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Overcoming Obstacles to Shared Mental Health Decision Making

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Abstract

Shared decision making (SDM) is difficult to implement in mental health practice, but it remains an ethical ideal for motivating therapeutic capacity in patient-clinician relationships; this discrepancy warrants attention from clinical and ethical perspectives. This article explores what some clinicians see as obstacles to even attempting SDM with patients with psychiatric disabilities. In particular, this article identifies 4 such obstacles: a patient's lack of decision-making capacity, a patient's poor insight, a health care professional's therapeutic pessimism or personal dislike, and a patient's or health care professional's conflicting recovery orientations or goals of care. This article argues that each obstacle could be overcome in many cases and that health care professionals, patients, and their caregivers should remain dedicated to attempting SDM in mental health practice.

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Sharing Mental Health Decisions

The 21st century has witnessed increasing support for shared decision making (SDM) as a model of the therapeutic relationship, including in mental health contexts. Unlike paternalism and consumerism, this model encourages a patient and health care professional (HCP) to partner in identifying and appreciating facts and values relevant to good decision making, even in cases in which patients' decision-making capacity or insight might be compromised by illness or disability. SDM includes recognition of the dual expertise of the HCP and patient, bidirectional informational exchange, collaborative decision making, and establishing trust and respect; each of these are components of therapeutic alliance in patient-clinician relationships.^{1,2,3,4,5,6}

Patients with psychiatric disabilities should be encouraged to contribute to SDM processes to the extent that they are able to do so. The Institute of Medicine and the Substance Abuse and Mental Health Services Administration champion SDM for this patient population.^{4,5} Multiple studies and surveys indicate that SDM is feasible and can

be productive in psychiatric treatment.^{3,6,7,8,9} Furthermore, SDM can help motivate self-determination, a key value in the user/survivor movement.¹⁰

In practice, however, SDM can be difficult to implement.^{2,3,6,11} In a survey published in 2009 that is notable for its detailed exploration of psychiatrists' judgments about SDM, 51% of 352 psychiatrists claimed that they implemented SDM; 5% reported that they most frequently aimed to implement whatever treatment the patient preferred; and a surprising 44% still preferred a paternalistic approach.¹² A subset of psychiatrists rated whether patient characteristics or decision topics would influence whether they used SDM with **patients with schizophrenia**. When patients demonstrated disturbance of thought, depression, mania, shallow affect, or poor insight, the ratings of the surveyed psychiatrists indicated that they would be less inclined to pursue SDM with patients.¹² And whereas psychosocial decisions (such as discharge options and psychoeducation) were considered prime topics for SDM, the surveyed psychiatrists viewed most medical and legal decisions (such as hospitalization options, prescriptions, and diagnostic procedures) as unacceptable topics for patient participation.¹² Many medical and legal decisions, however, are decisions that patients may reasonably care about most. (Interestingly, this study, as with others on this topic, focused on psychiatrists' views of taking a participatory approach with patients without considering how their attitudes might shift if surrogates and caregivers were included in the decision-making process.) The survey provides evidence that clinicians tend to implement SDM when doing so is uncomplicated. Patients who want to participate in SDM and who do not dispute their diagnosis, do not reject **relevant clinical facts** about their diagnosis or treatment, and do not experience negative emotional symptoms are more likely to be invited by clinicians to share in decision making about their care.

An ethical complexity worthy of exploration in the rest of this article, however, is that HCPs might hastily abandon their ethical commitment to SDM when patients' ability to participate in SDM could be undermined by their illness. This lack of commitment to SDM has important consequences for the patient-clinician relationship: what ethical commitment to decision sharing means is that clinicians trust in their patients' *worldview* and value their patients' *experiences*, both of which clinicians are obliged to support in order to nurture therapeutic capacity in their relationships with patients. Obstacles to trusting the worldview or valuing the experiences of patients with a psychiatric disability are numerous, however. This article considers 4 of the most important ones: patients' lack of decision-making capacity, patients' lack of or poor insight into their illness, clinicians' pessimism about treatment, and conflicting visions of a path to recovery.

Incapacity

One might think that SDM can only be achieved when all stakeholders have decision-making capacity. To have capacity to make a particular health decision at a particular point in time, a patient needs to communicate a choice and demonstrate not only sufficient understanding of and reasoning about treatment choices, but also appreciation of the likely consequences of a choice.¹³ Since psychiatric disability can diminish a patient's capacity to make health decisions, especially high-stakes decisions, it might seem that an incapacitated patient cannot meaningfully participate in SDM.

Nevertheless, many patients with psychiatric disabilities **retain capacity** for all or most decisions.¹⁴ Thus, HCPs should be careful not to assume that patients with schizophrenia, for example, cannot make their own decisions on the basis of the diagnosis alone.¹⁴ Additionally, a patient's capacity can fluctuate, so even when a

patient has difficulty contributing to decision sharing during, say, an acute exacerbation of an illness, that patient's capacity to participate in decisions about her care should be reevaluated.¹⁵ While a patient has capacity, an HCP can facilitate current and future SDM by recording the patient's preferences, values, and health experiences (eg, hospitalizations and treatments). A psychiatric advance directive or other form of documentation can help patients clarify their values and preferred care plan during acute episodes.^{4,5,16}

Even when a patient lacks capacity to make a specific health decision, the patient perspective is still worthy of regard and should be considered. Patients lacking capacity can still have enduring interests and values, and their input might provide critical information about, say, how a particular medication makes them feel or how difficult or easy it is to adhere to specific treatment demands. Successful SDM can also incorporate input from family members, friends, caregivers, or others with a long-standing relationship with the patient who can clarify the patient's particular interests and who can assist the patient in communicating preferences.

Poor Insight

Insight refers to patients' self-understanding of their condition. Patients' insight tends to be assessed when they reject a diagnosis or treatment. If an HCP believes a patient lacks or has poor insight, it might seem pointless to try to share treatment decisions with that patient. In fact, numerous studies have found that HCPs consider lack of or poor insight a substantial barrier to SDM.^{11,17}

I have argued elsewhere that insight is conceptually ambiguous, that insight assessments are made without standardized bedside tools, and that such assessments carry too much weight in clinical decision making.¹⁸ But even when a patient lacks insight, as Marga Reimer points out, some patients can nonetheless identify interests that could be served with a treatment plan.¹⁹ For example, patients might disagree that they have any kind of thought disorder but still want help for calming their nerves.¹⁹ In a 2016 study of patients with psychiatric disorders, motivation and perception of treatment benefit predicted treatment adherence significantly better than insight.²⁰ This finding suggests that a patient's lack of or poor insight should not predispose HCPs to abandon decision sharing with a patient.

Clinicians' Therapeutic Pessimism

Numerous studies over the years have shown that HCPs tend to have negative attitudes toward patients with certain diagnoses, especially personality disorders, and these attitudes manifest as doubts about treatment efficacy (therapeutic pessimism) and strong personal dislike.²¹ SDM requires empathic communication, especially from the clinician; creative problem solving; and close attention to one another's perspectives. SDM can thus seem out of reach when the therapeutic relationship is tainted with intense negative attitudes.

Part of the professional obligation to communicate empathically with patients is to be self-aware, particularly about **negative countertransference** that can undermine therapeutic capacity in one's relationship with a patient. Clinicians are further obligated to prevent, or at least not to exacerbate, stigma suffered by patients with psychiatric disabilities. Resources promoting anti-stigma education²¹ could help HCPs remain vigilant about their negative countertransference reactions, how these reactions influence their ability to take care of patients, and ways of cultivating more appropriate clinical dispositions, including empathy. Jodi Halpern, for example, argues that engaged

curiosity is necessary for developing and expressing clinical empathy. With engaged curiosity, “[T]he basic stance is one in which the physician recognizes that he or she does not fully understand and has more to learn about the patient’s situated experience.”²² Halpern also emphasizes that conflict does not necessarily mean empathy has failed and that “simply making the effort to understand the other person’s perspectives plays a helpful role in conflict resolution.”²² As long as an HCP does not give in to hopelessness or distrust, empathic engagement remains possible, which means that SDM might be a possible and a reliable way to nourish therapeutic capacity in one’s relationship with a patient.

Conflicting Visions of a Path to Recovery

In SDM, an HCP and a patient should forge an agreement about the therapeutic goals of their work together. Therapeutic goals reflect values and priorities in decisions about what counts as a benefits, harms, or acceptable trade-offs. HCPs tend to have a clinical orientation to what “recovery” looks like, so, for HCPs, getting better would likely include symptom alleviation and restoration of a patient’s ability to pursue activities of daily living independently.²³ But a patient might prioritize self-esteem, hopefulness, or other conceptions of what it means to live well.^{23,24,25} Such differences in vision are important because SDM can come to a halt when HCPs and patients disagree on what counts as getting better. If a medication, for example, is perceived by a patient as threatening their personal goals and perceived by a clinician as valuable because it minimizes symptoms, the therapeutic capacity of the patient-clinician relationship will be stymied by distrust and incommensurable visions of how to proceed and of what’s worth doing.

Asking patients what getting better means to them should be a first step in SDM; this question elicits patients’ values and overall perspectives on their condition and treatments. If at all possible, an HCP and a patient (and perhaps a surrogate) should work together to formulate a care plan that protects what the patient finds valuable while also addressing the patient’s needs from a clinical perspective. The patient’s lived experiences will be critical for understanding which personal costs of treatment are acceptable. One example of this approach is the CommonGround program, which incorporates a peer-run decision support center, decision support software, and specialized training of HCPs to support SDM in behavioral health.²⁵ Founder Patricia Deegan, a patient advocate and clinical psychologist, has described how the HCP and patient can collaborate on recovery goals so that psychiatric medication supports what a patient finds meaningful.

Conclusion

HCPs and patients should work at identifying how each of the 4 obstacles to implementing SDM in mental health care—patients’ lack of decision making capacity, patients’ lack of or poor insight into their illness, clinicians’ pessimism about treatment, and conflicting visions of a path to recovery—undermine therapeutic capacity in their relationship and in specific decisions. Doing so can make available the benefits of SDM and can help remind all stakeholders of the persistent importance of trust, humility, and learning from one another during clinical encounters and in patient-clinician relationships.

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