Hawn, M. T. (2012). Factors influencing emergency department preference for access to healthcare. *Western Journal of Emergency Medicine*, 13(5), 410–415. <https://doi.org/10.5811/westjem.2011.11.6820>
- Burgess, D. J., Warren, J., Phelan, S., Dovidio, J., & van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine*, 25(Suppl 2), 169–177. <https://doi.org/10.1007/s11606-009-1221-4>
- Butler, B. N. (1973). Final report of the Tuskegee Syphilis study ad hoc advisory panel. <https://biotech.law.lsu.edu/cphl/history/reports/tuskegee/complete%20report.pdf>
- Bybee, S., Cloyes, K., Baucom, B., Supiano, K., Mooney, K., & Ellington, L. (2022). Bots and notes: Safeguarding online survey research with underrepresented and diverse populations. *Psychology & Sexuality*, 13(4), 901–911. <https://doi.org/10.1080/19419899.2021.1936617>
- Cao, Q., Krok-Schoen, J. L., Guo, M., & Dong, X. (2023). Trust in physicians, health insurance, and health care utilization among Chinese older immigrants. *Ethnicity & Health*, 28(1), 78–95. <https://doi.org/10.1080/13557858.2022.2027881>
- Carter-Harris, L. (2016). Facebook targeted advertisement for research recruitment: A primer for nurse researchers. *Applied Nursing Research*, 32, 144–147. <https://doi.org/10.1016/j.apnr.2016.07.006>
- Cené, C. W., Roter, D., Carson, K. A., Miller, E. R., & Cooper, L. A. (2009). The effect of patient race and blood pressure control on patient-physician communication. *Journal of General Internal Medicine*, 24(9), 1057–1064. <https://doi.org/10.1007/s11606-009-1051-4>
- Centers for Disease Control and Prevention. (2010). *A closer look at African American men and high blood pressure control*. <https://stacks.cdc.gov/view/cdc/40501>
- Centers for Disease Control and Prevention. (2020, February 5). *Hypertension prevalence in the U.S. | Million Hearts®*. <https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html>
- Centers for Disease Control and Prevention. (2021, May 18). *High blood pressure symptoms, causes, and problems*. <https://www.cdc.gov/bloodpressure/about.htm>
- Centers for Disease Control and Prevention. (2023, May 12). *Hypertension prevalence in the U.S. | Million Hearts®*. <https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html>
- Chan, K. Y., Srivastava, N., Wang, Z., Xia, X., Huang, Z., Poon, A. N., & Reidpath, D. D. (2023). A systematic review and meta-analysis of the effectiveness of hypertension interventions in faith-based organisation settings. *Journal of Global Health*, 13, Article 04075. <https://doi.org/10.7189/jogh.13.04075>
- Chang, T. J., Bridges, J. F. P., Bynum, M., Jackson, J. W., Joseph, J. J., Fischer, M. A., Lu, B., & Donneyong, M. M. (2021). Association between patient-clinician relationships and adherence to antihypertensive medications among Black adults: An observational study design. *Journal of the American Heart Association*, 10(14), Article e019943. <https://doi.org/10.1161/JAHA.120.019943>

- Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango). *Social Science & Medicine*, 44(5), 681–692. [https://doi.org/10.1016/S0277-9536\(96\)00221-3](https://doi.org/10.1016/S0277-9536(96)00221-3)
- Cheatham, C. T., Barksdale, D. J., & Rodgers, S. G. (2008). Barriers to health care and health-seeking behaviors faced by Black men. *Journal of the American Academy of Nurse Practitioners*, 20(11), 555–562. <https://doi.org/10.1111/j.1745-7599.2008.00359.x>
- Chen, L., Shi, G., Huang, D., Li, Y., Ma, C., Shi, M., Su, B., & Shi, G. (2019). Male sexual dysfunction: A review of literature on its pathological mechanisms, potential risk factors, and herbal drug intervention. *Biomedicine & Pharmacotherapy*, 112, Article 108585. <https://doi.org/10.1016/j.biopha.2019.01.046>
- Chen, Y., Freedman, N. D., Albert, P. S., Huxley, R. R., Shiels, M. S., Withrow, D. R., Spillane, S., Powell-Wiley, T. M., & Berrington de González, A. (2019). Association of cardiovascular disease with premature mortality in the United States. *JAMA Cardiology*, 4(12), 1230–1238. <https://doi.org/10.1001/jamacardio.2019.3891>
- Chevalier, B. A. M., Watson, B. M., Barras, M. A., & Cottrell, W. N. (2016). Examining hospital pharmacists' goals for medication counseling within the communication accommodation theoretical framework. *Research in Social and Administrative Pharmacy*, 12(5), 747–755. <https://doi.org/10.1016/j.sapharm.2015.10.008>
- Chrysant, S. G. (2015). Antihypertensive therapy causes erectile dysfunction. *Current Opinion in Cardiology*, 30(4), 383–390. <https://doi.org/10.1097/HCO.0000000000000189>
- Chun, J., & Carson, C. C. (2001). Physician-patient dialogue and clinical evaluation of erectile dysfunction. *The Urologic Clinics of North America*, 28(2), 249–258. [https://doi.org/10.1016/S0094-0143\(05\)70135-X](https://doi.org/10.1016/S0094-0143(05)70135-X)
- Chung, S., Huang, Q., LaMori, J., Doshi, D., & Romanelli, R. J. (2020). Patient-reported experiences in discussing prescribed medications with a health care provider: Evidence for racial/ethnic disparities in a large health care delivery system. *Population Health Management*, 23(1), 78–84. <https://doi.org/10.1089/pop.2018.0206>
- Churchwell, K., Elkind, M. S. V., Benjamin, R. M., Carson, A. P., Chang, E. K., Lawrence, W., Mills, A., Odom, T. M., Rodriguez, C. J., Rodriguez, F., Sanchez, E., Sharrief, A. Z., Sims, M., & Williams, O. (2020). Call to action: Structural racism as a fundamental driver of health disparities: A presidential advisory From the American Heart Association. *Circulation*, 142(24). <https://doi.org/10.1161/CIR.0000000000000936>
- Cohen, J. (2013). *Statistical power analysis for the behavioral sciences*. Routledge. <https://doi.org/10.4324/9780203771587>
- Coleman-Kirumba, L. M., Cornish, M. A., Horton, A. J., & Alvarez, J. C. (2023). Experiences of Black men: Forms of masculinity and effects on psychological help-seeking variables. *Journal of Black Psychology*, 49(1), 32–57. <https://doi.org/10.1177/00957984221098122>
- Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology*, 41(1), 1–20. <https://doi.org/10.1146/annurev-soc-073014-112142>

- Cooper, L. A., Beach, M. C., Johnson, R. L., & Inui, T. S. (2006). Delving below the surface. *Journal of General Internal Medicine*, 21(Suppl 1), S21–S27. <https://doi.org/10.1111/j.1525-1497.2006.00305.x>
- Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine*, 139(11), 907–915. <https://doi.org/10.7326/0003-4819-139-11-200312020-00009>
- Corbie-Smith, G., Thomas, S. B., & St George, D. M. M. (2002). Distrust, race, and research. *Archives of Internal Medicine*, 162(21), 2458–2463. <https://doi.org/10.1001/archinte.162.21.2458>
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men’s well-being: A theory of gender and health. *Social Science & Medicine*, 50(10), 1385–1401. [https://doi.org/10.1016/S0277-9536\(99\)00390-1](https://doi.org/10.1016/S0277-9536(99)00390-1)
- Coy, T., Brinza, E., DeLozier, S., Gornik, H. L., Webel, A. R., Longenecker, C. T., & White Solaru, K. T. (2023). Black men’s awareness of peripheral artery disease and acceptability of screening in barbershops: A qualitative analysis. *BMC Public Health*, 23(1), Article 46. <https://doi.org/10.1186/s12889-022-14648-x>
- Creswell, J. W. (2015). *A concise introduction to mixed methods research*. SAGE.
- Creswell, J. W., & Creswell, J. D. (2023). *Research design: Qualitative, quantitative, and mixed methods approaches*. SAGE.
- Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research*. SAGE.
- Crits-Christoph, P., Rieger, A., Gaines, A., & Gibbons, M. B. C. (2019). Trust and respect in the patient-clinician relationship: Preliminary development of a new scale. *BMC Psychology*, 7(1), Article 91. <https://doi.org/10.1186/s40359-019-0347-3>
- Crittendon, D. R., LaNoue, M., & George, B. (2022). Does perceived racism affect prostate cancer screening rates and patient-provider shared discussions among Black and White men? *Journal of Health Care for the Poor and Underserved*, 33(1), 5–19. <https://doi.org/10.1353/hpu.2022.0003>
- Cuevas, A. G., O’Brien, K., & Saha, S. (2019). Can patient-centered communication reduce the effects of medical mistrust on patients’ decision making? *Health Psychology: Official Journal of the Division of Health Psychology, American Psychological Association*, 38(4), 325–333. <https://doi.org/10.1037/hea0000721>
- Cuypers, M., Lamers, R. E. D., De Vries, M., Husson, O., Kil, P. J. M., & Van De Poll-Franse, L. V. (2016). Prostate cancer survivors with a passive role preference in treatment decision-making are less satisfied with information received: Results from the PROFILES registry. *Urologic Oncology: Seminars and Original Investigations*, 34(11), 482.e11–482.e18. <https://doi.org/10.1016/j.urolonc.2016.06.015>
- Czajkowska, Z., Wang, H., Hall, N. C., Sewitch, M., & Körner, A. (2017). Validation of the English and French versions of the Brief Health Care Climate Questionnaire. *Health Psychology Open*, 4(2), Article 2055102917730675. <https://doi.org/10.1177/2055102917730675>
- Dangerfield, D. T., Lipson, A., & Anderson, J. N. (2022). HIV PrEP clinician communication preferences among Black sexual minority men. *AIDS Education*

- and Prevention: Official Publication of the International Society for AIDS Education, 34(2), 168–181. <https://doi.org/10.1521/aeap.2022.34.2.168>
- Deber, R. B., Kraetschmer, N., & Irvine, J. (1996). What role do patients wish to play in treatment decision making? *Archives of Internal Medicine*, 156(13), 1414–1420. <https://doi.org/10.1001/archinte.1996.00440120070006>
- Deci, E. L., & Ryan, R. M. (1980). Self-determination theory: When mind mediates behavior. *The Journal of Mind and Behavior*, 1(1), 33–43. <https://www.jstor.org/stable/43852807>
- Deniz, S., Akbolat, M., Çimen, M., & Ünal, Ö. (2021). The mediating role of shared decision-making in the effect of the patient–physician relationship on compliance with treatment. *Journal of Patient Experience*, 8. <https://doi.org/10.1177/237437352111018066>
- Dennison Himmelfarb, C. R., Beckie, T. M., Allen, L. A., Commodore-Mensah, Y., Davidson, P. M., Lin, G., Lutz, B., & Spatz, E. S. (2023). Shared decision-making and cardiovascular health: A scientific statement from the American Heart Association. *Circulation*, 148(11), 912–931. <https://doi.org/10.1161/CIR.0000000000001162>
- de Visser, R. O., & McDonnell, E. J. (2013). “Man points”: Masculine capital and young men’s health. *Health Psychology: Official Journal of the Division of Health Psychology, American Psychological Association*, 32(1), 5–14. <https://doi.org/10.1037/a0029045>
- Dhaliwal, A., & Gupta, M. (2023). PDE5 inhibitors. In *StatPearls [Internet]*. StatPearls Publishing.
- Dolezsar, C. M., McGrath, J. J., Herzig, A. J. M., & Miller, S. B. (2014). Perceived racial discrimination and hypertension: A comprehensive systematic review. *Health Psychology: Official Journal of the Division of Health Psychology, American Psychological Association*, 33(1), 20–34. <https://doi.org/10.1037/a0033718>
- Eaton, L. A., Driffin, D. D., Kegler, C., Smith, H., Conway-Washington, C., White, D., & Cherry, C. (2015). The role of stigma and medical mistrust in the routine health care engagement of Black men who have sex with men. *American Journal of Public Health*, 105(2), e75-82. <https://doi.org/10.2105/AJPH.2014.302322>
- Echeverri, M., Felder, K., Anderson, D., Apantaku, E., Leung, P., Hoff, C., & Dennar, P. (2022). Fostering shared decision-making about prostate cancer screening among African American men patients and their primary care providers: A randomized behavioral clinical trial. *Trials*, 23(1), Article 653. <https://doi.org/10.1186/s13063-022-06605-1>
- Edley, N., & Wetherell, M. (1996). *Masculinity, power and identity* (M. Mac an Ghail, Ed.; pp. 97–113). Open University Press.
- Edwards, A., & Elwyn, G. (2006). Inside the Black box of shared decision making: Distinguishing between the process of involvement and who makes the decision. *Health Expectations*, 9(4), 307–320. <https://doi.org/10.1111/j.1369-7625.2006.00401.x>
- Eliacin, J., Salyers, M. P., Kukla, M., & Matthias, M. S. (2015). Factors influencing patients’ preferences and perceived involvement in shared decision-making in mental health care. *Journal of Mental Health*, 24(1), 24–28. <https://doi.org/10.3109/09638237.2014.954695>

- Elwyn, G. (2021). Shared decision making: What is the work? *Patient Education and Counseling*, 104(7), 1591–1595. <https://doi.org/10.1016/j.pec.2020.11.032>
- Elwyn, G., Cochran, N., & Pignone, M. (2017). Shared decision making—the importance of diagnosing preferences. *JAMA Internal Medicine*, 177(9), Article 1239. <https://doi.org/10.1001/jamainternmed.2017.1923>
- Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine*, 27(10), 1361–1367. <https://doi.org/10.1007/s11606-012-2077-6>
- Elwyn, G., Price, A., Franco, J. V. A., & Gulbrandsen, P. (2023). The limits of shared decision making. *BMJ Evidence-Based Medicine*, 28(4), 218–221. <https://doi.org/10.1136/bmjebm-2022-112089>
- Ende, J., Kazis, L., Ash, A., & Moskowitz, M. A. (1989). Measuring patients' desire for autonomy: Decision making and information-seeking preferences among medical patients. *Journal of General Internal Medicine*, 4(1), 23–30. <https://doi.org/10.1007/bf02596485>
- Engelhardt, E. G., Smets, E. M. A., Sorial, I., Stiggelbout, A. M., Pieterse, A. H., & Hillen, M. A. (2020). Is there a relationship between shared decision making and breast cancer patients' trust in their medical oncologists? *Medical Decision Making*, 40(1), 52–61. <https://doi.org/10.1177/0272989X19889905>
- Etti, M., Fofie, H., Razai, M., Crawshaw, A. F., Hargreaves, S., & Goldsmith, L. P. (2021). Ethnic minority and migrant underrepresentation in COVID-19 research: Causes and solutions. *EClinicalMedicine*, 36, Article 100903. <https://doi.org/10.1016/j.eclinm.2021.100903>
- Evans, J., Frank, B., Oliffe, J. L., & Gregory, D. (2011). Health, illness, men and masculinities (HIMM): A theoretical framework for understanding men and their health. *Journal of Men's Health*, 8(1), 7–15. <https://doi.org/10.1016/j.jomh.2010.09.227>
- Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, 39(2), 175–191. <https://doi.org/10.3758/BF03193146>
- Ferdinand, D. P., Nedunchezian, S., & Ferdinand, K. C. (2020). Hypertension in African Americans: Advances in community outreach and public health approaches. *Progress in Cardiovascular Diseases*, 63(1), 40–45. <https://doi.org/10.1016/j.pcad.2019.12.005>
- Ferdinand, K. C. (2022). Cardiovascular disparities up south: The intersection of geography, social determinants, and race. *Mayo Clinic Proceedings*, 97(1), 7–9. <https://doi.org/10.1016/j.mayocp.2021.11.008>
- Ferdinand, K. C., Charbonnet, R. M., Laurent, J., & Villavaso, C. D. (2023). Eliminating hypertension disparities in U.S. non-Hispanic Black adults: Current and emerging interventions. *Current Opinion in Cardiology*, 38(4), 304–310. <https://doi.org/10.1097/HCO.0000000000001040>
- Ferdinand, K. C., & Graham, R. M. (2019). Uncontrolled hypertension in Black men. *Circulation*, 139(1), 20–23. <https://doi.org/10.1161/circulationaha.118.038240>

- Ferdinand, K. C., Yadav, K., Nasser, S. A., Clayton - Jeter, H. D., Lewin, J., Cryer, D. R., Senatore, F. F., & Clayton-Jeter, H. D. (2017). Disparities in hypertension and cardiovascular disease in Blacks: The critical role of medication adherence. *Journal of Clinical Hypertension*, *19*(10), 1015–1024. <https://doi.org/10.1111/jch.13089>
- Fisher, J. A., & Kalbaugh, C. A. (2011). Challenging assumptions about minority participation in US clinical research. *American Journal of Public Health*, *101*(12), 2217–2222. <https://doi.org/10.2105/AJPH.2011.300279>
- Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316–340. <https://doi.org/10.1037/pst0000172>
- Fong, J., Venables, M., D'Souza, D., & Maskerine, C. (2023). Patient communication preferences for prostate cancer screening discussions: A scoping review. *The Annals of Family Medicine*, *21*(5), 448–455. <https://doi.org/10.1370/afm.3011>
- Franks, P., & Bertakis, K. D. (2003). Physician gender, patient gender, and primary care. *Journal of Women's Health*, *12*(1), 73–80. <https://doi.org/10.1089/154099903321154167>
- Frazier, R., Levine, S., Porteny, T., Tighiouart, H., Wong, J. B., Isakova, T., Koch-Weser, S., Gordon, E. J., Weiner, D. E., & Ladin, K. (2022). Shared decision making among older adults with advanced CKD. *American Journal of Kidney Diseases: The Official Journal of the National Kidney Foundation*, *80*(5), 599–609. <https://doi.org/10.1053/j.ajkd.2022.02.017>
- Freimuth, V. S., Quinn, S. C., Thomas, S. B., Cole, G., Zook, E., & Duncan, T. (2001). African Americans' views on research and the Tuskegee Syphilis study. *Social Science & Medicine*, *52*(5), 797–808. [https://doi.org/10.1016/S0277-9536\(00\)00178-7](https://doi.org/10.1016/S0277-9536(00)00178-7)
- Frosch, D. L., & Kaplan, R. M. (1999). Shared decision making in clinical medicine: Past research and future directions. *American Journal of Preventive Medicine*, *17*(4), 285–294. [https://doi.org/10.1016/S0749-3797\(99\)00097-5](https://doi.org/10.1016/S0749-3797(99)00097-5)
- Fuertes, J. N., Toporovsky, A., Reyes, M., & Osborne, J. B. (2017). The physician-patient working alliance: Theory, research, and future possibilities. *Patient Education and Counseling*, *100*(4), 610–615. <https://doi.org/10.1016/j.pec.2016.10.018>
- Gabriel, A. C., Bell, C. N., Bowie, J. V., LaVeist, T. A., & Thorpe, R. J. (2020). The role of social support in moderating the relationship between race and hypertension in a low-income, urban, racially integrated community. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, *97*(2), 250–259. <https://doi.org/10.1007/s11524-020-00421-1>
- Gadson, S. L. (2006). The third world health status of Black American males. *Journal of the National Medical Association*, *98*(4), 488–491. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569255/>
- Gagnon, M., Hébert, R., Dubé, M., & Dubois, M.-F. (2006). Development and validation of an instrument measuring individual empowerment in relation to personal health care: The Health Care Empowerment Questionnaire (HCEQ). *American Journal of Health Promotion*, *20*(6), 429–435. <https://doi.org/10.4278/0890-1171-20.6.429>

- Gallagher, S. M. (1998). Paternalism in healthcare decision making. *Ostomy/Wound Management*, 44(4), 22, 24–25. <https://europepmc.org/article/med/9611603>
- Galletta, M., Piazza, M. F., Meloni, S. L., Chessa, E., Piras, I., Arnetz, J. E., & D'Aloja, E. (2022). Patient involvement in shared decision-making: Do patients rate physicians and nurses differently? *International Journal of Environmental Research and Public Health*, 19(21), Article 14229. <https://doi.org/10.3390/ijerph192114229>
- Ganguli, I., Sheridan, B., Gray, J., Chernew, M., Rosenthal, M. B., & Neprash, H. (2020). Physician work hours and the gender pay gap—evidence from primary care. *The New England Journal of Medicine*, 383(14), 1349–1357. <https://doi.org/10.1056/NEJMsa2013804>
- Garfield, C. F., Isacco, A., & Rogers, T. E. (2008). A review of men's health and masculinity. *American Journal of Lifestyle Medicine*, 2(6), 474–487. <https://doi.org/10.1177/1559827608323213>
- Gartlehner, G., & Matyas, N. (2016). How contextual issues can distort shared decision making. *Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen*, 118, 17–23. <https://doi.org/10.1016/j.zefq.2016.10.002>
- George, D., & Mallery, P. (2016). *IBM SPSS Statistics 23 Step by Step* (0 ed.). Routledge. <https://doi.org/10.4324/9781315545899>
- George, M., Arcia, A., Chung, A., Coleman, D., & Bruzzese, J.-M. (2020). African Americans want a focus on shared decision-making in asthma adherence interventions. *The Patient-Patient-Centered Outcomes Research*, 13(1), 71–81. <https://doi.org/10.1007/s40271-019-00382-x>
- George, S., Duran, N., & Norris, K. (2014). A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American Journal of Public Health*, 104(2), e16–e31. <https://doi.org/10.2105/AJPH.2013.301706>
- Gilbert, K. L., Ray, R., Siddiqi, A., Shetty, S., Baker, E. A., Elder, K., & Griffith, D. M. (2016). Visible and invisible trends in Black Men's health: Pitfalls and promises for addressing racial, ethnic, and gender inequities in health. *Annual Review of Public Health*, 37, 295–311. <https://doi.org/10.1146/annurev-publhealth-032315-021556>
- Giuliano, F. A., Leriche, A., Jaudinot, E. O., & de Gendre, A. S. (2004). Prevalence of erectile dysfunction among 7689 patients with diabetes or hypertension, or both. *Urology*, 64(6), 1196–1201. <https://doi.org/10.1016/j.urology.2004.08.059>
- Glover, L. M., Cain-Shields, L. R., Wyatt, S. B., Gebreab, S. Y., Diez-Roux, A. V., & Sims, M. (2020). Life course socioeconomic status and hypertension in African American adults: The Jackson Heart Study. *American Journal of Hypertension*, 33(1), 84–91. <https://doi.org/10.1093/ajh/hpz133>
- Gordon, B.-B. E., Basak, R., Carpenter, W. R., Usinger, D., Godley, P. A., & Chen, R. C. (2019). Factors influencing prostate cancer treatment decisions for African American and White men. *Cancer*, 125(10), 1693–1700. <https://doi.org/10.1002/cncr.31932>
- Graham, L. F., Scott, L., Lopeyok, E., Douglas, H., Gubrium, A., & Buchanan, D. (2018). Outreach strategies to recruit low-income African American men to participate in health promotion programs and research: Lessons From the men of

- Color Health Awareness (MOCHA) Project. *American Journal of Men's Health*, 12(5), 1307–1316. <https://doi.org/10.1177/1557988318768602>
- Green, J., & Thorogood, N. (2018). *Qualitative methods for health research*. SAGE.
- Green, M. D., Dalmage, M. R., Lusk, J. B., Kadhim, E. F., Skalla, L. A., & O'Brien, E. C. (2023). Public reporting of Black participation in anti-hypertensive drug clinical trials. *American Heart Journal*, 258, 129–139. <https://doi.org/10.1016/j.ahj.2023.01.001>
- Gregory, P. A. M., & Austin, Z. (2021). Understanding the psychology of trust between patients and their community pharmacists. *Canadian Pharmacists Journal: CPJ = Revue Des Pharmaciens Du Canada: RPC*, 154(2), 120–128. <https://doi.org/10.1177/1715163521989760>
- Griffith, D. M., Metzler, J. M., & Gunter, K. (2011). Considering intersections of race and gender in interventions that address US men's health disparities. *Public Health*, 125(7), 417–423. <https://doi.org/10.1016/j.puhe.2011.04.014>
- Gilbert, K. L., Ray, R., Siddiqi, A., Shetty, S., Baker, E. A., Elder, K., & Griffith, D. M. (2016). Visible and Invisible Trends in Black Men's Health: Pitfalls and Promises for Addressing Racial, Ethnic, and Gender Inequities in Health. *Annual Review of Public Health*, 37(1), 295–311. <https://doi.org/10.1146/annurev-publhealth-032315-021556>
- Gu, A., Yue, Y., Desai, R. P., & Argulian, E. (2017). Racial and ethnic differences in antihypertensive medication use and blood pressure control among US adults with hypertension: The National Health and Nutrition Examination Survey, 2003 to 2012. *Circulation: Cardiovascular Quality and Outcomes*, 10(1), Article e003166. <https://doi.org/10.1161/CIRCOUTCOMES.116.003166>
- Ha, Y. P., Seifu, L. D., Lewis, L. M., Dupuis, R., Brawner, B. M., & Cannuscio, C. C. (2018). Partnering medical students with barbers to cut hypertension in Black men. *American Journal of Public Health*, 108(6), 785–787. <https://doi.org/10.2105/AJPH.2018.304374>
- Haile, R., Magalhaes, L., & Laliberte Rudman, D. (2017). Hypertension experiences of Black men: A critical narrative study. In *Research in the sociology of health care* (Vol. 35, pp. 193–209). <https://doi.org/10.1108/S0275-495920170000035010>
- Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health*, 105(12), e60–76. <https://doi.org/10.2105/AJPH.2015.302903>
- Hamann, J., Neuner, B., Kasper, J., Vodermaier, A., Loh, A., Deinzer, A., Heesen, C., Kissling, W., Busch, R., Schmieder, R., Spies, C., Caspari, C., & Härter, M. (2007). Participation preferences of patients with acute and chronic conditions. *Health Expectations*, 10(4), 358–363. <https://doi.org/10.1111/j.1369-7625.2007.00458.x>
- Hammond, W. P. (2010). Psychosocial correlates of medical mistrust among African American men. *American Journal of Community Psychology*, 45(1–2), 87–106. <https://doi.org/10.1007/s10464-009-9280-6>
- Hamrahian, S. M., Maarouf, O. H., & Fülöp, T. (2022). A critical review of medication adherence in hypertension: Barriers and facilitators clinicians should consider.

- Patient Preference and Adherence*, 16, 2749–2757.
<https://doi.org/10.2147/PPA.S368784>
- Hardy, S. T., Chen, L., Cherrington, A. L., Moise, N., Jaeger, B. C., Foti, K., Sakhuja, S., Wozniak, G., Abdalla, M., & Muntner, P. (2021). Racial and ethnic differences in blood pressure among US adults, 1999-2018. *Hypertension*, 78(6), 1730–1741.
<https://doi.org/10.1161/HYPERTENSIONAHA.121.18086>
- Harmon, G., Lefante, J., & Krousel-Wood, M. (2006). Overcoming barriers: The role of providers in improving patient adherence to antihypertensive medications. *Current Opinion in Cardiology*, 21(4), 310–315.
<https://doi.org/10.1097/01.hco.0000231400.10104.e2>
- Hart, A., Jr., Smith, W. R., Tadem, R. H., McClish, D. K., & McCreary, M. (2009). Health decision-making preferences among African American men recruited from urban barbershops. *Journal of the National Medical Association*, 101(7), 684–689. [https://doi.org/10.1016/S0027-9684\(15\)30977-9](https://doi.org/10.1016/S0027-9684(15)30977-9)
- Hayes, D. K., Jackson, S. L., Li, Y., Wozniak, G., Tsipas, S., Hong, Y., Thompson-Paul, A. M., Wall, H. K., Gillespie, C., Egan, B. M., Ritchey, M. D., & Loustalot, F. (2022). Blood pressure control among non-Hispanic Black adults is lower than non-Hispanic White adults despite similar treatment with antihypertensive medication: NHANES 2013-2018. *American Journal of Hypertension*, 35(6), 514–525. <https://doi.org/10.1093/ajh/hpac011>
- Heisler, M. (2008). Actively engaging patients in treatment decision making and monitoring as a strategy to improve hypertension outcomes in diabetes mellitus. *Circulation*, 117(11), 1355–1357.
<https://doi.org/10.1161/circulationaha.108.764514>
- Hess, P. L., Reingold, J. S., Jones, J., Fellman, M. A., Knowles, P., Ravenell, J. E., Kim, S., Raju, J., Ruger, E., Clark, S., Okoro, C., Ogunji, O., Knowles, P., Leonard, D., Wilson, R. P., Haley, R. W., Ferdinand, K. C., Freeman, A., & Victor, R. G. (2007). Barbershops as hypertension detection, referral, and follow-up centers for Black men. *Hypertension*, 49(5), 1040–1046.
<https://doi.org/10.1161/hypertensionaha.106.080432>
- Hewins-Maroney, B., Schumaker, A., & Williams, E. (2005). Health seeking behaviors of African Americans: Implications for health administration. *Journal of Health and Human Services Administration*, 28(1), 68–95.
<https://www.jstor.org/stable/41288058>
- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America*, 113(16), 4296–4301.
<https://doi.org/10.1073/pnas.1516047113>
- Hood, K. B., Hart, A., Belgrave, F. Z., Tadem, R. H., & Jones, R. A. (2012). The role of trust in health decision making among African American men recruited from urban barbershops. *Journal of the National Medical Association*, 104(7–8), 351–359. [https://doi.org/10.1016/S0027-9684\(15\)30176-0](https://doi.org/10.1016/S0027-9684(15)30176-0)
- Hooper, G. L., Allen, R. S., Payne-Foster, P., & Oliver, J. S. (2017). A qualitative study to determine barriers for prostate cancer screening in rural African-American

- men. *Urologic Nursing*, 37(6), 285–291. <https://doi.org/10.7257/1053-816X.2017.37.6.285>
- Horvath, A. O. (2018). Research on the alliance: Knowledge in search of a theory. *Psychotherapy Research*, 28(4), 499–516. <https://doi.org/10.1080/10503307.2017.1373204>
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, 36(2), 223–233. <https://doi.org/10.1037/0022-0167.36.2.223>
- Hoskin, M. N. (2022, March 31). *Black masculinity and mental health: What Black men should consider about their emotional and mental wellness*. Forbes. <https://www.forbes.com/sites/maiahoskin/2022/03/31/Black-masculinity-and-mental-health-what-Black-men-should-consider-about-their-emotional-and-mental-wellness/>
- Howard, G., Cushman, M., Moy, C. S., Oparil, S., Muntner, P., Lackland, D. T., Manly, J. J., Flaherty, M. L., Judd, S. E., Wadley, V. G., Long, D. L., & Howard, V. J. (2018). Association of clinical and social factors with excess hypertension risk in Black compared with White US adults. *JAMA*, 320(13), 1338. <https://doi.org/10.1001/jama.2018.13467>
- Husserl, E. (2012). *Ideas*. Routledge.
- Inagaki, N., Seto, N., Lee, K., Takahashi, Y., Nakayama, T., & Hayashi, Y. (2023). The role of critical care nurses in shared decision-making for patients with severe heart failure: A qualitative study. *PLOS ONE*, 18(7), Article e0288978. <https://doi.org/10.1371/journal.pone.0288978>
- Jacobs, E. A., Rolle, I., Ferrans, C. E., Whitaker, E. E., & Warnecke, R. B. (2006). Understanding African Americans' views of the trustworthiness of physicians. *Journal of General Internal Medicine*, 21(6), 642–647. <https://doi.org/10.1111/j.1525-1497.2006.00485.x>
- Jaiswal, J. (2019). Whose responsibility is it to dismantle medical mistrust? Future directions for researchers and health care providers. *Behavioral Medicine*, 45(2), 188–196. <https://doi.org/10.1080/08964289.2019.1630357>
- James, S. A. (1994). John Henryism and the health of African-Americans. *Culture, Medicine and Psychiatry*, 18(2), 163–182. <https://doi.org/10.1007/BF01379448>
- Javed, Z., Haisum Maqsood, M., Yahya, T., Amin, Z., Acquah, I., Valero-Elizondo, J., Andrieni, J., Dubey, P., Jackson, R. K., Daffin, M. A., Cainzos-Achirica, M., Hyder, A. A., & Nasir, K. (2022). Race, racism, and cardiovascular health: Applying a social determinants of health framework to racial/ethnic disparities in cardiovascular disease. *Circulation: Cardiovascular Quality and Outcomes*, 15(1). <https://doi.org/10.1161/CIRCOUTCOMES.121.007917>
- Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health*, 94(12), 2084–2090. <https://doi.org/10.2105/ajph.94.12.2084>
- Jones, C., & Jablonski, R. A. (2014). “I don’t want to be a guinea pig”: Recruiting older African Americans. *Journal of Gerontological Nursing*, 40(3), 3–4. <https://doi.org/10.3928/00989134-20140116-01>

- Jones, R. A., Steeves, R., & Williams, I. (2010). Family and friend interactions among African-American men deciding whether or not to have a prostate cancer screening. *Urologic Nursing*, 30(3), 189–166.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3616189/>
- Joseph-Williams, N., Elwyn, G., & Edwards, A. (2013). Knowledge is not power for patients: A systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making. *Patient Education and Counseling*, 94(3), 291–309. <https://doi.org/10.1016/j.pec.2013.10.031>
- Kaplan, S., Calman, N. S., Golub, M., Davis, J. H., Ruddock, C., & Billings, J. (2006). Racial and ethnic disparities in health: A view from the South Bronx. *Journal of Health Care for the Poor and Underserved*, 17(1), 116–127.
<https://doi.org/10.1353/hpu.2006.0026>
- Keij, S. M., van Duijn-Bakker, N., Stiggebout, A. M., & Pieterse, A. H. (2021). What makes a patient ready for shared decision making? A qualitative study. *Patient Education and Counseling*, 104(3), 571–577.
<https://doi.org/10.1016/j.pec.2020.08.031>
- Kelley, J. M., Kraft-Todd, G., Schapira, L., Kossowsky, J., & Riess, H. (2014). The influence of the patient-clinician relationship on healthcare outcomes: A systematic review and meta-analysis of randomized controlled trials. *PLoS One*, 9(4), e94207. <https://doi.org/10.1371/journal.pone.0094207>
- Kershaw, K. N., Diez Roux, A. V., Carnethon, M., Darwin, C., Goff, D. C., Post, W., Schreiner, P. J., & Watson, K. (2010). Geographic variation in hypertension prevalence among Blacks and whites: The multi-ethnic study of atherosclerosis. *American Journal of Hypertension*, 23(1), 46–53.
<https://doi.org/10.1038/ajh.2009.211>
- Khan, M. U., Shah, S., & Hameed, T. (2014). Barriers to and determinants of medication adherence among hypertensive patients attended National Health Service Hospital, Sunderland. *Journal of Pharmacy & Bioallied Sciences*, 6(2), 104–108.
<https://doi.org/10.4103/0975-7406.129175>
- Kibria, G. M. A., Crispen, R., Chowdhury, M. A. B., Rao, N., & Stennett, C. (2023). Disparities in absolute cardiovascular risk, metabolic syndrome, hypertension, and other risk factors by income within racial/ethnic groups among middle-aged and older US people. *Journal of Human Hypertension*, 37(6), 480–490.
<https://doi.org/10.1038/s41371-021-00513-8>
- Kim, C., McEwen, L. N., Gerzoff, R. B., Marrero, D. G., Mangione, C. M., Selby, J. V., & Herman, W. H. (2005). Is physician gender associated with the quality of diabetes care? *Diabetes Care*, 28(7), 1594–1598.
<https://doi.org/10.2337/diacare.28.7.1594>
- Kirkland, E. B., Heincelman, M., Bishu, K. G., Schumann, S. O., Schreiner, A., Axon, R. N., Mauldin, P. D., & Moran, W. P. (2018). Trends in healthcare expenditures among US adults with hypertension: National estimates, 2003–2014. *Journal of the American Heart Association*, 7(11), Article e008731.
<https://doi.org/10.1161/JAHA.118.008731>
- Komatsu, Y. (2023). Polypharmacy and sustainable developmental goals: Linking evidence-based medicine, patient engagement, and shared decision-making. *Renal*

- Replacement Therapy*, 9(1), Article 20. <https://doi.org/10.1186/s41100-023-00474-3>
- Kriston, L., Scholl, I., Hölzel, L., Simon, D., Loh, A., & Härter, M. (2010). The 9-item Shared Decision Making Questionnaire (SDM-Q-9). Development and psychometric properties in a primary care sample. *Patient Education and Counseling*, 80(1), 94–99. <https://doi.org/10.1016/j.pec.2009.09.034>
- Kunneman, M., Henselmans, I., Gärtner, F. R., Bomhof-Roordink, H., & Pieterse, A. H. (2019). Do shared decision-making measures reflect key elements of shared decision making? A content review of coding schemes. *Medical Decision Making*, 39(7), 886–893. <https://doi.org/10.1177/0272989X19874347>
- Langford, A. T., Williams, S. K., Applegate, M., Ogedegbe, O., & Braithwaite, R. S. (2019). Partnerships to improve shared decision making for patients with hypertension—health equity implications. *Ethnicity & Disease*, 29(Suppl 1), 97–102. <https://doi.org/10.18865/ed.29.S1.97>
- La Torre, A., Giupponi, G., Duffy, D., Conca, A., & Catanzariti, D. (2015). Sexual dysfunction related to drugs: A critical review. Part IV: Cardiovascular drugs. *Pharmacopsychiatry*, 48(1), 1–6. <https://doi.org/10.1055/s-0034-1395515>
- Lauffenburger, J. C., Barlev, R. A., Khatib, R., Glowacki, N., Siddiqi, A., Everett, M. E., Albert, M. A., Keller, P. A., Samal, L., Hanken, K., Sears, E. S., Haff, N., & Choudhry, N. K. (2023). Clinicians’ and patients’ perspectives on hypertension care in a racially and ethnically diverse population in primary care. *JAMA Network Open*, 6(2), Article e230977. <https://doi.org/10.1001/jamanetworkopen.2023.0977>
- LaVeist, T. A., Isaac, L. A., & Williams, K. P. (2009). Mistrust of health care organizations is associated with underutilization of health services. *Health Services Research*, 44(6), 2093–2105. <https://doi.org/10.1111/j.1475-6773.2009.01017.x>
- Lee, R. T., Perez, A. D., Boykin, C. M., & Mendoza-Denton, R. (2019). On the prevalence of racial discrimination in the United States. *PloS One*, 14(1), Article e0210698. <https://doi.org/10.1371/journal.pone.0210698>
- Légaré, F., Elwyn, G., Fishbein, M., Frémont, P., Frosch, D., Gagnon, M.-P., Kenny, D. A., Labrecque, M., Stacey, D., St-Jacques, S., & Van Der Weijden, T. (2008). Translating shared decision-making into health care clinical practices: Proof of concepts. *Implementation Science*, 3(1), Article 2. <https://doi.org/10.1186/1748-5908-3-2>
- Levinson, W., Hudak, P. L., Feldman, J. J., Frankel, R. M., Kuby, A., Bereknyei, S., & Braddock, C. (2008). “It’s not what you say ...”: Racial disparities in communication between orthopedic surgeons and patients. *Medical Care*, 46(4), 410–416. <https://doi.org/10.1097/MLR.0b013e31815f5392>
- Levinson, W., Kao, A., Kuby, A., & Thisted, R. A. (2005). Not all patients want to participate in decision making. A national study of public preferences. *Journal of General Internal Medicine*, 20(6), 531–535. <https://doi.org/10.1111/j.1525-1497.2005.04101.x>
- Lewis, L. M., Schoenthaler, A. M., & Ogedegbe, G. (2012). Patient factors, but not provider and health care system factors, predict medication adherence in

- hypertensive Black men. *The Journal of Clinical Hypertension*, 14(4), 250–255. <https://doi.org/10.1111/j.1751-7176.2012.00591.x>
- Liburd, L. C., Namageyo-Funa, A., Jack, L., & Gregg, E. (2004). Views from within and beyond: Illness narratives of African-American men with type 2 diabetes. *Diabetes Spectrum*, 17(4), 219–224. <https://doi.org/10.2337/diaspect.17.4.219>
- Long, E., Ponder, M., & Bernard, S. (2017). Knowledge, attitudes, and beliefs related to hypertension and hyperlipidemia self-management among African-American men living in the southeastern United States. *Patient Education and Counseling*, 100(5), 1000–1006. <https://doi.org/10.1016/j.pec.2016.12.011>
- Lou, I. X., Chen, J., Ali, K., & Chen, Q. (2023). Relationship between hypertension, antihypertensive drugs and sexual dysfunction in men and women: A literature review. *Vascular Health and Risk Management*, 19, 691–705. <https://doi.org/10.2147/VHRM.S439334>
- Lu, Y., Elwyn, G., Moulton, B. W., Volk, R. J., Frosch, D. L., & Spatz, E. S. (2022). Shared Decision-making in the U.S.: Evidence exists, but implementation science must now inform policy for real change to occur. *Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen*, 171, 144–149. <https://doi.org/10.1016/j.zefq.2022.04.031>
- Lu, Y., Van Zandt, M., Liu, Y., Li, J., Wang, X., Chen, Y., Chen, Z., Cho, J., Dorajoo, S. R., Feng, M., Hsu, M.-H., Hsu, J. C., Iqbal, U., Jonnagaddala, J., Li, Y.-C., Liaw, S.-T., Lim, H.-S., Ngiam, K. Y., Nguyen, P.-A., ... Xu, H. (2022). Analysis of dual combination therapies used in treatment of hypertension in a multinational cohort. *JAMA Network Open*, 5(3), Article e223877. <https://doi.org/10.1001/jamanetworkopen.2022.3877>
- Makoul, G., & Clayman, M. L. (2006). An integrative model of shared decision making in medical encounters. *Patient Education and Counseling*, 60(3), 301–312. <https://doi.org/10.1016/j.pec.2005.06.010>
- Manolis, A., & Doumas, M. (2012). Antihypertensive treatment and sexual dysfunction. *Current Hypertension Reports*, 14(4), 285–292. <https://doi.org/10.1007/s11906-012-0276-5>
- Martin, K. D., Roter, D. L., Beach, M. C., Carson, K. A., & Cooper, L. A. (2013). Physician communication behaviors and trust among Black and White patients with hypertension. *Medical Care*, 51(2), 151–157. <https://doi.org/10.1097/MLR.0b013e31827632a2>
- Martinez, K. A., Rood, M., Jhangiani, N., Kou, L., Rose, S., Boissy, A., & Rothberg, M. B. (2018). Patterns of use and correlates of patient satisfaction with a large nationwide direct to consumer telemedicine service. *Journal of General Internal Medicine*, 33(10), 1768–1773. <https://doi.org/10.1007/s11606-018-4621-5>
- Maskrey, N. (2019). Shared decision making: Why the slow progress? An essay by Neal Maskrey. *BMJ*, Article l6762. <https://doi.org/10.1136/bmj.l6762>
- Mendy, V. L., Perryman, B., Hawkins, J., & Dove, C. (2014). Planning for the strategic recruitment of barbershops for blood pressure screening and referral in the Mississippi Delta region. *Preventing Chronic Disease*, 11, Article 140179. <https://doi.org/10.5888/pcd11.140179>
- Metz, M. E., & McCarthy, B. W. (2004). *Coping with erectile dysfunction: How to regain confidence and enjoy great sex*. New Harbinger.

- Mhaimed, N., Mhaimed, N., Mhaimed, O., Alanni, J., Burney, Z., Elshafeey, A., Laws, S., & Choi, J. J. (2023). Shared decision making with Black patients: A scoping review. *Patient Education and Counseling*, *110*, Article 107646. <https://doi.org/10.1016/j.pec.2023.107646>
- Miller, A. N., Duvuuri, V. N. S., Vishanagra, K., Damarla, A., Hsiao, D., Todd, A., & Toledo, R. (2023). The relationship of race/ethnicity concordance to physician-patient communication: A mixed-methods systematic review. *Health Communication*, 1–15. <https://doi.org/10.1080/10410236.2023.2223402>
- Mills, K. T., Stefanescu, A., & He, J. (2020). The global epidemiology of hypertension. *Nature Reviews. Nephrology*, *16*(4), 223–237. <https://doi.org/10.1038/s41581-019-0244-2>
- Minheere, A., Lambrechts, W., Mampaey, J., Stough, T., Caniëls, M. C. J., & Semeijn, J. (2023). Patient power and empowerment: Mitigating elements of valuable patient participation in healthcare collaboratives. *Behavioral Sciences*, *13*(4), Article 347. <https://doi.org/10.3390/bs13040347>
- Mitropoulou, P., Grüner-Hegge, N., Reinhold, J., & Papadopoulou, C. (2023). Shared decision making in cardiology: A systematic review and meta-analysis. *Heart*, *109*(1), 34–39. <https://doi.org/10.1136/heartjnl-2022-321050>
- Moin, T., Duru, O. K., Turk, N., Chon, J. S., Frosch, D. L., Martin, J. M., Jeffers, K. S., Castellon-Lopez, Y., Tseng, C.-H., Norris, K., & Mangione, C. M. (2019). Effectiveness of shared decision-making for diabetes prevention: 12-month results from the Prediabetes Informed Decision and Education (PRIDE) Trial. *Journal of General Internal Medicine*, *34*(11), 2652–2659. <https://doi.org/10.1007/s11606-019-05238-6>
- Montori, V. M., Gafni, A., & Charles, C. (2006). A shared treatment decision-making approach between patients with chronic conditions and their clinicians: The case of diabetes. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *9*(1), 25–36. <https://doi.org/10.1111/j.1369-7625.2006.00359.x>
- Montori, V. M., Ruissen, M. M., Hargraves, I. G., Brito, J. P., & Kunneman, M. (2023). Shared decision-making as a method of care. *BMJ Evidence-Based Medicine*, *28*(4), 213–217. <https://doi.org/10.1136/bmjebm-2022-112068>
- Monzani, D., Vergani, L., Pizzoli, S. F. M., Marton, G., Mazzocco, K., Bailo, L., Messori, C., Pancani, L., Cattelan, M., & Pravettoni, G. (2020). Sexism interacts with patient–physician gender concordance in influencing patient control preferences: Findings from a vignette experimental design. *Applied Psychology: Health and Well-Being*, *12*(2), 471–492. <https://doi.org/10.1111/aphw.12193>
- Motley, R., & Banks, A. (2018). Black males, trauma, and mental health service use: A systematic review. *Perspectives on Social Work: The Journal of the Doctoral Students of the University of Houston Graduate School of Social Work*, *14*(1), 4–19. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6292675/>
- Mozaffarian, D., Benjamin, E. J., Go, A. S., Arnett, D. K., Blaha, M. J., Cushman, M., de Ferranti, S., Després, J.-P., Fullerton, H. J., Howard, V. J., Huffman, M. D., Judd, S. E., Kissela, B. M., Lackland, D. T., Lichtman, J. H., Lisabeth, L. D., Liu, S., Mackey, R. H., Matchar, D. B., ... Turner, M. B. (2015). Heart disease and stroke

- statistics 2015 update: a report from the American Heart Association. *Circulation*, 131(4). <https://doi.org/10.1161/CIR.000000000000152>
- Mueller, M., Purnell, T. S., Mensah, G. A., & Cooper, L. A. (2015). Reducing racial and ethnic disparities in hypertension prevention and control: What will it take to translate research into practice and policy? *American Journal of Hypertension*, 28(6), 699–716. <https://doi.org/10.1093/ajh/hpu233>
- Muntner, P., Hardy, S. T., Fine, L. J., Jaeger, B. C., Wozniak, G., Levitan, E. B., & Colantonio, L. D. (2020). Trends in blood pressure control among US adults with hypertension, 1999-2000 to 2017-2018. *JAMA*, 324(12), 1190–1200. <https://doi.org/10.1001/jama.2020.14545>
- Murray, A., Toledo, L., Brown, E. E., & Sutton, M. Y. (2017). “We as Black men have to encourage each other.” Facilitators and barriers associated with HIV testing among Black/African American men in rural Florida. *Journal of Health Care for the Poor and Underserved*, 28(1), 487–498. <https://doi.org/10.1353/hpu.2017.0035>
- Nambiar, L., LeWinter, M. M., VanBuren, P. C., & Dauerman, H. L. (2020). Decade-long temporal trends in U.S. hypertension-related cardiovascular mortality. *Journal of the American College of Cardiology*, 75(20), 2644–2646. <https://doi.org/10.1016/j.jacc.2020.03.009>
- Nazione, S., Perrault, E. K., & Keating, D. M. (2019). Finding common ground: Can provider-patient race concordance and self-disclosure bolster patient trust, perceptions, and intentions? *Journal of Racial and Ethnic Health Disparities*, 6(5), 962–972. <https://doi.org/10.1007/s40615-019-00597-6>
- Nease, R. F., & Brooks, W. B. (1995). Patient desire for information and decision making in health care decisions. *Journal of General Internal Medicine*, 10(11), 593–600. <https://doi.org/10.1007/BF02602742>
- Nguyen, A. M., Siman, N., Barry, M., Cleland, C. M., Pham-Singer, H., Ogedegbe, O., Berry, C., & Shelley, D. (2020). Patient-physician race/ethnicity concordance improves adherence to cardiovascular disease guidelines. *Health Services Research*, 55(Suppl 1), Article 51. <https://doi.org/10.1111/1475-6773.13398>
- Nguyen, B. T., Brown, A. L., Jones, F., Jones, L., Withers, M., Ciesielski, K. M., Franks, J. M., & Wang, C. (2021). “I’m not going to be a guinea pig:” Medical mistrust as a barrier to male contraception for Black American men in Los Angeles, CA. *Contraception*, 104(4), 361–366. <https://doi.org/10.1016/j.contraception.2021.06.001>
- Nicolai, M. P. J., Liem, S. S., Both, S., Pelger, R. C. M., Putter, H., Schali, M. J., & Elzevier, H. W. (2014). A review of the positive and negative effects of cardiovascular drugs on sexual function: A proposed table for use in clinical practice. *Netherlands Heart Journal*, 22(1), 11–19. <https://doi.org/10.1007/s12471-013-0482-z>
- Odedosu, T., Schoenthaler, A., Vieira, D. L., Agyemang, C., & Ogedegbe, G. (2012). Overcoming barriers to hypertension control in African Americans. *Cleveland Clinic Journal of Medicine*, 79(1), 46–56. <https://doi.org/10.3949/ccjm.79a.11068>
- Ogunniyi, M. O., Commodore-Mensah, Y., & Ferdinand, K. C. (2021). Race, ethnicity, hypertension, and heart disease: JACC focus seminar 1/9. *Journal of the*

- American College of Cardiology*, 78(24), 2460–2470.
<https://doi.org/10.1016/j.jacc.2021.06.017>
- Okoli, C., Brough, G., Allan, B., Castellanos, E., Young, B., Eremin, A., Corbelli, G. M., Mc Britton, M., Muchenje, M., Van de Velde, N., & de Los Rios, P. (2021). Shared decision making between patients and healthcare providers and its association with favorable health outcomes among people living with HIV. *AIDS and Behavior*, 25(5), 1384–1395. <https://doi.org/10.1007/s10461-020-02973-4>
- Oliver, M. N., Wells, K. M., Joy-Gaba, J. A., Hawkins, C. B., & Nosek, B. A. (2014). Do physicians' implicit views of African Americans affect clinical decision making? *Journal of the American Board of Family Medicine*, 27(2), 177–188.
<https://doi.org/10.3122/jabfm.2014.02.120314>
- Ong, L. M., Visser, M. R., Lammes, F. B., & de Haes, J. C. (2000). Doctor-patient communication and cancer patients' quality of life and satisfaction. *Patient Education and Counseling*, 41(2), 145–156. [https://doi.org/10.1016/s0738-3991\(99\)00108-1](https://doi.org/10.1016/s0738-3991(99)00108-1)
- Osterberg, L., & Blaschke, T. (2005). Adherence to medication. *New England Journal of Medicine*, 353(5), 487–497. <https://doi.org/10.1056/NEJMra050100>
- Otte, S. V. (2022). Improved patient experience and outcomes: Is patient-provider concordance the key? *Journal of Patient Experience*, 9.
<https://doi.org/10.1177/23743735221103033>
- Palmer, K., Rivers, P., Melton, F., McClelland, J., Hatcher, J., Marrero, D. G., Thomson, C., & Garcia, D. O. (2020). Protocol for a systematic review of health promotion interventions for African Americans delivered in US barbershops and hair salons. *BMJ Open*, 10(4), Article e035940. <https://doi.org/10.1136/bmjopen-2019-035940>
- Palmer, K. N. B., Rivers, P. S., Melton, F. L., McClelland, D. J., Hatcher, J., Marrero, D. G., Thomson, C. A., & Garcia, D. O. (2021). Health promotion interventions for African Americans delivered in U.S. barbershops and hair salons- a systematic review. *BMC Public Health*, 21(1), Article 1553. <https://doi.org/10.1186/s12889-021-11584-0>
- Park, S. G., Derman, M., Dixon, L. B., Brown, C. H., Klingaman, E. A., Fang, L. J., Medoff, D. R., & Kreyenbuhl, J. (2014). Factors associated with shared decision-making preferences among veterans with serious mental illness. *Psychiatric Services*, 65(12), 1409–1413. <https://doi.org/10.1176/appi.ps.201400131>
- Peek, M. E., Odoms-Young, A., Quinn, M. T., Gorawara-Bhat, R., Wilson, S. C., & Chin, M. H. (2010). Race and shared decision-making: Perspectives of African-Americans with diabetes. *Social Science & Medicine* (1982), 71(1), 1–9.
<https://doi.org/10.1016/j.socscimed.2010.03.014>
- Peek, M. E., Gorawara-Bhat, R., Quinn, M. T., Odoms-Young, A., Wilson, S. C., & Chin, M. H. (2013). Patient trust in physicians and shared decision-making among African-Americans with diabetes. *Health Communication*, 28(6), 616–623.
<https://doi.org/10.1080/10410236.2012.710873>
- Peek, M. E., Harmon, S. A., Scott, S. J., Eder, M., Roberson, T. S., Tang, H., & Chin, M. H. (2012). Culturally tailoring patient education and communication skills training to empower African-Americans with diabetes. *Translational Behavioral Medicine*, 2(3), 296–308. <https://doi.org/10.1007/s13142-012-0125-8>

- Peek, M. E., Lopez, F. Y., Williams, H. S., Xu, L. J., McNulty, M. C., Acree, M. E., & Schneider, J. A. (2016). Development of a conceptual framework for understanding shared decision making among African-American LGBT patients and their clinicians. *Journal of General Internal Medicine*, *31*(6), 677–687. <https://doi.org/10.1007/s11606-016-3616-3>
- Peek, M. E., Tang, H., Cargill, A., & Chin, M. H. (2011). Are there racial differences in patients' shared decision-making preferences and behaviors among patients with diabetes? *Medical Decision Making: An International Journal of the Society for Medical Decision Making*, *31*(3), 422–431. <https://doi.org/10.1177/0272989X10384739>
- Peek, M. E., Wilson, S. C., Gorawara-Bhat, R., Odoms-Young, A., Quinn, M. T., & Chin, M. H. (2009). Barriers and facilitators to shared decision-making among African-Americans with diabetes. *Journal of General Internal Medicine*, *24*(10), 1135–1139. <https://doi.org/10.1007/s11606-009-1047-0>
- Pellowski, J. A., Price, D. M., Allen, A. M., Eaton, L. A., & Kalichman, S. C. (2017). The differences between medical trust and mistrust and their respective influences on medication beliefs and ART adherence among African-Americans living with HIV. *Psychology & Health*, *32*(9), 1127–1139. <https://doi.org/10.1080/08870446.2017.1324969>
- Perez Jolles, M., Richmond, J., & Thomas, K. C. (2019). Minority patient preferences, barriers, and facilitators for shared decision-making with health care providers in the USA: A systematic review. *Patient Education and Counseling*, *102*(7), 1251–1262. <https://doi.org/10.1016/j.pec.2019.02.003>
- Piette, J. D., Heisler, M., Krein, S., & Kerr, E. A. (2005). The role of patient-physician trust in moderating medication nonadherence due to cost pressures. *Archives of Internal Medicine*, *165*(15), 1749–1755. <https://doi.org/10.1001/archinte.165.15.1749>
- Pokhilenko, I., van Esch, T. E. M., Brabers, A. E. M., & de Jong, J. D. (2021). Relationship between trust and patient involvement in medical decision-making: A cross-sectional study. *PloS One*, *16*(8), e0256698. <https://doi.org/10.1371/journal.pone.0256698>
- Powell, W., Richmond, J., Mohottige, D., Yen, I., Joslyn, A., & Corbie-Smith, G. (2019). Medical mistrust, racism, and delays in preventive health screening among African-American men. *Behavioral Medicine*, *45*(2), 102–117. <https://doi.org/10.1080/08964289.2019.1585327>
- Pozzar, R., Hammer, M. J., Underhill-Blazey, M., Wright, A. A., Tulsy, J. A., Hong, F., Gundersen, D. A., & Berry, D. L. (2020). Threats of bots and other bad actors to data quality following research participant recruitment through social media: Cross-sectional questionnaire. *Journal of Medical Internet Research*, *22*(10), Article e23021. <https://doi.org/10.2196/23021>
- Quinn, G. P., Bell, B. A., Bell, M. Y., Caraway, V. D., Conforte, D., Graci, L. B., Powell-Stafford, V. L., Sapp, A. L., Shimizu, C. O., Vaughn, E. J., Williams, C., & Bepler, G. (2007). The guinea pig syndrome: Improving clinical trial participation among thoracic patients. *Journal of Thoracic Oncology*, *2*(3), 191–196. <https://doi.org/10.1097/JTO.0b013e318031cdb6>

- Ravenell, J., Green, T., Arabadjian, M., Schoenthaler, A., & Ogedegbe, O. (2023). Barbershop-facilitated community-to-clinic linkage implementation program: Rationale and protocol for a novel program to prevent hypertension among Black men. *American Journal of Hypertension*, 36(5), 240–247. <https://doi.org/10.1093/ajh/hpac133>
- Roter, D. L., Hall, J. A., & Aoki, Y. (2002). Physician gender effects in medical communication: A meta-analytic review. *JAMA*, 288(6), 756–764. <https://doi.org/10.1001/jama.288.6.756>
- Ruhnke, G. W., Tak, H. J., & Meltzer, D. O. (2020). Association of preferences for participation in decision-making with care satisfaction among hospitalized patients. *JAMA Network Open*, 3(10), Article e2018766. <https://doi.org/10.1001/jamanetworkopen.2020.18766>
- Sacks, F. M., Svetkey, L. P., Vollmer, W. M., Appel, L. J., Bray, G. A., Harsha, D., Obarzanek, E., Conlin, P. R., Miller, E. R., Simons-Morton, D. G., Karanja, N., Lin, P. H., & DASH-Sodium Collaborative Research Group. (2001). Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. DASH-Sodium Collaborative Research Group. *The New England Journal of Medicine*, 344(1), 3–10. <https://doi.org/10.1056/NEJM200101043440101>
- Saeed, A., Dixon, D. L., & Yang, E. (2020, April 6). *Racial disparities in hypertension prevalence and management: A crisis control?* American College of Cardiology. <https://www.acc.org/Latest-in-Cardiology/Articles/2020/04/06/08/53/Racial-Disparities-in-Hypertension-Prevalence-and-Management>
- Saha, S., & Beach, M. C. (2020). Impact of physician race on patient decision-making and ratings of physicians: A randomized experiment using video vignettes. *Journal of General Internal Medicine*, 35(4), 1084–1091. <https://doi.org/10.1007/s11606-020-05646-z>
- Sampson, U. K. A., Edwards, T. L., Jahangir, E., Munro, H., Wariboko, M., Wassef, M. G., Fazio, S., Mensah, G. A., Kabagambe, E. K., Blot, W. J., & Lipworth, L. (2014). Factors associated with the prevalence of hypertension in the southeastern United States: Insights from 69,211 Blacks and Whites in the southern community cohort study. *Circulation: Cardiovascular Quality and Outcomes*, 7(1), 33–54. <https://doi.org/10.1161/CIRCOUTCOMES.113.000155>
- Say, R., Murtagh, M., & Thomson, R. (2006). Patients' preference for involvement in medical decision making: A narrative review. *Patient Education and Counseling*, 60(2), 102–114. <https://doi.org/10.1016/j.pec.2005.02.003>
- Schoenthaler, A., Basile, M., West, T. V., & Kalet, A. (2018). It takes two to tango: A dyadic approach to understanding the medication dialogue in patient-provider relationships. *Patient Education and Counseling*, 101(8), 1500–1505. <https://doi.org/10.1016/j.pec.2018.02.009>
- Schoenthaler, A., Chaplin, W. F., Allegrante, J. P., Fernandez, S., Diaz-Gloster, M., Tobin, J. N., & Ogedegbe, G. (2009). Provider communication effects medication adherence in hypertensive African Americans. *Patient Education and Counseling*, 75(2), 185–191. <https://doi.org/10.1016/j.pec.2008.09.018>
- Schoenthaler, A., Fei, K., Ramos, M. A., Richardson, L. D., Ogedegbe, G., & Horowitz, C. R. (2019). Comprehensive examination of the multilevel adverse risk and

- protective factors for cardiovascular disease among hypertensive African Americans. *Journal of Clinical Hypertension*, 21(6), 794–803. <https://doi.org/10.1111/jch.13560>
- Scholl, I., Loon, M. K., Sepucha, K., Elwyn, G., Légaré, F., Härter, M., & Dirmaier, J. (2011). Measurement of shared decision making – a review of instruments. *Zeitschrift Für Evidenz, Fortbildung Und Qualität Im Gesundheitswesen*, 105(4), 313–324. <https://doi.org/10.1016/j.zefq.2011.04.012>
- Sepucha Karen R. & Scholl Isabelle. (2014). Measuring Shared Decision Making. *Circulation: Cardiovascular Quality and Outcomes*, 7(4), 620–626. <https://doi.org/10.1161/CIRCOUTCOMES.113.000350>
- Serrano, V., Rodriguez-Gutierrez, R., Hargraves, I., Gionfriddo, M., Tamhane, S., & Montori, V. (2016). Shared decision-making in the care of individuals with diabetes. *Diabetic Medicine: A Journal of the British Diabetic Association*, 33. <https://doi.org/10.1111/dme.13143>
- Shabazz, D. L. (2016). Barbershops as cultural forums for African American males. *Journal of Black Studies*, 47(4), 295–312. <https://doi.org/10.1177/0021934716629337>
- Shawahna, R., Khalaily, S., & Abu Saleh, D. (2021). Promoters of therapeutic inertia in managing hypertension: A consensus-based study. *The American Journal of Managed Care*, 27(11), 480–486. <https://doi.org/10.37765/ajmc.2021.88775>
- Shen, M. J., Peterson, E. B., Costas-Muñiz, R., Hernandez, M. H., Jewell, S. T., Matsoukas, K., & Bylund, C. L. (2018). The effects of race and racial concordance on patient-physician communication: A systematic review of the literature. *Journal of Racial and Ethnic Health Disparities*, 5(1), 117–140. <https://doi.org/10.1007/s40615-017-0350-4>
- Snyder, J. E., Upton, R. D., Hassett, T. C., Lee, H., Nouri, Z., & Dill, M. (2023). Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. *JAMA Network Open*, 6(4), Article e236687. <https://doi.org/10.1001/jamanetworkopen.2023.6687>
- Solomons, N., Kruger, H. S., & Puoane, T. (2020). Association between dietary adherence, anthropometric measurements and blood pressure in an urban Black population, South Africa. *South African Journal of Clinical Nutrition*, 33(1), 1–9. <https://doi.org/10.1080/16070658.2018.1489602>
- Spence, J. D., & Rayner, B. L. (2018). Hypertension in Blacks: Individualized therapy based on renin/aldosterone phenotyping. *Hypertension*, 72(2), 263–269. <https://doi.org/10.1161/hypertensionaha.118.11064>
- Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372–1380. <https://doi.org/10.1177/1049732307307031>
- Steinke, E. E., Jaarsma, T., Barnason, S. A., Byrne, M., Doherty, S., Dougherty, C. M., Fridlund, B., Kautz, D. D., Mårtensson, J., Mosack, V., & Moser, D. K. (2013). Sexual counseling for individuals with cardiovascular disease and their partners: A consensus document from the American Heart Association and the ESC Council on Cardiovascular Nursing and Allied Professions (CCNAP). *Circulation*, 128(18), 2075–2096. <https://doi.org/10.1161/CIR.0b013e31829c2e53>

- Stewart, K. A., Ristvedt, S., Brown, K. M., Waters, E. A., Trinkaus, K., McCray, N., & James, A. S. (2019). Giving voice to Black men: Guidance for increasing the likelihood of having a usual source of care. *American Journal of Men's Health*, 13(3), Article 1557988319856738. <https://doi.org/10.1177/1557988319856738>
- Sturgiss, E. A., Rieger, E., Haesler, E., Ridd, M. J., Douglas, K., & Galvin, S. L. (2018). Adaption and validation of the Working Alliance Inventory for General Practice: Qualitative review and cross-sectional surveys. *Family Practice*, 36(4), 516–522. <https://doi.org/10.1093/fampra/cmy113>
- Takeshita, J., Wang, S., Loren, A. W., Mitra, N., Shults, J., Shin, D. B., & Sawinski, D. L. (2020). Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA Network Open*, 3(11), Article e2024583. <https://doi.org/10.1001/jamanetworkopen.2020.24583>
- Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education*, 2, 53–55. <https://doi.org/10.5116/ijme.4dfb.8dfd>
- Taylor, L. A., Nong, P., & Platt, J. (2023). Fifty years of trust research in health care: A synthetic review. *The Milbank Quarterly*, 101(1), 126–178. <https://doi.org/10.1111/1468-0009.12598>
- Teitcher, J. E. F., Bockting, W. O., Bauermeister, J. A., Hoefler, C. J., Miner, M. H., & Klitzman, R. L. (2015). Detecting, preventing, and responding to “fraudsters” in internet research: Ethics and tradeoffs. *Journal of Law, Medicine & Ethics*, 43(1), 116–133. <https://doi.org/10.1111/jlme.12200>
- Te Vazquez, J., Feng, S. N., Orr, C. J., & Berkowitz, S. A. (2021). Food insecurity and cardiometabolic conditions: A review of recent research. *Current Nutrition Reports*, 10(4), 243–254. <https://doi.org/10.1007/s13668-021-00364-2>
- Thomas, S. J., Booth, J. N., III, Chen Dai, Xuelin Li, Allen, N., Calhoun, D., Carson, A. P., Gidding, S., Lewis, C. E., Shikany, J. M., Shimbo, D., Sidney, S., Muntner, P., Booth, J. N. 3rd, Dai, C., & Li, X. (2018). Cumulative incidence of hypertension by 55 years of age in Blacks and Whites: The CARDIA Study. *Journal of the American Heart Association*, 7(14), 1–10. <https://doi.org/10.1161/JAHA.117.007988>
- Tomaka, J., Thompson, S., & Palacios, R. (2006). The relation of social isolation, loneliness, and social support to disease outcomes among the elderly. *Journal of Aging and Health*, 18(3), 359–384. <https://doi.org/10.1177/0898264305280993>
- Tsao, C. W., Aday, A. W., Almarzooq, Z. I., Alonso, A., Beaton, A. Z., Bittencourt, M. S., Boehme, A. K., Buxton, A. E., Carson, A. P., Commodore-Mensah, Y., Elkind, M. S. V., Evenson, K. R., Eze-Nliam, C., Ferguson, J. F., Generoso, G., Ho, J. E., Kalani, R., Khan, S. S., Kissela, B. M., ... Martin, S. S. (2022). Heart disease and stroke statistics-2022 update: A report from the American Heart Association. *Circulation*, 145(8), e153–e639. <https://doi.org/10.1161/CIR.0000000000001052>
- Tsoutsos, S., & Kotsis, V. (2023). Erectile dysfunction and its correlation with arterial hypertension and cardiovascular diseases. *Journal of Atherosclerosis Prevention and Treatment*, 14(1), 23–34. <https://doi.org/10.53590/japt.02.1044>
- Tsugawa, Y., Jena, A. B., Figueroa, J. F., Orav, E. J., Blumenthal, D. M., & Jha, A. K. (2017). Comparison of hospital mortality and readmission rates for Medicare

- patients treated by male vs female physicians. *JAMA Internal Medicine*, 177(2), 206. <https://doi.org/10.1001/jamainternmed.2016.7875>
- Turkson-Ocran, R. N., Ogunwole, S. M., Hines, A. L., & Peterson, P. N. (2021). Shared Decision making in cardiovascular patient care to address cardiovascular disease disparities. *Journal of the American Heart Association*, 10(20), Article e018183. <https://doi.org/10.1161/JAHA.120.018183>
- US Preventive Services Task Force, Davidson, K. W., Mangione, C. M., Barry, M. J., Nicholson, W. K., Cabana, M. D., Caughey, A. B., Davis, E. M., Donahue, K. E., Doubeni, C. A., Kubik, M., Li, L., Ogedegbe, G., Pbert, L., Silverstein, M., Stevermer, J., Tseng, C.-W., & Wong, J. B. (2022). Collaboration and shared decision-making between patients and clinicians in preventive health care decisions and US Preventive Services Task Force recommendations. *JAMA*, 327(12), Article 1171. <https://doi.org/10.1001/jama.2022.3267>
- van Ryn, M., Burgess, D., Malat, J., & Griffin, J. (2006). Physicians' perceptions of patients' social and behavioral characteristics and race disparities in treatment recommendations for men with coronary artery disease. *American Journal of Public Health*, 96(2), 351–357. <https://doi.org/10.2105/AJPH.2004.041806>
- van Wees, M., Duijs, S. E., Mazurel, C., Abma, T. A., & Verdonk, P. (2023). Negotiating masculinities at the expense of health: A qualitative study on men working in long-term care in the Netherlands, from an intersectional perspective. *Gender, Work & Organization*. <https://doi.org/10.1111/gwao.12952>
- Victor, R. G., Blyler, C. A., Li, N., Lynch, K., Moy, N. B., Rashid, M., Chang, L. C., Handler, J., Brettler, J., Rader, F., & Elashoff, R. M. (2019). Sustainability of blood pressure reduction in Black barbershops. *Circulation*, 139(1), 10–19. <https://doi.org/10.1161/circulationaha.118.038165>
- Victor, R. G., Lynch, K., Li, N., Blyler, C., Muhammad, E., Handler, J., Brettler, J., Rashid, M., Hsu, B., Foxx-Drew, D., Moy, N., Reid, A. E., & Elashoff, R. M. (2018). A cluster-randomized trial of blood-pressure reduction in Black barbershops. *The New England Journal of Medicine*, 378(14), 1291–1301. <https://doi.org/10.1056/NEJMoa1717250>
- Watson, N. L., Mull, K. E., Heffner, J. L., McClure, J. B., & Bricker, J. B. (2018). Participant recruitment and retention in remote ehealth intervention trials: Methods and lessons learned from a large randomized controlled trial of two web-based smoking interventions. *Journal of Medical Internet Research*, 20(8), Article e10351. <https://doi.org/10.2196/10351>
- Wells, L., & Gowda, A. (2020). A legacy of mistrust: African Americans and the US healthcare system. *Proceedings of UCLA Health*, 24, 1–3. <https://africanamericanbehavioralhealth.org/ResourceMaterials/A%20legacy%20of%20mistrust-%20African%20Americans%20and%20the%20U.S.%20healthcare%20system.pdf>
- Whelton, P. K., Carey, R. M., Aronow, W. S., Casey, D. E., Collins, K. J., Dennison Himmelfarb, C., DePalma, S. M., Gidding, S., Jamerson, K. A., Jones, D. W., MacLaughlin, E. J., Muntner, P., Ovbiagele, B., Smith, S. C., Spencer, C. C., Stafford, R. S., Taler, S. J., Thomas, R. J., Williams, K. A., ... Wright, J. T. (2018). 2017

- ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: A report of the American College of Cardiology/American Heart Association Task Force on clinical practice guidelines. *Hypertension*, 71(6), e13–e115. <https://doi.org/10.1161/HYP.0000000000000065>
- Whitney, R. L., White, A. E. C., Rosenberg, A. S., Kravitz, R. L., & Kim, K. K. (2021). Trust and shared decision-making among individuals with multiple myeloma: A qualitative study. *Cancer Medicine*, 10(22), 8040–8057. <https://doi.org/10.1002/cam4.4322>
- Williams, D. R., & Mohammed, S. A. (2013). Racism and Health I: Pathways and Scientific Evidence. *American Behavioral Scientist*, 57(8), 1152–1173. <https://doi.org/10.1177/0002764213487340>
- Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health*, 93(2), 200–208. <https://doi.org/10.2105/ajph.93.2.200>
- Williams, G. C., Freedman, Z. R., & Deci, E. L. (1998). Supporting autonomy to motivate patients with diabetes for glucose control. *Diabetes Care*, 21(10), 1644–1651. <https://doi.org/10.2337/diacare.21.10.1644>
- Williams, G. C., Grow, V. M., Freedman, Z. R., Ryan, R. M., & Deci, E. L. (1996). Motivational predictors of weight loss and weight-loss maintenance. *Journal of Personality and Social Psychology*, 70(1), 115–126. <https://doi.org/10.1037//0022-3514.70.1.115>
- Williams, G. C., Grow, V. M., Freedman, Z. R., Ryan, R. M., & Deci, E. L. (2018). Health Care Climate Questionnaire [dataset]. *American Psychological Association*. <https://doi.org/10.1037/t68628-000>
- Williams, L. (2022, January 20). Residential segregation may increase risk for high blood pressure. Heart. <https://www.heart.org/en/news/2022/01/20/residential-segregation-may-increase-risk-for-high-blood-pressure>
- Williams, R. M., Zincke, N. L., Turner, R. O., Davis, J. L., Davis, K. M., Schwartz, M. D., Johnson, L., Kerner, J. F., & Taylor, K. L. (2008). Prostate cancer screening and shared decision-making preferences among African-American members of the Prince Hall Masons. *Psycho-Oncology*, 17(10), 1006–1013. <https://doi.org/10.1002/pon.1318>
- Williamson, L. D., & Bigman, C. A. (2018). A systematic review of medical mistrust measures. *Patient Education and Counseling*, 101(10), 1786–1794. <https://doi.org/10.1016/j.pec.2018.05.007>
- Wilson, B. N., Murase, J. E., Sliwka, D., & Botto, N. (2021). Bridging racial differences in the clinical encounter: How implicit bias and stereotype threat contribute to health care disparities in the dermatology clinic. *International Journal of Women's Dermatology*, 7(2), 139–144. <https://doi.org/10.1016/j.ijwd.2020.12.013>
- Woo, B. F. Y., Goh, Y. S., & Zhou, W. (2022). Understanding the gender gap in advanced practice nursing: A qualitative study. *Journal of Nursing Management*, 30(8), 4480–4490. <https://doi.org/10.1111/jonm.13886>
- Woodward, A. T., Taylor, R. J., & Chatters, L. M. (2011). Use of professional and informal support by Black Men with mental disorders. *Research on Social Work Practice*, 21(3), 328–336. <https://doi.org/10.1177/1049731510388668>

- World Health Organization. (2023, March 16). *Hypertension*.
<https://www.who.int/health-topics/hypertension>
- Yeh, J. H. B. (2018). When people become patients: Fluctuations in trust from the cancer patient's perspective. *Chinese Journal of Communication*, 11(4), 365–384.
<https://doi.org/10.1080/17544750.2018.1499546>
- Yeom, H.-E., & Lee, J. (2022). Impact of autonomy support on the association between personal control, healthy behaviors, and psychological well-being among patients with hypertension and cardiovascular comorbidities. *International Journal of Environmental Research and Public Health*, 19(7), Article 4132.
<https://doi.org/10.3390/ijerph19074132>
- Zisman-Ilani, Y., Khaikin, S., Savoy, M. L., Paranjape, A., Rubin, D. J., Jacob, R., Wieringa, T. H., Suarez, J., Liu, J., Gardiner, H., Bass, S. B., Montori, V. M., & Siminoff, L. A. (2023). Disparities in shared decision-making research and practice: The case for Black American patients. *The Annals of Family Medicine*, 21(2), 112–118. <https://doi.org/10.1370/afm.2943>

APPENDIX A. RESEARCH RECRUITMENT FLYERS



**Are you living with
high blood
pressure?**

We want to hear from you!

IRB NUMBER: 20-07532-XP
IRB APPROVAL DATE: 08/05/2020

**UT THE UNIVERSITY OF
TENNESSEE
HEALTH SCIENCE CENTER.**



IRB NUMBER: 20-07532-XP
IRB APPROVAL DATE: 08/05/2020

You are invited to participate in a research study that aims to learn more about the experiences of Black men talking with their health care providers about high blood pressure treatment options.

Do you meet these criteria?

- Are you a Black or African-American adult man (18 years or older)?
- Have you been diagnosed with high blood pressure or hypertension?
- Do you live in the mid-south area (TN, MS, AR)?
- Do you have access to a computer or web-enabled device?

What do I have to do?

- Answer a brief online pre-interview survey that will take approximately 2-3 minutes to complete.
- Participate in a one-on-one online interview.
- Answer interview questions about your experiences talking to a health care provider about high blood pressure treatment options.
- The interview will last approximately 60-90 minutes.

Participants will receive a \$25 gift card for completing study-related activities.

***Interested in participating in this study?
Have more questions?***

Contact Samatha Calhoun, RN

901-281-4996 or scalhou8@uthsc.edu



APPENDIX B. QUALITATIVE PRE-INTERVIEW ONLINE SURVEY



IRB NUMBER: 20-07532-XP
IRB APPROVAL DATE: 08/05/2020

African- American Men’s Preference for Participating in Shared Decision-Making for High Blood Pressure Management

Participant Pre-interview Survey

1. Name _____
2. How old are you today? _____
3. What date were you diagnosed with hypertension or high blood pressure?

(MM/DD/YY) ____/____/____
4. What’s the name of your health care provider who manages your blood pressure treatment?

5. Which of the following blood pressure medications were you prescribed?
 - Hydrochlorothiazide
 - (Microzide)
 - Triamterene
 - Atenolol
 - Metoprolol
 - Carvedilol
 - Lisinopril
 - Losartan
 - Amlodipine (Norvasc)
 - Clonidine
 - Hydralazine
 - Furosemide (Lasix)
 - Other
 - I do not remember
6. Do you ever forget to take your blood pressure medicine?
 - Not at all
 - Sometimes
 - Frequently
7. Do you ever have problems remembering to take your blood pressure medicine?
 - Not at all
 - Sometimes
 - Frequently
8. When you feel better, do you sometimes stop taking your blood pressure medicine?

- Not at all
- Sometimes
- Frequently

9. Sometimes if you feel worse when you take your blood pressure medicine, do you stop taking it?

- Not at all
- Sometimes
- Frequently

10. In general, how would you rate your overall health?

- Very Poor
- Poor
- Fair
- Good
- Very Good
- Excellent

11. What is your current tobacco smoking status?

- Current every day smoker
- Former smoker
- Current some day smoker
- Never smoker
- I prefer not to answer

12. Which of the following are you currently trying to do to improve or maintain your health? *[Select all that apply]*

- Exercise regularly
- Manage stress effectively
- Get enough sleep to feel well- rested
- Eat mostly healthy foods
- Not drink or limit alcoholic drinks
- Not smoke or quit smoking

13. Are you currently sexually active?

- Yes
- No

14. What is the gender of your primary care provider?

- Male
- Female
- Transgender
- Intersex/Other

15. What is the race/ethnicity of your primary care provider?

- Black or African American

- White
- Latino/Hispanic/Chicano
- Middle Eastern
- Asian, South Asian, or Pacific Islander
- Native American or American Indian, Alaskan Native
- Other _____

16. What is the highest level of school that you have completed?

- 8th grade or less
- Some high school, did not graduate
- High school graduate/GED
- Some college or 2-year degree
- 4-year college degree
- Some graduate school or more

17. What was your total household income before taxes in the last 12 months? [*Include money from all sources*]

- Less than \$20,000
- \$20,000 - \$29,999
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 - \$59,999
- \$60,000 - \$69,999
- \$70,000 - \$79,999
- \$80,000 - \$89,999
- \$90,000 - \$99,999
- \$100,000 or more

b. How many people, including yourself, did that income support in the last 12 months?

1 – 2 3 – 4 5 – 6 7 – 10 >10

18. What is your current relationship or partnership status?

- Divorced
- Widowed
- Single
- Single, dating but not exclusively
- Single, dating exclusively
- Engaged
- Married
- Separated

19. How do you describe your current sexual orientation?

- Heterosexual or straight
- Bisexual
- Queer
- I don't know/ Other
- I prefer not to answer

20. What is your present religion, if any?

- No religion (i.e., atheist, agnostic)
- Christian (all denominations)
- Buddhist
- Muslim
- Sikh
- Any other religion, write in _____

- I don't know/prefer not to answer
- Hindu
- Jewish

21. Do you currently have health insurance?

- Yes
- No

The following questions ask about your involvement in the process of decision- making with your health care provider(s) about your blood pressure treatment and management. Think about the consultation with your health care provider about your blood pressure treatment. Nine statements related to decision- making in your consultation are listed below: for each statement, please indicate how much you agree or disagree.

22. My doctor made clear that a decision needs to be made.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

23. My doctor wanted to know exactly how I want to be involved in making the decision.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

24. My doctor told me that there are different options for treating my medical condition.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

25. My doctor precisely explained the advantages and disadvantages of the treatment options.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

26. My doctor helped me understand all the information.

- Completely disagree

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

27. My doctor asked me which treatment options I prefer.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

28. My doctor and I thoroughly weighed the different treatment options.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

29. My doctor and I selected a treatment option together.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

30. My doctor and I reached an agreement on how to proceed.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

APPENDIX C. QUALITATIVE SEMI-STRUCTURED INTERVIEW GUIDE



IRB NUMBER: 20-07532-XP
IRB APPROVAL DATE: 08/05/2020

African American men's personal role preference for participating in shared decision making in high blood pressure management. In-depth interview guide

I want to thank you for taking time out of your schedule to talk to me today. As stated in the consent form, this interview will be recorded for research purposes only. If at any time during today's conversation you need to take a break or would like to move to a different set of questions, please let me know. Are you ready to begin?

[Rapport- building questions]

1). I'm looking forward to our discussion on today. I am excited to talk to you about how you find information about your health, manage your blood pressure, and describe your relationship with your provider(s).

Before we jump in, I'd like to take a moment to get to know you. So, [participant's name], tell me a little about yourself. Who are you?

[Information- seeking questions]

2). When you are looking for information, how do you go about finding the information you are looking for? 3). When you have a health- related question, how do you go about finding the information you are looking for?

Probe #1: You told me you use [repeat participant's health related information source]. Please rank each source from most important to least important or from the source you would use most to the one you would use least.

Probe #2: Of that group, what is the most reliable source of information for you? Tell me more about what makes this important for you.

4). Think back to the day you were diagnosed with high blood pressure. Tell me about what happened during your clinic visit.

Probe #1: Tell me if you were satisfied or not satisfied with the information that you received about blood pressure management.

5). *[if the participant was satisfied with information]*

I'm glad your provider gave you satisfactory information to help you manage your BP. Did you seek additional information about your condition? Why or why not?

Did you use any information source other than the ones we discussed earlier? If so, what sources did you use?

[if the participant was not satisfied with information]

It sounds like you were dissatisfied with the information your provider gave you to manage your blood pressure. How did you seek information to fill in the gaps?

[Management questions]

Thank you for describing your health information- seeking process. Now we are switching gears to talk about how you manage your blood pressure.

- 6). What do you consider to be a controlled blood pressure?
- 7). Describe how you manage your blood pressure.
- 8). What treatment strategy(s) do you find to be most effective for controlling your blood pressure?

[Relationship with provider questions]

- 9). Describe your relationship with Dr... [refer to patient's demographic form for provider's information]
- 10). How does Dr.... help you control your blood pressure?
- 11). If you can characterize your relationship with your provider as a football team, would you say that a) you are both on the same team with the same goal, b) your provider is the coach and you are the player, or c) you are on two different teams with two different goals?

Probe #1: How would you like for your relationship with your provider to be?

[Involvement questions]

- 12). Describe your level of involvement, either being high or low, in decision making about your blood pressure treatment and/or management. Why do you give yourself this rating?
- 13). How do you ensure that your preferences for blood pressure management, including lifestyle changes and medication, are addressed?

[For participants who describe high involvement]

Probe #1: Give me an example when you were proud of yourself for advocating for your treatment preferences.

Probe #2: What motivates you to remain involved in your healthcare? How do you deal with barriers when they arise?

[For participants who describe low involvement]

Probe #1: Describe a time when you wanted to be involved but felt you weren't able to?

[Patient- provider communication questions]

Thank you for describing your level of involvement in managing your blood pressure. Now we are switching gears to talk about how you communicate with your provider.

I see that you take the following medications for blood pressure control [refer to patient's demographic sheet]

- 14). What side effects did you experience from those medications? How do medication side effects impact how well you follow your regimen?

15). Have you had a conversation about the sexual side effects of your blood pressure medication? Describe the setting or surroundings where you had this conversation and what was discussed during the conversation.

Probe #1: Who initiated the sexual health discussion(s)?

Probe #2: How did this conversation impact your treatment plan?

16). Tell me your thoughts about discussing sexual health challenges with your provider compared to discussing other side effects or symptoms.

17). How important is discussing other side effects compared to discussing sexual health challenges?

18). What side effects or symptoms do you think are more important to your doctor?

Probe #1: Explain the reason that you think that is most important to your doctor

19). What might influence Black men to avoid conversations with their health care provider?

20). How do you think health care providers communicate with you compared to a man of another [enter demographic characteristic—age, race, sexual orientation, economic background, education level]?

[Empowerment questions]

21). What does empowerment mean to you?

Probe #1: What does empowerment in a relationship with a medical provider mean to you?

Probe #2: Can you give me an example of how empowerment looks when you deal with your medical provider?

22). Describe what empowers you to discuss your blood pressure treatment with your health-care provider?

[Peer support question]

23). What advice would you give a male family member or close friend about talking to their health care provider about their treatment options for controlling their blood pressure?

[Wrap-up question]

24). You and I had a great conversation today. I am grateful for the opportunity to talk to you about an intimate part of your life. Before we end the interview, is there anything else you'd like to add? Did I miss something? What other topic do you think we should have discussed?

[End recording. End interview. Provide participant compensation].

APPENDIX D. QUANTITATIVE WEB-SURVEY



IRB NUMBER: 20-07532-XP
IRB APPROVAL DATE: 10/26/2022

African- American Men’s Preference for Participating in Shared Decision-Making for High Blood Pressure Management Participant Online Survey

1. How old are you today? _____
2. What date were you diagnosed with hypertension or high blood pressure?
(MM/DD/YY) ____/____/____
3. Which of the following blood pressure medications were you prescribed?
 Hydrochlorothiazide (Microzide) Lisinopril Losartan
 Amlodipine (Norvasc)
 Furosemide (Lasix)
 Triamterene Atenolol
 Metoprolol Carvedilol Clonidine Hydralazine Clonidine Other
 I do not remember
4. Do you ever forget to take your blood pressure medicine?
 Not at all Sometimes Frequently
5. Do you ever have problems remembering to take your blood pressure medicine?
 Not at all Sometimes Frequently
6. When you feel better, do you sometimes stop taking your blood pressure medicine?
 Not at all Sometimes Frequently
7. Sometimes if you feel worse when you take your blood pressure medicine, do you stop taking it?
 Not at all Sometimes Frequently
8. In general, how would you rate your overall health?
 Very Poor Poor
 Fair
 Good
 Very Good Excellent
9. What is your current tobacco smoking status?
 •Current every day smoker
 •Former smoker
 •Current some day smoker
 •Never smoker
 •I prefer not to answer
10. Which of the following are you currently trying to do to improve or maintain your health?
[Select all that apply]
 •Exercise regularly
 •Manage stress effectively
 •Get enough sleep to feel well- rested
 •Eat mostly healthy foods
 •Not drink or limit alcoholic drinks
 •Not smoke or quit smoking

11. Are you currently sexually active? Yes
 No
12. What is the gender of your primary care provider?
 Male
 Female
 Transgender Intersex/Other
13. What is the race/ethnicity of your primary care provider?
 Black or African American White
 Latino/Hispanic/Chicano Middle Eastern
 Asian, South Asian, or Pacific Islander
 Native American or American Indian, Alaskan Native
 Other _____
14. What is the highest level of school that you have completed?
 8th grade or less
 Some high school, did not graduate High school graduate/GED
 Some college or 2-year degree
 4-year college degree
 Some graduate school or more
15. What was your total household income before taxes in the last 12 months? [*Include money from all sources*]
 Less than \$20,000 \$20,000 - \$29,999 \$30,000 - \$39,999 \$40,000 - \$59,999 \$60,000 - \$99,999 \$100,000 or more
16. How many people, including yourself, did that income support in the last 12 months?
 1-2 3-4 5-6 7 - 10 >10
17. What is your current relationship or partnership status?
 Single
 Single, dating but not exclusively Single, dating exclusively
 Engaged
 Married
 Separated
 Divorced
 Widowed
18. How do you describe your current sexual orientation?
 Heterosexual or straight Queer
 Bisexual
 I don't know/ Other
 I prefer not to answer
19. What is your present religion, if any?
 No religion (i.e., atheist, agnostic) Christian (all denominations)
 Buddhist
 Hindu
 Jewish
 Muslim
 Sikh
 Any other religion, write in _____
 I don't know/prefer not to answer
20. Do you currently have health insurance?
 1. Yes 2. No

The following questions ask about your involvement in the process of decision- making with your health care provider(s) about your blood pressure treatment and management. Think about the consultation with

your health care provider about your blood pressure treatment. Nine statements related to decision- making in your consultation are listed below: for each statement please indicate how much you agree or disagree.

21. My doctor made clear that a decision needs to be made.

- Completely disagree Strongly disagree
- Somewhat disagree Somewhat agree
- Strongly agree
- Completely agree

22. My doctor wanted to know exactly how I want to be involved in making the decision.

- Completely disagree Strongly disagree
- Somewhat disagree Somewhat agree
- Strongly agree
- Completely agree

23. My doctor told me that there are different options for treating my medical condition.

- Completely disagree
 - Strongly disagree
 - Somewhat disagree
 - Somewhat agree
 - Strongly agree
 - Completely agree

24. My doctor precisely explained the advantages and disadvantages of the treatment options. Completely disagree

- Strongly disagree Somewhat disagree Somewhat agree
- Strongly agree
- Completely agree

25. My doctor helped me understand all the information.

- Completely disagree Strongly disagree
- Somewhat disagree Somewhat agree
- Strongly agree
- Completely agree

26. My doctor asked me which treatment options I prefer.

- Completely disagree
- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Completely agree

27. My doctor and I thoroughly weighed the different treatment options.

- Completely disagree Strongly disagree
- Somewhat disagree Somewhat agree
- Strongly agree
- Completely agree

28. My doctor and I selected a treatment option together.

- Completely disagree Strongly disagree
- Somewhat disagree Somewhat agree
- Strongly agree
- Completely agree

29..My doctor and I reached an agreement on how to proceed.

- Completely disagree

- ·Strongly disagree
- ·Somewhat disagree
- ·Somewhat agree
- ·Strongly agree
- ·Completely agree

Autonomy Preference Index (23 questions)

I. Decision making preference scale

A. General items for decision making preference.

Response options: (1) Strongly disagree (2) Disagree (3) Neither agree nor disagree (4) Agree (5) Strongly agree

1. The important medical decisions should be made by your doctor, not by you.
2. You should go along with your doctor’s advice even if you disagree with it.
3. When hospitalized, you should not be making decisions about your own care.
4. You should feel free to make decisions about everyday medical problems.
5. If you were sick, as your illness became worse you would want your doctor to take greater control.
6. You should decide how frequently you need a check-up.

B. Clinical Vignettes

Response Options: (1) you alone, (2) mostly you, (3) the doctor and you equally, (4) mostly the doctor, (5) the doctor alone.

Upper Respiratory Tract Illness- “Suppose you developed a sore throat, stuffy nose, and cough that lasted for three days. You are about to call your doctor on the telephone. Who should make the following decisions?”

7. whether you should be seen by the doctor.
8. Whether a chest x-ray should be taken.
9. Whether you should try taking cough syrup.

High Blood Pressure. “Suppose you went to your doctor **for** a routine physical examination and he or she found that everything was all right except that your blood pressure was high (170/100). Who should make the following decisions?”

10. When the next visit to check your blood pressure should be.
11. Whether you should take some time **off** from work to relax.
12. Whether you should be treated with medication or diet.

Myocardial Infarction (heart attack)- “Suppose you had an attack of severe chest pain that lasted for almost an hour, frightening you enough so that you went to the emergency room. In the emergency room the doctors discover that you are having a heart attack. Your own doctor is called and you are taken up to the intensive care unit. Who should make the following decisions?”

13. How often the nurses should wake you up to check your temperature and blood pressure.
14. Whether you may have visitors aside from your immediate family.
15. Whether a cardiologist should be consulted.

II. Information preference scale

Response options: (1) Strongly disagree (2) Disagree (3) Neither agree nor disagree (4) Agree (5) Strongly agree

16. As you become sicker you should be told more and more about your illness.
17. You should understand completely what is happening inside your body as a result of your illness.
18. Even if the news is bad, you should be well informed.
19. Your doctor should explain the purpose of your laboratory tests.
20. You should be given information only when you ask for it.
21. It is important for you to know all the side effects of your medication.
22. Information about your illness is as important to you as treatment.
23. When there is more than one method to treat a problem, you should be told about each one.

IRB NUMBER: 20-07532-XP

IRB APPROVAL DATE: 10/26/2022

Medical Mistrust Index (7) questions

Response options: (1). Strongly disagree (2) Disagree (3) Agree (4) Strongly agree

- (1) You’d better be cautious when dealing with health care organizations
- (3) When health care organizations make mistakes they usually cover it up
- (5) Health care organizations don’t always keep your information totally private
- (7) Mistakes are common in health care organizations

(2) Patients have sometimes been deceived or misled by health care organizations
(4) Health care organizations have sometimes done harmful experiments on patients without their knowledge

(6) Sometimes I wonder if health care organizations really know what they are doing

IRB NUMBER: 20-07532-XP

IRB APPROVAL DATE: 10/26/2022

Trust in Physician Scale (11 questions)

Response options: (1) Strongly disagree (2) Disagree (3) Neither agree nor disagree (4) Agree (5) Strongly agree

1. I doubt that my doctor really cares about me as a person.
2. My doctor is usually considerate of my needs and puts them first.
3. I trust my doctor so much I always try to follow his/her advice.
4. If my doctor tells me something is so, then it must be true
5. I sometimes distrust my doctor's opinion and would like a second.
6. I trust my doctor's judgements about my medical care.
7. I feel my doctor does not do everything he/she should for my medical care.
9. My doctor is a real expert in taking care of medical problems like mine.
10. I trust my doctor to tell me if a mistake was made about my treatment.
11. I sometimes worry that my doctor may not keep the information we discuss totally private.
8. I trust my doctor to put my medical needs above all other considerations when treating my medical problems.

Health Care Climate Questionnaire (15 questions)

Response Options: (1) Strongly disagree (2) Moderately disagree (3) Slightly disagree (4) Neutral Disagree (5) Slightly agree (6) Moderately agree (7) Strongly agree

- 1) I feel that my health care practitioner has provided me choices and options about my health.
- 2) I feel my health care practitioner understands how I see things with respect to my health.
 3. 3) I am able to be open with my health care practitioner about my health.
 4. 4) My health care practitioner conveys confidence in my ability to make changes regarding my health.
 5. 5) I feel that my health care practitioner accepts me whether I follow their recommendations or not.
 7. 7) My health care practitioner encourages me to ask questions.
 8. 8) I feel a lot of trust in my health care practitioner.
- 9) My health care practitioner answers my questions related to my health fully and carefully.
- 10) My health care practitioner listens to how I would like to do things regarding my health.
- 11) My health care practitioner handles my emotions very well.
- 12) I feel that my health care practitioner cares about me as a person.
- 13) I don't feel very good about the way my health care practitioner talks to me about my health.
- 14) My health care practitioner tries to understand how I see my health before suggesting any changes.
- 15) I feel able to share my feelings with my health care practitioner.
- 16) My health care practitioner has made sure I really understand my health risk behaviors and the benefits of changing these behaviors without pressuring me to do so.

Working Alliance Inventory (12 questions)

Rate response options: (1) Seldom (2) Sometimes (3) Fairly Often (4) Very Often (5) Always

- 1) As a result of these sessions I am clearer as to how I might be able to change.
- 2) What I am doing in therapy gives me new ways of looking at my problem.
- 3) I believe likes me.
- 4) ___and I collaborate on setting goals for my therapy.
- 5) ___and I respect each other.
- 6) ___and I are working towards mutually agreed upon goals.
- 7) I feel that appreciates me.
- 8) _____ and I agree on what is important for me to work on.

- 9) I feel _____ cares about me even when I do things that he/she does not approve of.
- 10) I feel that the things I do in therapy will help me to accomplish the changes that I want.
- 11) _____ and I have established a good understanding of the kind of changes that would be good for me.
- 12) I believe the way we are working with my problem is correct.

Working Alliance Inventory- General Practice:

Rate response options: (1) Seldom (2) Sometimes (3) Fairly Often (4) Very Often (5) Always

- 1. As a result of seeing my GP, I am clearer as to how I can look after my health and wellbeing.
- 2. What I am doing with my GP gives me new ways of looking at my health and wellbeing.
- 3. I believe my GP cares about me.
- 4. My GP and I work together on setting goals for looking after my health and wellbeing.
- 5. My GP and I respect each other.
- 6. My GP and I are working towards health goals that we both agree on.
- 7. I feel that my GP understands me.
- 8. My GP and I agree on what is important for me to do to look after my health and wellbeing.
- 9. Even though I may do things that my GP does not advise or suggest, I know they still care about me.
- 10. I feel the things I do with my GP will help me to achieve my health goals.
- 11. My GP and I have a shared understanding of what I need to do to look after my health and wellbeing.
- 12. I think we're doing the right things for my health and well-being.

International Index of Erectile Function (IIEF-5)

Over the past 6 months:

Question **Response Rate options**



1. How do you rate your confidence that you could get and keep an erection?	1. Very Low 2. Low 3. Moderate 4. High 5. Very High
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	1. Almost never/never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half the time) 5. Almost always/always
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	1. Almost never/never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half the time) 5. Almost always/always
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	1. Extremely difficult 2. Very difficult 3. Difficult 4. Slightly difficult 5. Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

- 1. Almost never/never**
- 2. A few times (much less than half the time)**
- 3. Sometimes (about half the time)**
- 4. Most times (much more than half the time)**
- 5. Almost always/always**

VITA

Samantha Faith Calhoun was born in 1992 in Memphis, TN, and graduated from East High School. She completed her Bachelor of Science in Nursing degree in 2013 and her Master of Science in Nursing with a concentration in Nursing Education in 2017. She began her nursing career as a staff nurse, charge nurse, and preceptor in medical and cardiovascular progressive care inpatient settings. She was later appointed as clinical assistant professor of nursing in 2018 at the University of Memphis Loewenberg College of Nursing, where she passionately taught pre-licensure nursing students in the undergraduate nursing program. She has received multiple awards, including the Department of Health and Human Services Faculty Award, Sigma Theta Tau International Beta Theta Chapter Scholarship, Memphis's Top 20 Under 30, and the American Heart Association Woman of Impact. She is a member of the American Nurses Association, the Tennessee Nurses Association, and the Academy of Communication in Healthcare. In addition, she has presented research locally and nationally at the Tennessee Population Health Conference and the International Conference on Communication in Healthcare. She expects to graduate in April 2024 with a Doctor of Philosophy degree in Nursing Science.