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Special Feature Article

From "Supported Decision Making" to "Supported Desire Formation"

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Abstract

Most patients treated by psychiatrists are often ambivalent about their treatment and are unlikely to have a stable desire to be treated. For such patients, "supported desire formation "created by Koichiro Kokubun is considered necessary for the preliminary stage of "supported decision making", and it is the responsibility of the therapist. Open Dialogue (OD), a method/system/thought of dialogical practice developed in Finland, involves the entire process of restoration of the patient's subjectivity through dialogue, the discovery of his or her own desires, and making decisions. It is considered inadvisable to actively show the treatment plan to the patient, and arguing, persuading, interrogating, and advising are inappropriate for OD. These behaviors suppress the patient's autonomy and "disempower" them. In contrast, the seven principles of OD are those for respecting the patient's autonomy, initiative, or desire. It is important in OD practice to be flexible and responsive to patients' needs, and to engage in their social network restoratively.

In a safe and secure environment, we should listen to patients and their families, and respond to them through dialogical practice. Many voices are derived, creating a polyphonic space where no opinion is denied. If the patient's autonomy and subjectivity are restored in such a space, they will be led to the formation of desires. By carefully working together in the process up to this point, the patient's decision making will become

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automatic.

Keywords: supported decision making, supported desire formation, Open Dialogue, reflecting

Introduction: Discomfort with "Supported Decision-Making"

I feel some discomfort when considering decision support in psychiatry. This is because the therapist often assumes the patient's stable willingness to be treated. Even shared decision-making, which is a more elaborate procedure than informed consent, seems to have such an aspect.

As a person who has been involved in the support of hikikomori (social withdrawal) for many years, I believe that patients' willingness to be treated is usually unstable, and this is the main cause of the difficulty in supported decision-making. Many of the patients targeted by psychiatric treatment, not limited to those with hikikomori, often have ambivalent feelings and conflicts toward treatment. While the desire to be cured is fundamental, it is not uncommon for patients to have contradictory feelings such as "there is no way I can be cured", "I don't want to be cured easily", and "I don't want to be cured by being hospitalized". It is not difficult to imagine that these conflicting feelings are exacerbated when the patient does not have a trusting relationship with his or her therapist.

Some physicians may take the neoliberal view that they cannot treat patients who are not willing to be treated. I do not deny that there was a time when I also approached this seemingly rational position when I was a newcomer with limited clinical experience. This idea could be further justified by saying "I would rather take care of patients who are willing to be treated but do not have the opportunity to do so". However, the person that I am right now believes that this idea is doubly wrong. First, because it justifies the act of "doctors choosing patients", and second, because it does not take into account that the formation of the desire to treat is also a part of treatment.

The philosopher Koichiro Kokubun stated at a symposium that "support for desire formation is more important than support for decision-making" 3). This is an extremely important point, because patients' difficulties in decision-making

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are often considered to be due to difficulties in desire formation. In this paper, "desire" is defined as "a strong feeling to satisfy something that is lacking". Patients may lack "stability", "health", "freedom", or "happiness", and the desire for these things is considered to be the desire for treatment itself. Not many patients can spontaneously express their desire for treatment and treatment goals from the beginning, at least at the initial consultation stage. In many cases, the family members accompanying the patient strongly desire treatment, but the patient is unwilling to even go to the hospital in the first place, and is forced to do so at the family's insistence. How can such patients be motivated to seek treatment? Experience shows that patients must wait until they have established a relationship of sufficient trust with their therapists, and their family relationships have been restored to some degree. Only when these conditions are in place can the patient say "I am actually in pain, and I need help". If we take Kokubun's point seriously, we cannot help but notice that the responsibility of the therapist also extends to the formation of the patient's willingness to be treated.

I. Open Dialogue as Desire Formation Support

What kind of methods are possible as "supported desire formation"? I consider the method/system/idea of "Open Dialogue (OD)", developed in Finland, as one of the most effective dialogical practices. OD includes the entire process of the patient regaining independence through dialogue and, with it, discovering his or her desires, leading to decision-making. One thing that can be pointed out through the practice of OD is that neither "desire formation" nor "decision-making" is necessarily done as a preparatory step for treatment. Rather, the process of recovering autonomy and desire and reaching decision-making itself proceeds in parallel with the treatment process. In other words, the patient's "desire" and "will" are in flux, and the therapist needs to be attentive to the patient's desire and will, which change with each meeting. This is also quite different from the decision support provided in physical medicine.

Why does dialogue practice lead to decision support?

We will leave a detailed explanation of OD for another time, but here we would like to examine some principles or "methods" that lead to desire formation.

OD practically "forbids" the following: argument, persuasion, interrogation, and advice. Why are these considered undesirable? Because all of them are "conclusory" in nature, and all of them have the attitude of trying to get the other party to accept the conclusion.

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Advice may seem mild at first glance, but since the premise is "you are wrong", it may be perceived as an imposition of opinion. In the words of one patient, all of this "disempowers" rather than empowers the patient 2).

When introducing dialogue in OD, the patient's safety and security are of utmost importance. The treatment team first introduces themselves politely, tells the patient to call them by their first name rather than "doctor", and asks "open questions". This is a question that anyone can answer in any way, for example, “How would you like to spend this time today?”, and they do not ask, "How are you feeling?" or "What are you having trouble with?" as in a normal medical examination. Such a questioning style may fix the doctor-patient hierarchy. A space in which the role of patient is not imposed, and patients are free to talk however and about whatever they want is for their safety and security. Needless to say, security and safety are the very foundation for restoring desire. If patients feel safe and secure in participating in dialogue, the very act of speaking can be expected to lead to the formation of desire. This is because the act of speaking to others is the beginning of spontaneity, and entering the language system through dialogue activates and stabilizes desire in the form of verbalization.

II. Meaning of the Seven Principles

When considered from the perspective of desire formation, the seven principles in OD (Table) are all meaningful principles in promoting desire, namely, independence and spontaneity 4-8).

For example, the principle of "(1) Immediate Help" means that a treatment meeting is held within 24 hours of a request. This is also important in terms of responding immediately as soon as the patient becomes willing to be treated. This seemingly simple principle is extremely important, given that many patients abandon their visit while waiting for an appointment. However, it is not easy to follow this rule in the current situation of psychiatric treatment in Japan.

What about the principle of "(2) Social Networks Perspective"? In other words, this is a rule that tries to understand the problem as a crisis situation occurring within a network (human relationships among patients), without focusing on "individual pathology." This is not only a framework for understanding the problem, but it also implies that the responsibility for solving the problem is not left to the patient alone. Even if an individual patient does not seem to be "willing" to be treated, the network's consensus to continue the dialogue has the advantage of facilitating the meeting

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without coercion. Continued dialogue within the network can be expected to promote the restoration of relationships between patients and their families, which in turn can be expected to lead to the recovery of desire.

Incidentally, OD does not require the patient's consent at the beginning of the meeting. In other words, we do not explain, "I would like to start OD, and OD is a method of this and that...". It is common for the treatment team to visit the patient and, after introducing themselves, offer to "tell us your story". This is partly because the target of OD is often the acute phase of schizophrenia, when it is difficult to obtain sufficient informed consent. Even in non-acute cases, it is difficult to get patients to understand OD with just a verbal explanation, and there is concern that the explanation may lead to increased feelings of rejection. Therefore, strictly speaking, the introduction of OD may be criticized as a somewhat aggressive and violent intervention for the patient. In response, we suggest that the "violence of dialogue" may be acceptable if it avoids the violence of isolation and physical restraints that are commonly used with acutely ill patients. Please note that this is my own viewpoint, as I could not find any previous studies or writings on informed consent in OD.

This style of practice (without explanation or consent) has been used in Finland and other countries, and no particular problems have been reported. In my clinical experience, most patients agree to make an appointment for the next session at the end of the session, and at least, the fact that no one has ever complained that they were unwilling to start without their consent is considered to be a guarantee of the ethics of OD. In this sense, I believe that the initial session itself has a meaning similar to that of joint decision-making support.

To begin with, I believe that strict informed consent for psychotherapy in general is difficult to obtain. It is difficult to believe that a sufficient agreement can be reached on cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) simply by listening to explanations of the methods and effects of these therapies. It is difficult to reach a consensus without actually experiencing and feeling the effects and responses. From this perspective, the method of first having the patient experience OD and then obtaining consent to continue the session may be justifiable.

In OD, various considerations are made to ensure that the interactive practice is not an invasive experience for the patient; in the OD meeting, the patient's needs are first carefully listened to and then integrated by the

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treatment team. This is in accordance with the principle of "(3) Flexibility and Mobility". As mentioned earlier, in OD, the process of dialogue and consensus building are integrated. As the patient's needs change, the treatment team needs to respond flexibly to those changes. For example, if a patient expresses a desire that is quite outlandish given the circumstances, (such as "I want to be a lawyer" or "I want to be a cartoonist") they will not be reluctant or opposed to it, but will talk about what they can do to make it happen. Of course, if a high-risk decision is likely to be made, subjective concerns about the risk may be expressed in the reflective situation described below.

"(4) Team's Responsibility" and "(5) Psychological Continuity" mean that one treatment team is responsible for the entire process from beginning to end. Even if a patient requires the assistance of a specialist from another institution or department, we do not simply refer the patient to that specialist. First, they invite the specialist to a treatment meeting to participate in the dialogue. Or, if the patient is hospitalized, the treatment team may go to the ward to hold a meeting. The continuity of the therapeutic relationship is extremely important in the formation of desires and intentions. The change of therapists often has a detrimental effect because it means starting the decision-making process all over again with each change.

The principle (6) "Tolerance of Uncertainty", is perhaps the most important of the seven principles. To tolerate uncertainty, not knowing what will happen. This is, in essence, a recommendation not to plan ahead and not to make assessments. Putting aside planning and assessment, we should concentrate on the dialogue at hand. Many clinicians may find this principle difficult to accept, as they are the most out of touch with medical practice of the seven principles. However, I believe that this principle is

the most important, not only as a treatment principle, but also in desire and intention formation.

How likely is it that improvement will occur according to the therapist's pre-designed treatment plan, let alone the assessment? If the only issue is the patient's response to the medication, it may make sense to do so. However, if we are concerned with the patient's interpersonal relationships and social life, and the changes that occur within these relationships, there are too many parameters to be "according to plan”. Rather, this author believes that the desired therapeutic change always occurs in a way that is beyond the expectations of the therapist. A patient's desires and motivations are formed not by drugs, but by relationships and life.

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In this case, it would be desirable to respect the independence, spontaneity, and desires that emerge while being restoratively involved in the relationship and the patient's life.

Then, is there any risk in continuing treatment meetings without a plan? By continuing to affirm the patient's desires, is there a possibility that this will encourage the formation of delusions that are not desires, or that the patient will be hurt by the frustration of desires that do not fit the current situation? This is a valid question, and in theory, such a risk cannot be ruled out, but empirically such a possibility is close to zero. This may be due in part to the fact that the polyphonic process of dialogue, which will be discussed below, includes actions that promote appropriate recovery for the patient. As long as the dialogue continues, sooner or later improvement will occur, and the patient will gradually move closer to recovery. Our practice is based on such optimism, and they believe that in principle (7), "Dialogism" is almost synonymous with this optimism.

III. Reflecting

Reflecting, one of the techniques of family therapy, is incorporated in OD. Reflecting talk is a method developed by family therapist Andersen, T. and his colleagues, and is one of the fundamental techniques of OD 1)9).

The professional who hears the patient's or family member's complaint exchanges opinions in front of the patient or family member, and the patient or family member gives his or her impressions. In very simple terms, repeating this process several times is reflecting in OD. It is like a case conference between professionals in front of the patient and family. The significance of reflecting is that it introduces various "differences" into the dialogue and brings new ideas, activates the internal dialogue of the participating members, and provides a "space" for the parties involved to make decisions.

In the reflective situation, therapists exchange specific suggestions and advice with each other, such as "What about this treatment method?" or "How about this kind of response?". This is almost the only situation in OD in which the therapists can refer to the treatment plan. Rather than simple advice, various ideas are put forward and "put on the tray". Therefore, there can be conflicting ideas, and any number of ideas can be put on the tray. The patient observes the therapist's discussion and may pick up ideas from the "tray" that seem to fit, or may put his or her own ideas on the tray.

The advantage of this method is that it minimizes the "active" nature of the

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therapist's proposal of a treatment plan to the patient. When explaining a treatment plan, the stronger the therapist's intention is to have the patient accept the plan, the more active the therapist is, which sometimes suppresses the patient's initiative and spontaneity, and as a result, may reinforce the hierarchy of the doctor-patient relationship. The reflective method allows the patient to look at all suggestions for treatment from a bird's eye view, that is, on a tray, and thus allows for a variety of suggestions without compromising the patient's spontaneity.

As we have seen, OD is designed to minimize the expression of the therapist's intention to cure or improve the patient. This is because there is a basic concern that such an intention will suppress the patient's spontaneity and independence. This is in keeping with many of the paradoxes that I have experienced in my clinical work with hikikomori. For example, simple encouragement to work is often detrimental to hikikomori, and only when it is assured that "a person can survive without work" can he or she be motivated to work voluntarily. I extends from this to believe that in the case of mental illness, the more "freedom not to be cured" is allowed, the more likely it is that "the desire to be cured" will be acquired spontaneously.

IV. Polyphony and SPORN

Next, let us examine the concept of "polyphony", a concept that has received considerable attention in OD. The synonym for this word translated as "polyphony" is usually "monophony", but "symphony" and "harmony" are also used. OD does not strive for harmony or unity. As is often misunderstood, OD does not ideally seek to connect and melt the hearts and minds of its members into one under an inclusive dialogue space. Rather, it aims for a state in which different opinions from various perspectives coexist in a way that is different from fusion or harmony.

Harmony and unity can be very oppressive to those who do not fit in. It may be perceived as a form of coercion different from instructions or orders. Even if none of the participants intend to do so, there is always the possibility that harmony and togetherness will foster an "atmosphere that does not tolerate dissent". It becomes a stifling space that lacks space. The therapeutic significance of the polyphonic space lies in its margins. It is in this margin that the patient is able to act independently for the first time. In other words, the blank space provided by polyphony is an indispensable place for the formation of desire.

I believe that the following five elements are important in restoring

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subjectivity and forming desires. These are "Space", "Speed", "Opportunity", "Route", and "Narrative". We call them "SPORN" from the initial letters of each. These elements have not been described in previous OD works, and are my original ideas introduced for the first time in this paper. Let me briefly explain each of them.

"Space", as mentioned above, refers to a "margin" in which the patient can act independently, and "Pace" means respecting the speed of change in the individual patient's situation. Even when change seems too slow or too rapid, it should not be controlled by the therapist. "Opportunity" means respecting the patient's right to freely choose the opportunity to bring about change. "Route" is the point of passage in the recovery, and the patient has the right to choose this as well. The course chosen by the patient should always be respected, even if it appears to be a detour, and the patient should be free to change course once they have decided. "Narrative", on the contrary to "Route", means that the patient should be left to reflect on the course of recovery and how they interpret and narrate it.

Conclusion

We have examined the significance of OD in the support of desire formation prior to decision-making support.

To listen to and respond to the voices of patients and their families through dialogue and practice in a safe and secure environment. A variety of voices are drawn from this dialogue, and a polyphonic space is created in which no opinion is denied. If the patient's own independence and spontaneity are restored in such a space, this itself will lead to the formation of desires. Decisions will be made by themselves as the process is carefully carried out up to this point. OD has an excellent "mechanism" in the sense that it makes this possible. I believe that both desire formation and decision making are disease-specific treatment processes themselves, and will discuss this point on another occasion.

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表　オープンダイアローグの７つの原則

原語	定訳	意味
1. Immediate Help	即時対応	必要に応じてただちに対応する
2. Social Networks Perspective	社会的ネットワークの視点をもつ	クライアント，家族，つながりのある人々を皆，治療ミーティングに招く
3. Flexibility and Mobility	柔軟性と機動性	その時々のニーズに合わせて，どこででも，何にでも，柔軟に対応する
4. Team's Responsibility	チームが責任をもつ	治療チームは必要な支援全体に責任をもってかかわる
5. Psychological Continuity	心理的連続性	クライアントをよく知っている同じ治療チームが，最初からずっと続けて対応する
6. Tolerance of Uncertainty	不確実性に耐える	答えのない不確かな状況に耐える
7. Dialogism	対話主義	対話を続けることを目的とし，多様な声に耳を傾け続ける

Table: Seven Principles of Open Dialogue

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