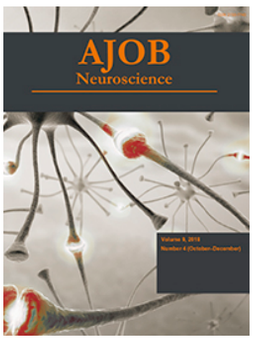

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Trusting Oneself and Others: Relational Vulnerability and DBS for Depression

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The use of implanted devices that apply therapeutic stimulation to areas of the brain, or deep brain stimulation (DBS), is currently being investigated as a possible therapeutic treatment for chronic, treatment-resistant depression. In their article "Patients' Beliefs About Deep Brain Stimulation for Treatment-Resistant Depression," Lawrence and colleagues seek to understand patients' potential "interest level, hopes, fears, and decision-making process" (Lawrence et al. 2019, 211) regarding DBS as a possible therapeutic option. In their analysis of their interview data, the authors seek specifically to address the ethical questions regarding this therapy, which they see as centering on vulnerability. In particular, they identify two kinds of relational vulnerability that patients may be susceptible to when making the choice to get DBS.

The first kind is drawn from a paper by Bell and colleagues that finds that the dynamics of the relationship between medical practitioner and patient produces a kind of vulnerability for the patient—that is, the patient's active depressive symptoms, lesser knowledge about the device, and lesser understanding of possible treatment alternatives produce a problematic power differential between the patient and their doctor. Lawrence and colleagues recognize that this imbalanced power relationship may negatively impact the patients' decision-making process. The authors claim that this vulnerability their patients face may be addressed by "expanding the number of people participating in the decision-making process" (211). For the second kind of relational vulnerability, the authors draw from a piece by Mackenzie and Walker to claim that one's interpersonal relational context shapes one's identity, with specific attention to the ways that then "changes [in] the way a person feels or acts" brought on by DBS "[affect] that person's relational context" (216). The authors emphasize two key ways the patients may be vulnerable: First, they could face stigma from the people around them for seeking DBS therapy, and second, the stimulator and its impact (negative or positive) may affect the user's relational context and (therefore) his or her identity.

In this commentary, we address how future studies could go further to address the full scope of how patients' interpersonal relationships shape their beliefs about DBS for treatment-resistant depression. To do this, we examine the ways that Lawrence and colleagues address relational vulnerability and point to two ways in which their analysis of these concerns is too narrowly scoped, thereby illuminating avenues for future attention and investigation.

First, we want to identify the ways that their construction of imbalanced power relational vulnerability neglects to consider important consequences of including more people in the decision-making process. Specifically, they do not consider that the additions will not necessarily alleviate the concerns about vulnerability resulting from imbalanced power relationships, but rather place people in danger of the same kind of vulnerability on different fronts. After all, we exist within complex networks of demands, expectations, and power hierarchies, so it stands to reason that we constantly balance different kinds of relational vulnerabilities. Thus, we must attend to the role these vulnerabilities play in the patient's decision making, even when they reach out to more people to help them make decisions about care. To illustrate why this is important, let's examine examples of what "expanding the number of people participating in the decision-making process" (Lawrence et al. 2019, 211) might look like in the context of imbalanced power relationships and the resulting vulnerability.

A whole host of problems could arise within the power dynamics of caregiving. If a patient's romantic partner, for example, provides care—be it physical, fiscal, emotional, or some other form of care—the complications of their relationship may impact the patient's decision-making process. If that person feels dependent on the loved one for important forms of care, the person may feel swayed to accept the loved one's advice regarding the choice to get DBS out of fear that disagreeing may result in an unwillingness to continue to provide care (Agid et al. 2006; Schüpbach et al. 2006). Another example is the possibility that the patient may feel guilty about being a burden to the loved one (Gilbert 2015), and such feelings may produce vulnerabilities resulting in the power dynamic of caregiver and care receiver, with the patient's choice being swayed by considering the impact on their loved one. In both of these examples,

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the imbalance of power may also be problematic if the caregiver points out the person's dependence or feelings of guilt in an effort to influence the person's therapy choice.

Moving beyond dyadic relationships, merely including more people in the decision-making process could make the patient more vulnerable. For example, if the patient reaches out to include others in making the decision to receive DBS, these others may disagree on what depression is, how severe it is, and what therapies are appropriate to treat it. Various interpersonal dynamics will inevitably shape the way the patient makes the decision: It would be easy to imagine the loudest voice directing the decision-making process, a situation that may minimize the power over the choice of therapy that the patient themselves exercise. Another example is the way that including a larger group of people in the decision-making process can shape the social uptake the patient receives for their desired treatment method, with disagreeing others disregarding their desires, or, alternatively, out of fear of hurting the patient's mental health further, being overly deferential to the decisions. In both examples, the relational vulnerability patients face from unequal relationships of power is not alleviated but complicated by the inclusion of more people in the patient's decision to get DBS, and this dynamic ought to be considered in future studies.

Second, we want to propose that Lawrence and colleagues' analysis of relational vulnerability is narrow in the sense that it neglects to consider the role one's relationship to oneself plays in the decision-making process. Catriona Mackenzie in "Imagining Oneself Otherwise" defines the process of self-definition "as a process of negotiating among three related but distinguishable elements of the person: her point of view; her self-conception; and her values, ideals, commitments, and cares" (Mackenzie 2000, 133). Achieving a sort of equilibrium of integration between these elements is, according to Mackenzie, a "necessary, if not sufficient, condition for autonomy" (Mackenzie 2000, 133). It seems, then, that something that disrupts this integrated equilibrium in one's relationship to oneself can produce a crucial kind of vulnerability that disrupts autonomy.

Further, in order to develop the self-conception necessary for autonomy, a person needs to be able to trust him- or herself. Carolyn McLeod and Susan Sherwin in their "Relational Autonomy, Self-Trust, and Health Care for Patients Who are Oppressed" explore the relationship between self-trust and the capacity to act autonomously, claiming that there is reason to be concerned when agents "doubt their own worth and ability to make appropriate choices. This lack of self-worth and self-trust may be devastating to agents' autonomy competency, interfering with their ability to act according to their own interests at all" (McLeod and Sherwin 2000, 261). The participants in Lawrence and colleagues' study seem to exhibit this lack of self-trust, when the "participants were asked whether, right now, they felt able to decide for or against having a deep brain stimulator: whether they felt able to weigh the risks and benefits and make a good decision for themselves. Several felt unable to make such a decision in their present state" (Lawrence et al. 2019, 214). Several responses demonstrate further that the struggle some participants felt exercising their autonomy stems from a lack of self-trust, with one saying directly, "Just recently, I don't know that I would have trusted my judgement" (Lawrence et al. 2019, 214), and another citing his or her own unreliability: "I don't know that a doctor should really consider that request [for DBS] very seriously … I wouldn't think that my particular desires one way or the other should carry much weight" (Lawrence et al. 2019, 214). These selections from their interviews indicate, at the very minimum, that there are reasons to consider patients' relationship to themselves as a critical component of the broader relational vulnerabilities they may be susceptible to, especially since "an agent requires a certain degree of self-trust to act autonomously" (McLeod and Sherwin 2000, 261).

To conclude, we commend Lawrence and colleagues' efforts to address the possible relational vulnerabilities people with depression face as they make the decision to use DBS therapy. We, however, propose that Lawrence and colleagues have scoped their conception of relational vulnerability too narrowly. This, we argue, leads the authors to reach an incomplete conclusion about how to counteract vulnerability and to neglect the key role self-trust plays in these vulnerabilities. We recommend that investigators attend to the concerns we have raised in future studies seeking to understand patients' perspectives as they contemplate possible therapeutic options. ■

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