Review Article

Understanding Patient-Centered Care (PCC) and Shared Decision-Making (SDM) for Strengthening Doctor-Patient Relationships: A Model-Based Review with Implications for Central Police Hospital, Bangladesh

Sarder Nurul Amin*

Additional Inspector General, Bangladesh Police and Director, Central Police Hospital, Dhaka-1000, Bangladesh.

*Email: dir_cph@police.gov.bd, nurul196901@gmail.com

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Abstract

Patient-centered care (PCC) and shared decision-making (SDM) are considered important models in current healthcare, which strengthen the doctor-patient relationship. This study assessed the relevance and challenges of these models in the context of Bangladesh Police Central Hospital. The objective of this study is to review the theoretical and model-based frameworks of patient-centered care and shared decision-making and assess their applicability in the practical context of Bangladesh Police Central Hospital. The study is based on qualitative analysis and presents data through analysis of global research, local context, and existing theoretical models. A context-based analysis was formed using the models of Stewart, Charles Epstein, and Street. The finding reveals that the implementation of patient-centered care (PCC) and shared decision-making (SDM) in an institutional setting like a police hospital is both necessary and challenging. In addition, the study found that power-centric organizational structures, lack of time, resource constraints, and patriarchal mindsets pose major barriers to patient voice and participation. However, contextually adapted PCC and SDM models can improve the doctor-patient relationship, facilitate long-term disease management, and contribute to positive changes in mental health care. This study provides a theoretical basis for humanizing treatment in specialized institutions such as police hospitals and recommends building a framework for implementing PCC and SDM in line with local realities. Since this study was based on secondary data rather than primary data, empirical observations were limited. There is a need to conduct primary data-based research on the implementation of PCC and SDM in police hospitals and similar institutions.

Keywords

Patient-Centered Care, Shared Decision-Making, Doctor-Patient Relationship, Police Healthcare, Theoretical Models, Bangladesh.

1. Introduction

In recent decades, the global healthcare paradigm has shifted from a disease-centered approach to a more holistic, patient-centered framework that emphasizes individual needs, values, and preferences in clinical decision-making. However, this shift is embodied in two interrelated concepts: patient-centered care (PCC) and shared decision-making (SDM), which aim to foster stronger, more collaborative doctor-patient relationships. Moreover, these models are particularly relevant in high-stress institutional settings such as police hospitals, where occupational hazards, psychological stress,

and procedural constraints can compromise both care delivery and patient engagement (Barry & Edgman-Levitan, 2012). PCC is defined by the Institute of Medicine as care that is "respectful and responsive to individual patient preferences, needs, and values" (IOM, 2001). Consequently, this model shifts the focus from the biomedical domain to a biosocial understanding of health, which includes emotional, social, and psychological dimensions (Mead & Bower, 2000). SDM, often conducted within the PCC framework, refers to a collaborative process in which clinicians and patients jointly make health-related decisions, informed by the best available evidence, and aligned with the patient's values (Charles et al.,1997). These models are associated with improved patient satisfaction, treatment adherence, and health outcomes, particularly in chronic disease management (Elwyn et al., 2012).

Despite documented benefits, implementation of PCC and SDM remains limited across healthcare systems, particularly in resource-limited or culturally stratified settings such as Bangladesh. In institutional settings such as the Central Police Hospital (CPH) which serves active-duty police officers and their families the complexity of care is further compounded by occupational stress, power differentials, and limited organizational resources. Police personnel are at risk of developing non-communicable diseases such as hypertension and PTSD due to the stressful nature of their profession (Muhammad & Arafat, 2024). These conditions require long-term management strategies that benefit from patient involvement and mutual trust – the core principles of PCC and SDM.

Furthermore, doctor-patient interactions within police hospitals may reflect patriarchal communication patterns, where authority structures discourage open dialogue. Research suggests that medical patriarchy is still common in South Asian contexts, where healthcare is often doctor-led and patient inaction is normalized. Despite increasing policy interest in humanizing healthcare in Bangladesh, such dynamics hinder the integration of PCC and SDM. Additionally, the absence of formal training in communication and decision-making frameworks among healthcare providers further hinders implementation (Krishnamoorthy et al., 2020). This review attempts to address these challenges by synthesizing existing theoretical models of PCC and SDM, with a particular emphasis on their applicability within the CPH context. Basic frameworks such as Stewart et al.'s patient-centered clinical approach (1995), Epstein and Street's integrated model (2011), and Charles et al.'s SDM typology (1997) provide structured ways to assess doctor-patient interactions.

Furthermore, improving the doctor-patient interaction is essential in the medical field, especially in law enforcement environments like Bangladesh's Central Police Hospital (CPH). This paper looks at how CPH's particular problems, like hierarchical structures and scarce resources, can be addressed by Patient-Centered Care (PCC) and Shared Decision-Making (SDM). The study intends to find methods for enhancing patient satisfaction, involvement, and trust by investigating these models. Notwithstanding the advantages, obstacles including a lack of communication and institutional opposition could prevent them from being fully implemented. This analysis offers useful advice for incorporating PCC and SDM into CPH's procedures, which will ultimately improve patient outcomes and promote a more patient-centered approach to law enforcement medical treatment.

Accordingly, applying these models in high-level, uniformed service environments may reveal both obstacles and opportunities for institutional reform. In Bangladesh empirical research on PCC and SDM is still emerging, especially in specialized health institutions such as police or military hospitals. While there has been some progress in adopting a people-centered healthcare strategy in public health planning (DGHS, 2021). The translation of theory into practice remains uneven. Therefore, a model-based review based on both global theory and local contexts is essential for guiding future interventions, policy formulation, and healthcare training. This paper aims to fill an important gap in the literature by exploring how PCC and SDM models can be adapted to strengthen the doctor-patient relationship in the central police hospital of Bangladesh. Analyzing global frameworks from a local perspective provides insights for evidence-based institutional reforms, improved patient engagement, and ultimately more humane healthcare delivery.

2. Literature Review

The doctor-patient relationship is the crucial foundation of effective healthcare delivery, which impacts patient outcomes and satisfaction. In a law enforcement healthcare setting, is essential to overcome unique challenges such as hierarchical professional structures and resource constraints. This literature review analyzes the theoretical foundations of PCC and SDM, highlighting how they contribute to improving communication, trust, and collaborative care. By analyzing existing research on these models, particularly in the light of institutional reform, medical education, and health governance, the review provides a framework for implementing these approaches in CPH. The integration of these models is not only consistent with patient-centered quality healthcare practice but also creates an environment where patients can act as active participants in their medical decisions.

2.1. The concept of Patient-Centered Care (PCC)

Patient-centered care has become a crucial perspective in modern healthcare, emphasizing the patient's values, preferences, and involvement in treatment planning. It is based on the biopsychosocial model, which considers health not only in terms of diagnosis but also in terms of emotional, cultural, and social contexts (Mead & Bower, 2000). The Institute of Medicine IOM., (2001) defines PCC as "care that is respectful and responsive to the patient's preferences, needs, and values"where the patient is at the center of every decision.

However, the key elements of PCC are: understanding the patient's experience, building a healing relationship, and involving the family. Stewart et al., (2024) proposed six components for implementing PCC: exploring the disease experience, understanding the whole person, consensus, incorporating prevention and health promotion, improving the doctor-patient relationship, and considering reality. This model has a positive impact on patient satisfaction, treatment adherence, and health outcomes in high-income and lower-middle-income countries (Dwamena et al., 1996). However, implementing these elements in a structurally rigid environment like Bangladesh is challenging due to time constraints, physician attitudes, and lack of training in empathetic communication.

2.2. Evolution and Model of Shared Decision-Making (SDM)

Shared Decision-Making (SDM) is an implementable extension of PCC which emphasizes the joint participation of physicians and patients in medical decisions. It involves at least two parties the physician and the patient sharing information, expressing treatment preferences, and participating in shared decision-making (Charles et al.,1997). Charles' proposed model highlights three basic elements: information sharing, discussion, and consensus. This contrasts with the traditional paternalistic model, where decisions are made solely by the physician. SDM is particularly effective for long-term and choice-dependent conditions, such as diabetes, cancer, or mental health problems (Elwyn et al., 2012). Tools have been developed to support this process, such as decision aids, risk communication frameworks, and quality assessment exercises.

Epstein and Street (2011) propose an integrated model in which patient involvement, information relevance, and relationship-based communication are identified as key to success. However, SDM is still underutilized in many LMICs, where resource constraints, time constraints, and educational disparities hinder its expansion. The medical environment in South Asia is typically hierarchical; patients may feel hesitant to challenge or express their own opinions. Such cultural and structural barriers are even more pronounced in settings such as the Central Police Hospital, where both providers and patients are subject to the same rigid framework.

2.3. Doctor-Patient Relationship Dynamics

The quality of the doctor-patient relationship is essential for PCC and SDM. A trusting and empathetic relationship enhances patient disclosure, satisfaction, and treatment adherence (Ridd et al., 2009). In institutional settings such as police hospitals, where patients may feel uncertain about expressing their mental health concerns or concerns, the foundation of trust becomes even more important. Open communication, consistent treatment, and cultural sensitivity are essential to improve this relationship. The medical system in Bangladesh is still dominated by one-sided treatment, where the doctor is considered the ultimate authority. Inequality of knowledge, class, and institutional status is widespread in this relationship.

Although patients want to be more involved, they often accept the doctor's decisions, either out of respect for the doctor's knowledge or out of fear. This position is even more complex in the context of CPH, where doctors are not only healthcare providers but also symbols of authority as part of the same system. However, research has shown that when doctors are trained in empathetic and culturally sensitive communication, the doctor-patient relationship improves (Donnelly et al.,2016). Emotional intelligence, active listening, and non-verbal communication techniques have been shown to build rapport even under systemic constraints. Moreover, peer support and family involvement a common cultural norm in South Asia can be leveraged to strengthen relational trust and continuity in care.

2.4. Relevant Considerations in the Context of Police Healthcare

Law enforcement personnel are exposed to different health risks, such as chronic stress, trauma, and lifestyle-related diseases. Studies around the world have shown that police officers have higher rates of PTSD, hypertension, and substance abuse (Violanti et al., 2017). In addition, the same picture is emerging in Bangladesh, especially in the area of mental health awareness and services. PCC and SDM are important in this context, as they provide person-centered care that takes into account the patient's occupational risks, mental state, and social complexity. The structural rigidity and

discipline of the police organization may conflict with the participatory values of PCC and SDM. The practice of treating illness as a sign of weakness and unilateral decision-making by physicians undermines this practice. Therefore, there is a need to adapt existing models to institutional realities. Hybrid approaches—where standardized rules are combined with participatory elements—are likely to be effective in settings like CPH.

2.5. Cultural and Institutional Barriers in South Asia

In South Asia, particularly in Bangladesh, authoritarian medical cultures are major barriers to the implementation of PCC and SDM. Here, the physician is considered the final authority, and patients are often discouraged from participating in decisions (Bell et al., 2022). Social class, gender, and educational disparities also complicate the medical relationship. These disparities are more exacerbated in settings like police hospitals, where military-style and rigid structures prevail. Implementing reformative PCC and SDM models also requires taking into account local religious beliefs, stigma surrounding mental illness, and limited health literacy (Elwyn et al., 2012; Stewart et al., 1995).

2.6. The Importance of Communication Skills and Empathy in Healthcare

The foundation of PCC and SDM is effective doctor-patient communication. Previous research has shown that empathy, active listening, and open-ended questions increase patient trust and satisfaction (Ridd et al., 2009; Epstein & Street, 2011). However, in many LMICs, these skills are underemphasized in medical education in Bangladesh (Donnelly *et al,.*2016). Such sensitive communication is essential for patients with PTSD or addiction problems in institutions such as police hospitals. Empathetic and culturally appropriate training leads to significant improvements in service delivery.

2.7. Health System Constraints and Staffing Pressures

Institutional support such as regulating physician working hours, adequate staffing, and appropriate incentives essential for implementing PCC and SDM. In government hospitals in Bangladesh, the number of patients per physician is so high that there is not enough time to talk to a patient. As a consequence, the time-intensive procedures required for PCC and SDM become almost impossible to follow. Many physicians suffer from burnout, which reduces their willingness and ability to engage emotionally with patients (Elwyn et al., 2012). In addition, the lack of decision support tools, confidential consultation rooms, and integrated health records create barriers to the implementation of SDM.

2.8. Gender Dynamics in Medicine

Gender plays an important role in patriarchal societies. Female patients often face barriers to seeking treatment such as being interrupted while speaking, treated disrespectfully, or denied decision-making power (Mead & Bower, 2000). This disparity is even more pronounced in male-dominated environments such as police hospitals (Bell et al., 2022). According to the report, Female physicians also face institutional discrimination, which hinders their implementation of PCC and SDM. Gender-sensitive training, gender-diverse recruitment, and prioritizing women's needs are ways to reduce gender disparities and create an inclusive medical environment.

3. Methodology

The nature of the review is anchored by qualitative synthesis of secondary data. Focused on conceptual and empirical insights into Patient-Centered Care (PCC) and Shared Decision-Making (SDM) were examined, particularly in institutional contexts such as the Central Police Hospital in Bangladesh. It critically assessed relevant theories, model, and which shape the doctor-patient relationship within healthcare systems influenced by hierarchy, occupational stress, and resource limitations.

3.1. Secondary Data and Conceptual Mapping

This study was conducted using a secondary data review strategy, using peer-reviewed journal articles, institutional reports, grey literature, and global health frameworks published between 2000 and 2024. Data were collected from recognized journal databases such as PubMed, Scopus, and Google Scholar. The search strategy was conducted by using keywords and Boolean operators such as “patient-centered care,” “shared decision-making,” “doctor-patient relationship,” and “Bangladesh health system.” The literature was selected based on relevance, methodological rigor, and relevance to

the characteristics of the government hospital and police health care systems in Bangladesh. The selected sources were categorized thematically, allowing for inductive mapping of challenges, capabilities, and cultural variables related to PCC (Patient-Centered Care) and SDM (Shared Decision-Making).

3.2. Theoretical and Model-Based Integration

This study compiles several key conceptual models to form the analytical framework. According to Stewart et al. (1995)'s "Patient-Centered Clinical Method" provides a foundational perspective, emphasizing patient personhood, power sharing, and the therapeutic alliance. Elwyn et al.'s (2012) "Three-Talk Model of SDM" comprised of "Team Talk," "Option Talk," and "Decision Talk" has been used to assess the interactive dynamics of collaborative decision-making in resource-limited settings. Moreover, Mead and Bower's, *(*2000) "Multidimensional Concept of Patient-Centeredness" has further enriched the analysis, emphasizing the importance of a biopsychosocial perspective, the physician-as-person, and power sharing. It has guided the analysis of how institutional culture, professional norms, and structural elements influence the implementation and impact of PCC and SDM particularly in contexts such as the Central Police Hospital.

3.3. Contextual Adaptation in Low-Resource and Class-Based Contexts

Considering the institutional framework of Bangladeshi police hospitals—where clinical interviews are influenced by militarized culture and occupational hazards—this framework draws on insights from the contextual adaptation literature. These include culturally sensitive service delivery, trauma-sensitive frameworks, and integrated approaches to biopsychosocial care (Epstein & Street, 2011). Theoretical sensitivity is maintained by taking into account local nuances such as health literacy levels, gender dynamics, and mental health stigma.

3.4. Limitations of the Methodological Approach

While this theoretical model-based review enabled a comprehensive exploration of the constructs of PCC and SDM, it is somewhat limited by the lack of primary data from the Central Police Hospital. Nevertheless, by triangulating international literature, and regional, and institutional reports, it has been possible to create a pragmatic, yet adaptable framework that can guide future primary research, policy reform, and the development of training programs for police healthcare systems.

4. Results and Discussions

4.1 Theoretical Foundations of PCC and SDM

An early model of PCC is Stewart et al. (2024)'s Patient-Centered Clinical Method, which presents PCC as a multi-level process that includes understanding the patient's illness experience, integrating biopsychosocial factors, building a therapeutic alliance, and sharing power in decision-making. Stewart et al. have argued six key elements: exploring both the disease and the illness experience, understanding the patient as a whole person, finding common ground regarding management, incorporating prevention and health promotion, strengthening the doctor-patient relationship, and being realistic about time and resources (Stewart et al.2024). it highlights the importance of viewing patients from a holistic perspective, not just their immediate medical complaints. Complementing Stewart's work, Charles et al., 1999) developed a detailed conceptual framework for SDM, in which SDM is defined as a process between at least two parties the patient and the healthcare professional who share information, consider options, and agree on treatment decisions. Moreover, it emphasizes the importance of recognizing patient preferences and values and taking them into account alongside clinical evidence, making SDM a dynamic, negotiated process not a unilateral mandate (Charles et al., 1997; Charles et al., 1999). As a result, this framework has played a key role in distinguishing SDM from related concepts such as informed consent and paternalism.

Table 01: Summarizing the Key Theoretical Models of PCC and SDM

Model / Author (s)	Core Components	Focus / Emphasis	Relevance to PCC and SDM
Stewart et al. (2024)	- Exploring both disease and illness experience - Understanding the whole person	Holistic understanding of patient's experience and context; therapeutic alliance; partnership	Emphasizes viewing patient as a whole person; foundational for PCC; supports

	- Finding common ground - Prevention and health promotion - Enhancing doctor-patient relationship - Realistic about time/resources		shared power and collaboration in care.
Charles, Gafni & Whelan (1999)	- Two-way exchange of information - Deliberation of options - Agreement on treatment decision - Recognition of patient preferences alongside clinical evidence	Interactive negotiation process; decision-making mechanics	Clarifies SDM as a process distinct from paternalism and informed consent; central for operationalizing shared decisions
Epstein & Street (2011)	- Fostering healing relationships - Exchanging information - Responding to emotions - Managing uncertainty - Collaborative decision-making - Enabling patient self-management	Communication quality and relational dynamics in healthcare	Highlights communication as the vehicle for PCC and SDM; integrates emotional and relational context into decision-making
Source: Compiled by the Author (2025)			

According to the theoretical framework, Epstein and Street (2011) present a comprehensive model that places communication at the heart of PCC and SDM. The above six key functions of communication in healthcare: building therapeutic relationships, sharing information, responding to emotions, managing uncertainty, sharing decisions, and enabling patient self-management (Epstein & Street, 2011). This model is built around communication, which captures the nuances of interpersonal interaction and emotional engagement that are essential for effective PCC and SDM, and conveys the message that clinical decisions are in no way separate from their relational and emotional context. Collectively, these models offer complementary perspectives: Stewart et al. prioritize holistic understanding and partnership; Charles et al. analyze the mechanics of the decision-making process; and Epstein and Street emphasize the quality of communication—through which PCC and SDM are implemented. In practice, these theoretical foundations provide a strong framework for analyzing and developing the doctor-patient relationship, especially in challenging environments like the Central Police Hospital in Bangladesh, where formal cultural structures and professional pressures complicate traditional medical interactions.

4.2. Relevance of PCC and SDM in Police or High-Stress Institutional Settings

Patient-centered care (PCC) and Shared Decision-Making (SDM) are particularly important but challenging to implement in high-stress institutional settings, such as police hospitals. These environments have unique stressors, hierarchical organizational cultures, and specific health needs—particularly those related to occupational risks, such as post-traumatic stress disorder (PTSD), hypertension, and substance use disorders, that are common among law enforcement personnel (Violanti et al., 2017).

There are several challenges in the command-and-control culture of police organizations. This culture often creates a healthcare environment where there is a strict separation of authority, which can hinder open communication and patient autonomy (Kaur, 2025). Patients, who are often police officers themselves, may feel restricted from challenging medical authority or expressing their concerns or preferences. Similarly, healthcare providers working in such environments may prioritize efficiency and control over workload and the need for rapid decision-making in acute care settings. These elements conflict with the core principles of PCC and SDM such as time, trust building, and two-way communication.

In addition, occupational stress and its physical and mental health impacts further complicate the implementation of PCC and SDM. High rates of anxiety, depression, and PTSD among police officers may inhibit patients' ability or willingness to actively participate in decision-making (Andersen et al., 2015). According to the report, Healthcare providers have not

received training in trauma-sensitive care or in mitigating stigma surrounding mental health, further limiting the effectiveness of SDM (Sinko et al., 2021).Despite these challenges, integrating PCC and SDM yields significant benefits. Evidence shows that patient-centered approaches can improve health outcomes, treatment adherence, and patient satisfaction, even in stressful institutional settings (Beach et al., 2005). In the case of police, building trusting and collaborative relationships with healthcare providers can reduce the negative effects of occupational stress and increase psychological safety. In addition, SDM allows patients to participate in treatment choices, which can improve the management of chronic diseases common among police (Charles et al., 1997).

Table 02: Summarizing the Key Points About the Relevance, Challenges, and Benefits of PCC and SDM in Police or High-Stress Institutional Settings

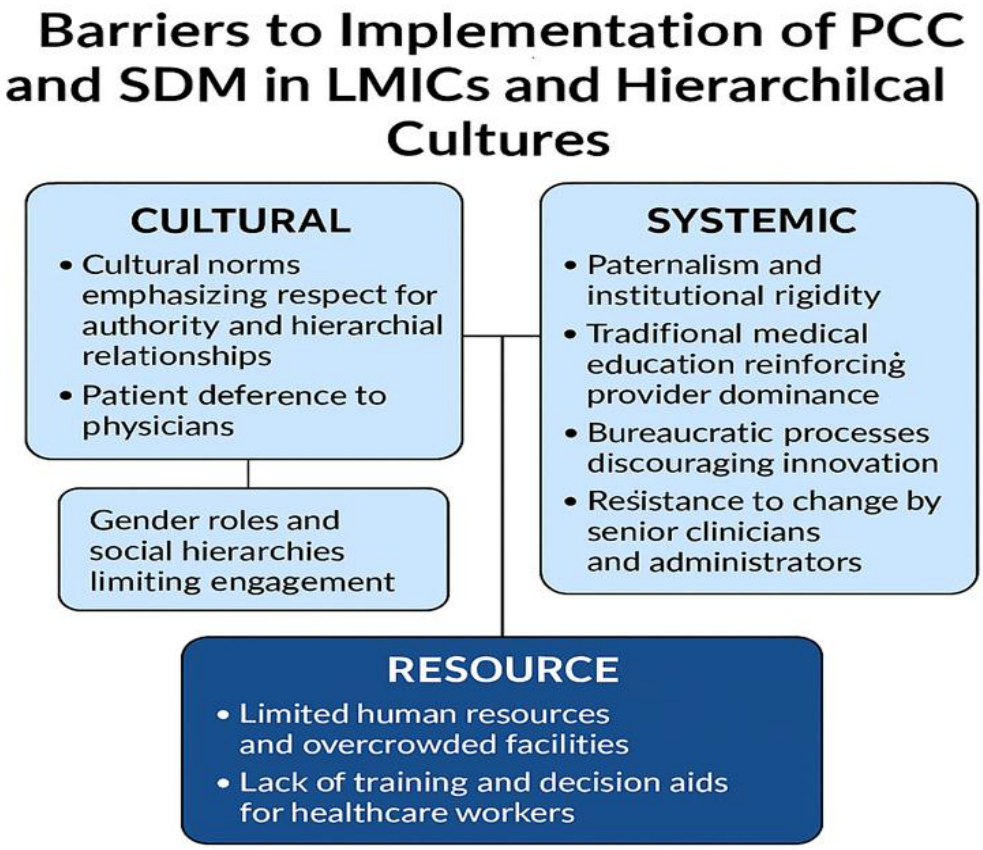
Aspect	Description	Challenges	Benefits	References
Institutional Culture	Police hospitals operate within a hierarchical, command-driven system influencing provider-patient dynamics.	Authority gradients limit open communication and patient autonomy; providers prioritize efficiency and control.	Potential to shift culture towards collaboration; enhances respect and partnership in care.	Kaur (2015)
Occupational Stressors	High rates of PTSD, hypertension, anxiety, and depression among police personnel affect health outcomes and care engagement.	Mental health stigma and trauma reduce patient participation; providers may lack trauma-informed training.	PCC/SDM can improve psychological safety and trust; and supports better management of chronic stress.	Andersen et al. (2015); Sinko et al., 2021
Communication Dynamics	Communication quality is essential for fostering trust and understanding in stressful healthcare encounters.	Time constraints and workload pressures reduce meaningful dialogue; emotional responses may be overlooked.	Effective communication promotes shared decisions and patient satisfaction.	Epstein & Street (2011); Elwyn et al. (2012)
Contextual Adaptation	Models need tailoring to fit cultural norms, gender dynamics, stigma, and institutional priorities specific to police healthcare settings.	Standard PCC/SDM models may be too generic; cultural and contextual mismatch hinders implementation.	Context-sensitive approaches improve acceptability, adherence, and health outcomes.	Elwyn et al. (2012)
Source: Compiled by the Author (2025)				

However, in the context of police hospitals such as the Central Police Hospital in Bangladesh, adapting PCC and SDM models to reflect local hierarchical norms, workload realities, and cultural sensitivities is essential. This could involve tailored communication training for providers, inclusion of family members in decision-making, and trauma-informed practices that respect the complex needs of law enforcement patients (Elwyn et al., 2012). Overall, while challenging, the relevance of PCC and SDM in these settings is undeniable and critical for enhancing the quality of care.

4.3. Barriers to Implementation in LMICs and Hierarchical Cultures

The implementation of Patient-Centered Care (PCC) and Shared Decision-Making (SDM) in low- and middle-income countries (LMICs) and the context of progressive cultures faces a number of complex barriers. These barriers stem from deeply rooted social, cultural, and structural factors that limit the practical acceptance of these models.

Figure 01: Barriers to Implementation in LMICs and Hierarchical Cultures



Source: Compiled by the Author, 2025

LMICs often emphasize respect in cultural norms for authority and hierarchical relationships, especially in the context of healthcare. Patients may accept physician decisions out of respect or fear, viewing physicians as the ultimate experts whose authority should not be questioned. This cultural patriarchy conflicts with the participatory principles of PCC and SDM, which encourage patient choice and active participation. Furthermore, gender roles and social hierarchies further marginalize women or people from lower social classes, limiting their participation in healthcare Resource constraints are a pervasive challenge in healthcare settings in LMICs. Limited human resources, overcrowded facilities, and inadequate infrastructure reduce consultation times and impede the deep patient-provider communication necessary for PCC and SDM (Ridde et al.,2009) . Furthermore, a lack of training and decision-making support tools for healthcare workers limits their ability to effectively practice SDM (Kruk et al., 2018). These types of constraints often force providers to prioritize efficiency over patient engagement, reinforcing the trend toward transactional care.

Moreover, patriarchy and institutional rigidity have remained major barriers. Traditional medical education and the progressive healthcare system maintain provider dominance and control over the clinical encounter (Berwick, 2009). Institutional protocols and bureaucratic processes discourage flexibility and innovation, which hinders the creation of a culture of partnership and shared decision-making (Gilson, 2016). Reluctance to change among senior physicians and administrators can stall implementation, especially when PCC/SDM is perceived as a threat to established power dynamics.

Table 03: Facilitators and Enablers of PCC/SDM in Bangladesh

Category	Facilitator/Enabler	Description	Implications
Policy and Governance	National Health Policies and UHC Commitment	Government prioritization of patient rights, quality care, and participatory governance through national strategies and programs.	Establishes a supportive regulatory environment; promotes provider accountability and systemic reform.

Healthcare Provider Training	Communication & Cultural Competence Training	Structured training programs enhance providers' empathy, communication skills, and ability to involve patients in decisions.	Improves the quality of patient-provider interaction and builds trust in care relationships.
Digital Health Technologies	Mobile Health (mHealth), EHRs, and Telemedicine	Technology platforms enable remote access, streamline communication, and enhance information sharing and follow-up.	Facilitates continuous care, empowers patient involvement, and reduces barriers to SDM.
Community & Patient Engagement	Advocacy by Civil Society and Patient Groups	Growing demand for inclusive care practices through community mobilization and patient advocacy, especially for underserved groups.	Increases pressure for transparency and respect in healthcare delivery; strengthens bottom-up reforms.
Source: Compiled by the Author (2025)			

Finally, patient advocacy and community engagement enhance the demand for patient-centered approaches. Civil society organizations and patient groups have begun advocating for greater transparency, respect, and involvement in healthcare decisions, particularly for vulnerable populations. This advocacy pressures healthcare providers and institutions to adopt more inclusive and respectful care practices, reinforcing PCC and SDM at the grassroots level. Together, these facilitators create a supportive ecosystem that can overcome traditional barriers and advance patient-centered healthcare in Bangladesh's unique socio-cultural context.

4.5. Impact on Chronic Disease Management and Mental Health in Law Enforcement

Law enforcement officers have faced significant health challenges, particularly in the areas of chronic diseases such as hypertension and mental health problems such as post-traumatic stress disorder (PTSD). Patient-centered care (PCC) and Shared Decision-Making (SDM) have offered promising strategies to develop the management and outcomes of these complex conditions within this high-stress professional group. Chronic disease management, especially hypertension, benefits from PCC and SDM because it increases patient self-care behaviors and adherence to treatment plans. When healthcare providers actively involve police officers in decision-making about medication choices, lifestyle changes, and monitoring, patients feel more empowered and responsible. Studies show that PCC, by adapting care to individual preferences and psychosocial contexts, helps control blood pressure and reduce cardiovascular risk (Kelley et al., 2014). The emphasis on trust and open communication ensures better disclosure of symptoms and challenges, which enables more effective treatment coordination (Roter et al., 2002).

Table 04: Impact of PCC and SDM on Chronic Disease and Mental Health in Law Enforcement

Health Focus Area	Mechanism (PCC/SDM Element)	Description	Implications
Chronic Disease Management	Patient Engagement and Self-Care Support	PCC and SDM promote active participation of police personnel in managing conditions like hypertension through shared goal setting and tailored treatment plans.	Improves adherence to medication and lifestyle changes, leading to better control of blood pressure.
Chronic Disease Management	Trust-Building and Open Communication	Patient-centered dialogue encourages honest disclosure about health behaviors and challenges, enabling timely and appropriate adjustments in care.	Reduces risks of complications and supports more responsive chronic disease care.
Mental Health (PTSD)	Reduction of Stigma and Cultural Barriers	SDM facilitates respectful exploration of mental health treatment options in a non-judgmental environment, lowering stigma-related avoidance.	Increases the likelihood of help-seeking and reduces symptom underreporting in police populations.
Mental Health (PTSD)	Therapeutic Alliance and Emotional Validation	PCC emphasizes empathy, respect, and autonomy, validating emotional experiences and building trust between patients and providers.	Enhances treatment engagement, improves symptom outcomes, and builds psychological resilience.

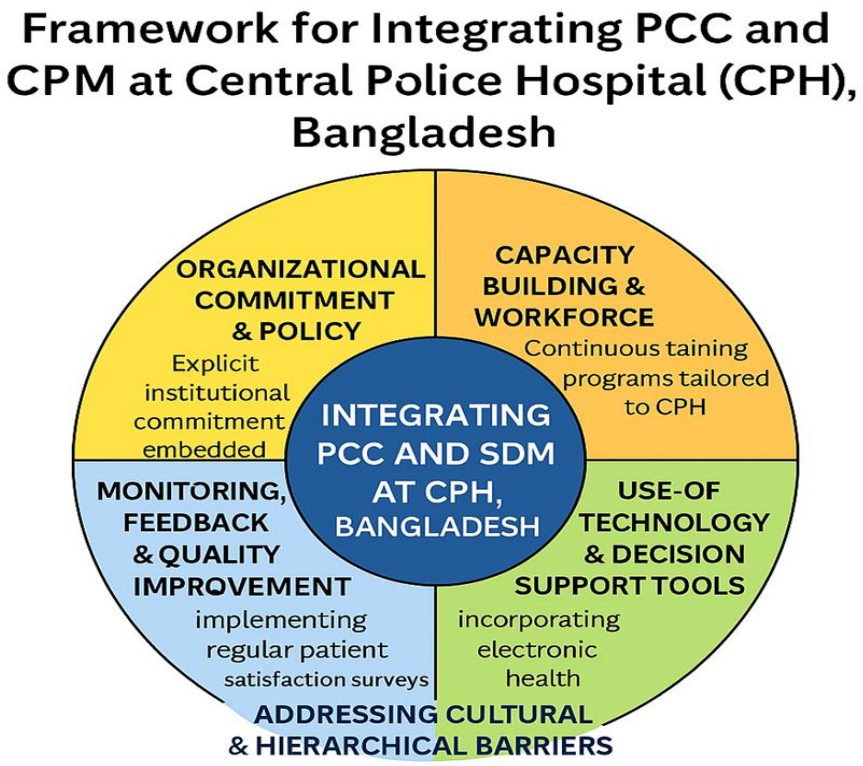
Integrated Care	Holistic Care Approach	PCC/SDM recognizes the interconnection of physical and mental health, tailoring interventions to occupational stressors, trauma, and work schedules.	Supports sustainable recovery and improved occupational functioning; reduces long-term healthcare burden.
Source: Compiled by the Author (2025)			

Regarding mental health, particularly PTSD, PCC and SDM help address stigma and enhance therapeutic alliance. Police officers often underreport psychological symptoms due to fears of career repercussions or cultural norms discouraging vulnerability (Karaffa & Koch, 2016a). By incorporating SDM, clinicians can collaboratively explore treatment options, including counseling, pharmacotherapy, and peer support, thereby respecting patients' values and readiness for intervention PCC approaches that validate emotional experiences and encourage patient autonomy contribute to increased treatment engagement, reduced symptom severity, and improved quality of life. Furthermore, PCC and SDM foster holistic care that integrates physical and mental health management, recognizing the bidirectional influence between chronic diseases and psychological distress common among law enforcement personnel (Violanti et al., 2017). Tailored interventions that consider occupational stressors, shift work, and trauma exposure demonstrate greater effectiveness in achieving sustainable health outcomes (Natterson-Horowitz et al., 2023). In summary, implementing PCC and SDM in police healthcare settings significantly enhances the management of hypertension and PTSD by promoting empowerment, trust, and individualized care, ultimately leading to better health and occupational functioning.

4.6. Framework for Integrating PCC and SDM at Central Police Hospital (CPH)

The integration of Patient-Centered Care (PCC) and Shared Decision-Making (SDM) at Central Police Hospital (CPH) necessitates a tailored framework that aligns with the unique organizational culture, patient demographics, and resource constraints of the institution. Drawing on established theoretical models and contextual insights from high-stress healthcare settings, the proposed framework emphasizes a multi-level, iterative approach designed to enhance doctor-patient relationships, improve health outcomes, and foster sustainable practice changes.

Figure 02: Integrating PCC and SDM at Central Police Hospital (CPH), Bangladesh



Source: Adapted by Author, 2025

4.6.1. Core Components of the Framework

a) ***Organizational Commitment and Policy Alignment***: At the foundation lies explicit institutional commitment from hospital leadership to prioritize PCC and SDM principles, embedded within policies, protocols, and performance metrics. This commitment should include formal recognition of patient rights, confidentiality, and culturally sensitive care (Epstein & Street, 2011). Policies should incentivize collaborative practice and allocate resources for training and technology adoption.

b) ***Capacity Building and Workforce Development:*** Regular training programs for CPH healthcare providers are crucial. These trainings should include communication skills, cultural competence, stress management, and SDM implementation strategies, which should take into account the occupational stress and stigma associated with mental health among police personnel (Smith,2006). Peer learning environments and platforms for reflective practice can encourage behavioral change.

c) ***Patient and Family Engagement:*** Empowering patients and their families through education, decision support tools, and digital platforms increases their participation. Tailored educational materials should be developed based on hypertension, PTSD, and other relevant conditions, taking into account the specific needs of the police population (Elwyn et al., 2012). Family engagement recognizes the collectivist cultural context of Bangladesh and ensures shared responsibility for health care.

d) ***Monitoring, Feedback, and Quality Improvement:*** Implementation of regular patient satisfaction surveys, clinical audits, and feedback mechanisms develop and ensure accountability and accelerate continuous improvement of PCC/SDM practices (Barry & Edgman-Levitan, 2012). Driven quality of data improvement initiatives will maintain motivation by addressing identified gaps and celebrating achieved successes.

e) ***Addressing Cultural and Hierarchical Barriers:*** It is essential to identify and proactively address cultural norms and hierarchy dynamics through empowerment workshops and leadership plays a crucial role model to shifting the balance of power and normalizing patient participation.

The journey of this framework has begun with institutional preparation and training, followed by patient engagement initiatives and technology integration pilots. Continuous monitoring and incremental development activities build momentum, which is reinforced by leadership support. Patient feedback and clinical outcomes guide adaptation to keep the framework relevant and responsive to the changing needs of CPH.

4.7. Strengthening Doctor-Patient Relationships Through Patient-Centered Care and Shared Decision-Making

At Central Police Hospital (CPH), strengthening doctor-patient relationships is a critical priority due to the unique health challenges and occupational stressors faced by law enforcement personnel. Patient-centered care (PCC) and Shared Decision-Making (SDM) emerge as transformative approaches to rebuild trust, enhance communication, and foster collaborative healthcare practices. These strategies recognize the patient as an active partner in their care journey, encouraging mutual respect and a shared sense of accountability between healthcare providers and police patients.

As a result, the integration of PCC emphasizes empathetic communication, respect for individual preferences, and responsiveness to the psychosocial contexts in which care occurs. This is particularly vital in managing chronic diseases like hypertension, where personalized care plans and consistent engagement can significantly improve treatment adherence and outcomes. By involving patients in decisions about medication, diet, and lifestyle modifications, doctors at CPH can build trust, reduce resistance, and promote a sense of control that is often lost in hierarchical healthcare settings.

Table 05: Implications of PCC and SDM on Strengthening Doctor-Patient Relationships at CPH

Implication Area	How (Mechanism of Impact)	Where (Context of Application)	When (Stage or Condition of Application)
Trust Building	Through empathetic listening, respectful dialogue, and patient validation	During initial consultations and follow-ups with police personnel	From first contact and throughout the treatment journey
Improved Adherence	Via shared goal-setting and involving patients in treatment decisions	In chronic disease clinics (e.g., for hypertension or diabetes)	At treatment initiation, during check-ins, and for therapy changes
Stigma Reduction	By allowing safe disclosure of mental health issues in a judgment-free environment	In mental health units or during general physician screenings	Particularly during PTSD screening, counseling, or diagnosis

Empowerment and Autonomy	Encouraging patient agency in choosing between care options (e.g., therapy vs. medication)	Across all care units—especially mental health and lifestyle counseling	When presenting treatment alternatives or consent-based procedures
Integrated Care Planning	Aligning physical and psychological care plans via team-based coordination	In multidisciplinary care teams at CPH	When chronic illness is complicated by psychological distress
Cultural Sensitivity	Tailoring communication styles and educational materials to fit police culture norms	Inpatient education sessions and family-inclusive consultations	During onboarding, diagnosis, and major decision-making discussions
Continuity of Care	Using digital tools (EHRs, follow-up calls, mHealth apps) to stay connected with patients	In outpatient departments and post-discharge care	After initial hospitalization, during long-term condition management
Source: Compiled by the Author (2025)			

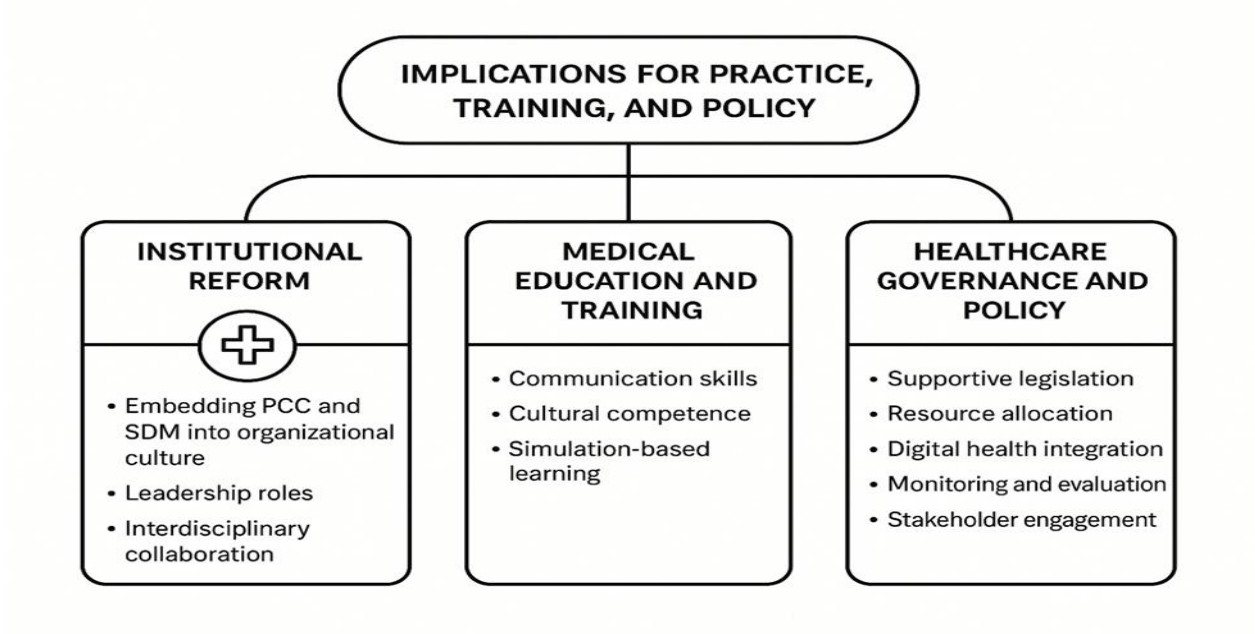
Moreover, in the domain of mental health—especially in managing post-traumatic stress disorder (PTSD)—SDM plays a critical role in overcoming barriers like stigma and fear of professional consequences. When patients are given a voice in selecting treatment options such as therapy, medication, or peer support, it not only affirms their autonomy but also helps reduce psychological resistance. PCC frameworks that validate emotional experiences contribute to the therapeutic alliance, which is essential for sustained mental health improvement among law enforcement professionals.

Furthermore, adopting PCC and SDM enables a holistic care model that bridges physical and mental health, which are often interconnected in high-stress professions. Tailoring care delivery to occupational realities such as shift work, trauma exposure, and organizational culture creates a more responsive and effective healthcare system within CPH. Over time, these practices not only improve clinical outcomes but also humanize healthcare delivery, ultimately strengthening the relational fabric between doctors and patients in meaningful and measurable ways.

5. Implications for Practice, Training, and Policy

The integration of Patient-Centered Care (PCC) and Shared Decision-Making (SDM) at Central Police Hospital (CPH) carries significant implications for clinical practice, professional training, and healthcare policy, particularly in the context of Bangladesh's hierarchical and resource-constrained healthcare environment.

Figure 03: Institutional Reform, Medical Education, and Healthcare Governance



Source: Adapted by Author, 2025

However, institutional reform should focus on integrating patient-centered care (PCC) and shared decision-making (SDM) into the hospital's organizational culture and operational framework. Patient-centered values should be promoted

from the leadership level and PCC and SDM should be included as criteria for quality control and performance. It means restructuring the healthcare delivery structure to encourage interdisciplinary collaboration, reduce power-based barriers, and create an environment where patients can be engaged as active partners.

In addition, a dedicated patient rights and advocacy unit should be established in the CPH to ensure impartial responses to patient needs and rights (Epstein & Street, 2011). A fundamental shift in medical education and training is required to make communication skills, cultural competence, and SDM practices part of continuous professional development, starting from the undergraduate level (Roter et al., 2002). Empathy and shared decision-making skills can be developed through simulation-based learning and reflective practice. Training programs should also include occupational stress and mental health issues in law enforcement health care so that providers can provide sensitive, trauma-informed care (Karaffa & Koch, 2016).

Accordingly, health governance and policy should be developed at the national and institutional levels to support the implementation of PCC and SDM, including supporting legislation, equitable resource allocation, and integration of digital health systems Policies should encourage innovation in patient engagement and support equitable access to decision-support tools. Monitoring and evaluation frameworks should be developed to track PCC/SDM outcomes, ensuring accountability and continuous improvement (Barry & Edgman-Levitan, 2012). Moreover, active engagement of all stakeholders, including patients, families, and law enforcement leadership, should be institutionalized to ensure that policies are relevant and sustainable. Advancing PCC and SDM in CPH requires a holistic approach that aligns practice, education, and governance with patient-centered policies. These efforts will enhance the quality of care, improve health outcomes, and build trust among law enforcement personnel.

6. Limitations of the Study

While this review provides valuable insights into the integration of Patient-Centered Care (PCC) and Shared Decision-Making (SDM) in strengthening doctor-patient relationships at Central Police Hospital (CPH), several limitations must be considered. These limitations primarily stem from the scope of the literature reviewed, the generalizability of findings, the lack of primary data from CPH, and challenges related to institutional resistance and the absence of longitudinal data. These factors may affect the applicability and long-term effectiveness of the proposed models in the specific context of law enforcement healthcare settings.

6.1. Scope of Literature Reviewed

The study relies heavily on existing literature, which primarily focuses on broader healthcare settings rather than the unique challenges of law enforcement healthcare environments. This limits the direct applicability of some findings to Central Police Hospital (CPH), Bangladesh. While the models of Patient-Centered Care (PCC) and Shared Decision-Making (SDM) are well-studied in general healthcare, there is limited research specifically addressing their integration in law enforcement healthcare contexts, making it difficult to draw direct comparisons.

6.2. Generalizability of Findings

Although the study offers valuable insights for CPH, the findings may not be fully generalizable to other law enforcement healthcare settings with different organizational cultures, resource availability, and patient demographics. The specific challenges faced at CPH may differ from those experienced at other similar institutions, which could influence the effectiveness of the proposed models.

6.3. Limited Data from CPH

The study does not include primary data from CPH, such as surveys, interviews, or case studies involving staff and patients. The lack of direct empirical data from the hospital limits the ability to assess how well PCC and SDM have been implemented at CPH and the specific barriers or successes observed in practice.

6.4. Institutional Resistance to Change

One of the major limitations is the assumption that CPH's organizational culture can easily incorporate PCC and SDM. Resistance to change in hierarchical and resource-constrained environments can be significant, and the study does not fully address the complexities of overcoming this resistance or the strategies needed to facilitate smooth integration.

6.5. Lack of Longitudinal Data

This review does not provide longitudinal data to assess the long-term effectiveness of PCC and SDM implementation at CPH. The outcomes of these models may take time to manifest, and without follow-up studies, the review cannot fully evaluate their sustainability and lasting impact on doctor-patient relationships at CPH.

7. Conclusion

Patient-centered care (PCC) and shared decision-making (SDM) are increasingly recognized as important strategies to strengthen the patient-provider relationship, especially in high-stress healthcare environments such as the Central Police Hospital (CPH) in Bangladesh. However, these approaches represent a fundamental shift from traditional, provider-led models of care to collaborative relationships that respect and integrate patients' values, preferences, and life experiences. In this way, PCC and SDM can enhance trust, improve communication, and contribute to more effective and personalized healthcare outcomes.

Moreover, theoretical models proposed by Stewart (1995), Charles et al. (1997), and Epstein and Street (2011) provide a strong foundation for understanding the essential components of PCC and SDM and their application in clinical practice. In the unique environment of CPH—where chronic diseases such as hypertension and mental health issues such as post-traumatic stress disorder (PTSD) are prevalent among law enforcement officers—implementing these models presents both challenges and opportunities. Accordingly, evidence suggests that implementing PCC and SDM in such institutional settings can significantly improve chronic disease management and mental health outcomes, empower patients, increase treatment adherence, and reduce stigma associated with mental health care.

Despite these benefits, several systemic barriers remain. These barriers include entrenched hierarchical cultures of care, limited resources unique to low- and middle-income countries, and authoritarian clinical practices that discourage patient engagement. Overcoming these barriers requires developing context-specific strategies to promote inclusive care. Key enablers include supportive health policies, focused training for healthcare providers, adoption of digital decision support tools, and patient advocacy efforts that protect patient rights and encourage active participation.

In Addition, the proposed framework for integrating PCC and SDM into CPH emphasizes six key elements: (1) strong organizational commitment and policy alignment; (2) capacity building for healthcare providers; (3) patient and family education; (4) integration of technology and digital tools; (5) continuous quality improvement; and (6) cultural sensitivity to address hierarchical norms. The model not only addresses the structural and institutional limitations of the Central Police Hospital (CPH) but also leverages Bangladesh's cultural strengths (e.g., family involvement and collective decision-making norms) to encourage patient participation and shared responsibility for care.

Consequently, this review concludes by highlighting the need for systemic reforms in medical practice, professional training, and governance. Institutional policies should formally incorporate post-traumatic stress disorder (PCC) and post-traumatic stress disorder management (SDM) into health care standards, while medical education should prioritize communication skills and trauma-informed care based on the needs of law-abiding patients. In addition, governance structures should support innovations in patient-centered care and establish accountability mechanisms for continued advancement.

In conclusion, the advancement of PCC and SDM at the Central Police Hospital offers great potential to improve the quality, inclusiveness, and responsiveness of health care for police officers and their families. By building strong, trust-based patient-provider relationships and institutionalizing collaborative care practices, the CPH can improve patient satisfaction, clinical outcomes, and long-term well-being. This review lays the foundation for further evidence-based initiatives and policy reforms to effectively and sustainably implement PCC and SDM in the evolving healthcare landscape of Bangladesh.

Declarations

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Conflicts of Interest

The author declares no conflict of interest. This research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

References

Andersen, J. P., Papazoglou, K., Koskelainen, M., Nyman, M., Gustafsberg, H., & Arnetz, B. B. (2015). Applying resilience promotion training among special forces police officers. SAGE Open, 5(2), 2158244015590446. https://doi.org/10.1177/2158244015590446

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—The pinnacle of patient-centered care. *New England Journal of Medicine, 366*(9), 780–781.https://doi.org/10.1056/NEJMp1109283

Beach, M. C., Sugarman, J., Johnson, R. L., Arbelaez, J. J., Duggan, P. S., & Cooper, L. A. (2005). Do patients treated with dignity report higher satisfaction, adherence, and receipt of preventive care? *The Annals of Family Medicine, 3*(4), 331–338.

Bell, E. F., Hintz, S. R., Hansen, N. I., Bann, C. M., Wyckoff, M. H., DeMauro, S. B., Walsh, M. C., Vohr, B. R., Stoll, B. J., & Carlo, W. A. (2022). Mortality, in-hospital morbidity, care practices, and 2-year outcomes for extremely preterm infants in the US, 2013–2018. *JAMA, 327*(3), 248–263.

Berwick, D. M. (2009). What 'patient-centered' should mean: Confessions of an extremist. *Health Affairs, 28*(Supplement 1), w555–w565. https://doi.org/10.1377/hlthaff.28.4.w555

Cambridge University Press. (2016). Care perceptions among residents of LTC facilities purporting to offer person-centred care. *Canadian Journal on Aging / La Revue canadienne du vieillissement, 35*, 149. https://doi.org/10.1017/S0714980816000078

Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician–patient encounter: Revisiting the shared treatment decision-making model. *Social Science & Medicine, 49*(5), 651–661.https://doi.org/10.1016/S0277-9536(99)00145-8

DGHS. (2021). *Health Bulletin 2021*. Directorate General of Health Services, Ministry of Health and Family Welfare, Bangladesh. https://old.dghs.gov.bd/index.php/en/publications/health-bulletin/dghs-health-bulletin

Dwamena, F., Holmes-Rovner, M., Gaulden, C. M., Jorgenson, S., Sadigh, G., Sikorskii, A., Lewin, S., Smith, R. C., Coffey, J., & Olomu, A. (2013). Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database of Systematic Reviews, 2013*(12). https://doi.org/10.1002/14651858.CD003267

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

Institute of Medicine (IOM). (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press.

Karaffa, K. M., & Koch, J. M. (2016a). Stigma, pluralistic ignorance, and attitudes toward seeking mental health services among police officers. *Criminal Justice and Behavior, 43*(6), 759-777. https://doi.org/10.1177/0093854815613103

Karaffa, K. M., & Koch, J. M. (2016b). Stigma, pluralistic ignorance, and attitudes toward seeking mental health services among police officers. *Criminal Justice and Behavior, 43*(6), 759–777. https://doi.org/10.1177/0093854815613103

Kaur, R. (2025). Influences of work stressors and family support: The mediating role of job performance. *Vilakshan - XIMB Journal of Management, 22*(1), 100–115.

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

Krishnamoorthy, Y., Majella, M. G., & Rajaa, S. (2020). Equity in coverage of maternal and newborn care in India: Evidence from a nationally representative survey. *Health Policy and Planning, 35*(5), 616–623.

Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., & Doubova, S. V. (2018). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. *The Lancet Global Health, 6*(11), e1196–e1252.

Muhammad, F., & Arafat, S. M. Y. (2024). Technology-based interventions for mental health support in Bangladesh. In S. M. Y. Arafat (Ed.), *Mental health in Bangladesh* (pp. 271– 291). Springer Nature Singapore. https://doi.org/10.1007/978-981-97-0610-5_16

Natterson-Horowitz, B., Aktipis, A., Fox, M., Gluckman, P. D., Low, F. M., Mace, R., Read, A., Turner, P. E., & Blumstein, D. T. (2023). The future of evolutionary medicine: Sparking innovation in biomedicine and public health. *Frontiers in Science, 1*, 997136. https://doi.org/10.3389/fsci.2023.997136

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087–1110. https://doi.org/10.1016/S0277-9536(00)00098-8

Roter, D. L., & Hall, J. A. (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

Stewart, M., Brown, J. B., Weston, W. W., Freeman, T., Ryan, B. L., McWilliam, C. L., & McWhinney, I. R. (2024). *Patient-centered medicine: Transforming the clinical method* (3rd ed.). CRC Press.

The Annals of Family Medicine. (2011). The values and value of patient-centered care. *The Annals of Family Medicine, 9*(2), 100. https://www.annfammed.org/content/9/2/100.short

The British Journal of General Practice. (2009). The patient–doctor relationship: A synthesis of the qualitative literature on patients' perspectives. *British Journal of General Practice, 59*(561), e116. https://bjgp.org/content/59/561/e116.short

The International Journal of Surgery. (2006). The big debate: "This house believes that surgeons' outcomes should be published in the lay press." *International Journal of Surgery, 4*(4), 199. https://journals.lww.com/international-journal-of- surgery/fulltext/2006/10000/the_big_debate__this_house_believes_that_surgeons.3.asp x

Violanti, J. M., Charles, L. E., McCanlies, E., Hartley, T. A., Baughman, P., Andrew, M. E., Fekedulegn, D., Ma, C. C., Mnatsakanova, A., & Burchfiel, C. M. (2017). Police stressors and health: A state-of-the-art review. *Policing: An International Journal of Police Strategies & Management, 40*(4), 642–656.

Sinko, L., Burns, C. J., O'Halloran, S., & Saint Arnault, D. (2021). Trauma recovery is cultural: Understanding shared and different healing themes in Irish and American survivors of gender-based violence. *Journal of Interpersonal Violence, 36*(13–14), NP7765–NP7790. https://doi.org/10.1177/0886260519829284