Freedom of delusion
– Interdisciplinary views concerning freedom of belief and opinion meet the individual with psychosis

Mari Stenlund
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Abstract

The purpose of this study is to seek a definition of freedom of belief and opinion which would allow this freedom to be seen as a human right for a person with psychosis. This study has four research questions: 1) How can the freedom of belief and opinion be understood as a human right? 2) In what kinds of discourses, concepts and presuppositions are the different views of freedom of belief and opinion based? 3) What aspects are relevant when the realization of and interferences with freedom of belief and opinion are considered in the case of an individual with psychosis? 4) How are views about freedom of belief and opinion challenged in the case of an individual with psychosis?

In this study materials from different fields are analysed by philosophical conceptual analysis in order to realize interdisciplinary two-way interaction in human rights theory. The material includes: (1) legislation and ethical principles which guide psychiatric care, (2) human rights theory, legislation and conventions concerning the freedom of belief and opinion, (3) textbooks on psychiatric diagnosis, (4) discussions concerning philosophy and the ethics of psychiatry, (5) (political) philosophical discussions concerning freedom and human rights and (6) studies and reports which concentrate on the views and experiences of patients with psychotic disorder.

In this study necessary criteria of irrationality (with a loss of insight), being unwell and alienation are presented for a psychotic view of reality in order to distinguish it from other exceptional views of reality. However, it is noted, that in human rights theory the concepts of thought and opinion are defined in such a manner that they also seem to include delusions. Because it is also declared that there is an absolute right to hold thoughts and opinions (forum internum), it seems to follow that a person has an absolute right to hold a delusion. This conclusion challenges the formulations presented in human rights theory and reveals that there is a tension between human rights theory and views on, and the practice of, psychiatry. In order to arrive at an appropriate view of freedom of belief and opinion, three different views concerning the freedom of belief and opinion are analysed in this study and their applicability and the challenges they present in the case of an individual with psychosis are clarified.

First, freedom of belief and opinion has been understood in classical human rights discussion in the negative sense, which means that other people do not interfere technically or physically with an individual holding and manifesting his or her beliefs and opinions. Non- and involuntary treatment is seen as an interference in an individual’s negative liberty. One problem with this point of view is that when it is applied to a person with psychosis, the consequences seem to be ethically problematic. It seems to follow from this view that the use of involuntary antipsychotic medication is absolutely against an individual’s human rights. Alternatively, it might be argued that a person with psychosis is no longer deemed to be entitled to freedom of belief and opinion because as an incompetent person he or she does not fulfil the requirements of this right. This view of freedom does not take into account that the person with psychosis may need help in order to develop and
manifest his or her beliefs and opinions and in order to live a life which is sufficiently in accordance with his or her values. If the forum internum was redefined as a negative right to competence, the view of negative liberty might be partly helpful in understanding freedom of belief and opinion.

Second, especially in some philosophical and ethical discussions freedom of belief and opinion is understood in terms of authenticity, which means the right to hold such beliefs and opinions which are really one’s own and the right to manifest them in a way that is in harmony with them. From this viewpoint, a psychotic disorder which distorts a person’s beliefs and opinions can be defined as a violator of authenticity. One problem with this viewpoint is that there are different views about how such authenticity should be evaluated. Moreover, the criteria for any such evaluation seem to be, on the one hand, too demanding in order to understand freedom of belief and opinion as a human right in general. On the other hand, some people with delusions still fulfil these criteria, and should be regarded, because of that, as holding authentic beliefs and opinions and left without treatment.

Third, freedom of belief and opinion can be understood in terms of capability, which signifies that the individual is capable of choosing a way of life which he or she considers valuable and which is worthy of human dignity. For example, stigmatization and the undesirable effects of both a psychotic disorder and antipsychotic medication can be seen as impediments to such a capability. This view encourages patients to participate in the treatment and to find their place in society and encourages carers to listen to patients’ voice including their existential considerations. Because of its background suppositions, the view of capability also seems to be relevant to people with psychosis. For example, the view of capability guides one to understand the forum internum not as something which protects holding thoughts and opinions or believing and thinking processes, but instead as something which protects the abilities needed in believing and thinking. This kind of redefinition would allow one to see the forum internum also as an absolute human right for a person with psychosis. However, one problem with this view is that the relationships between legal rights and what is ethically good are undefined. Moreover, it seems that many decisions are left to be considered individually in each case. This is why a capabilities approach is difficult to apply in a juridical context. However, the view of freedom in terms of capability could be developed in interdisciplinary discussion and cooperation so that juridical challenges concerning freedom of belief and opinion could be discussed and resolved in more detail.

In psychiatry, the approach of values-based practice could be used in order to develop the view of freedom of belief and opinion in terms of capability. Developing human rights theory also requires more cooperation between conceptual research and practical psychiatry in order to clarify what we really want to protect under the term freedom of belief and opinion.
Acknowledgements

I don’t usually have dreams. However, in 2005, when I was choosing my graduate seminar and the topic of my master’s thesis, I had a dream about what my research should be about. Since having that dream I have had both an inner ambition to clarify how a psychotic individual’s freedom of belief and opinion could be understood and external support, which has made this possible in practice. So, perhaps this has been one of my callings during these years.

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external challenges. I hope that what I have been doing in my research could
in its own way help build a world where all that diversity fits into humanity
and is better taken into account.

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1. Introduction

People in the field of psychiatry have both an ethical mission and ethical power in society and over people’s lives. As an ethical mission, psychiatry is seen as a way of doing good: it helps people who suffer from mental disorders. It is the task of psychiatry to support patients in finding mental well-being and autonomous agency. However, in psychiatric practice ethical power is also used, which means that psychiatry has the power to define what is good. Definitions of mental well-being and mental disorders are created in psychiatry. These definitions have ethical and juridical consequences, since they influence the way people see each other and themselves, and what is thought about their ability to make decisions, be responsible, determine their values and ascribe thoughts and beliefs worthy of respect. For example, individuals who are diagnosed as psychotic\(^1\) may be prescribed non- or involuntary\(^2\) treatment regardless of or against their will. It is also part of psychiatry’s ethical mission to protect society from deviance which is considered to represent a dangerous and serious threat to other people. This ethical power has been given to psychiatry so that it can ensure a safe and peaceful society. One of the ways in which it does this is in deciding that some people be given non- or involuntary treatment.

One companion of this ethical mission and ethical power is ethical responsibility, namely, facing the consequences of one’s actions. History shows that people acting in the field of psychiatry have not always been successful in meeting these ethical challenges. Even though their intentions may have been good, they have made mistakes because they have not been sufficiently aware of all the relevant issues concerning what is good for patients. Sometimes psychiatrists and other carers are not aware of the limitations of their own skills, and malpractice as an ethical failure is a consequence of that.\(^3\)

However, even more seriously, psychiatry has also been used as a powerful weapon when there has been a lack of tolerance in a society or when there has been a perceived need to create a society with homogeneous views and beliefs. People with unwelcome ideas and beliefs have sometimes been punished by a resort to psychiatry even though their ideas and beliefs were not symptoms of mental disorder. For example, in the former Soviet Union some political dissenters were diagnosed as having a “sluggish schizophrenia”.

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\(^1\) Sometimes psychosis is discussed as mental illness, severe mental disorder or psychotic disorder.

\(^2\) When I use the term involuntary, I focus on the fact that a person’s expressed opinion or attitude towards treatment is negative. When I use the term nonvoluntary the focus is on the fact that the person is seen as incompetent to decide about his or her treatment. For more discussion about these terms, see chapter 3.2.2.

\(^3\) See Chodoff 2009, 99.
Their political opinions, which deviated from the politically acceptable views of a totalitarian society were interpreted as delusions, the symptoms of psychosis. This made it possible to sentence dissenters to involuntary treatment and in this way exclude them from political discussion.\(^4\) During World War II, Seventh-Day Adventists were persecuted in Germany and some of them were sent to mental hospitals.\(^5\) Involuntary psychiatric hospitalization has also been used in China against political and religious dissidents. For example, some of the Falun Gong practitioners have been diagnosed in China as having an “evil cult-induced mental disorder”.\(^6\) In the western world there might be a tendency to overdiagnose people in some ethnic groups. The behaviour and beliefs of individuals who belong to a minority are not always interpreted in the context of their own subculture.\(^7\)

After abuses of psychiatry were revealed, ethical norms were developed to guide psychiatric care and to protect the rights of psychiatric patients. Human rights came to be a central ethical issue in psychiatry.\(^8\) They can be seen as one of the tools which are used when the ethical mission of psychiatry is carried out and ethical power is used: they are tools for ensuring ethical responsibility in psychiatry. Both the ethical norms governing psychiatry and the human rights that, it is argued, apply to everyone, psychiatric patients included, hold that freedom of belief and opinion\(^9\) should be protected in the context of psychiatry, also when the person concerned has a psychotic disorder. However, even though it is widely acknowledged that psychiatry may be abused and even though there is a consensus that people without a mental disorder should not be treated as if they had, it is not always clear where the border between exceptional ideological or religious views and mental disorder lies. Moreover, even though it might be clear that a psychotic person’s freedom of belief and opinion should be protected, it is far from clear how freedom of belief and opinion should be understood when a person has psychotic delusions, which are defined in the \textit{Diagnostic and Statistical

\(^4\) Chodoff 2009, 99-101; Fulford, Thorton & Graham 2006, 149-151, 575.
\(^5\) Nussbaum 2008, 135-136. See also Chodoff 2009, 102-103.
\(^6\) Chodoff 2009, 103-104.
\(^7\) See, for example, the DSM-IV-TR 2000, 307; Viljanen, Hagert & Blomerus 2010, 97-100.
\(^8\) Lönnqvist & Lehtonen 2007, 19; Välimäki 2000, 86. See also Chodoff (2009, 108-109), who argues that in order to prevent the abuse of psychiatry “psychiatric organizations need to be governed by enforceable codes of ethics”. In addition, practitioners of psychiatry should be guided towards “proper ethical conduct” in their education and continuing professional development.
\(^9\) In this study the expression “freedom of belief and opinion” includes all human rights which protect believing and thinking and manifesting one’s beliefs and opinions. They are freedom of religion, freedom of belief, freedom of conscience, freedom of thought, freedom of opinion and freedom of expression. For the sake of brevity, I have chosen to use the concept of belief because delusions are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV and DSM-V) as beliefs and there is a debate as to whether they are indeed such. The concept of opinion signifies in human rights discussion the internal ideas that a person holds in their mind, which is linked to the question concerning the possibility of a right to hold a delusion.
Manual of Mental Disorders (DSM-IV) as false beliefs “based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary”. It is also unclear how freedom of belief and opinion should be valued among other important values and rights. Thus, it seems that ethical responsibility in psychiatry is partly governed by rules and ideas which are unclear.

1.1. The ethical implications of psychotic diagnosis

Why are some people treated as non- or involuntary patients and some are not? Who are considered competent to decide what they do in their life and whether to accept treatment or not? Whose beliefs and opinions are treated as delusional and on what grounds? Derek Bolton and Natalie Banner put it this way:

we tolerate differences often enough, happily or otherwise – so why do we worry so much about psychiatric delusion?  

The following four cases enlighten the challenges that delusions and psychotic disorder present.

For example, John Nash, a mathematical genius, the inventor of a theory of rational behaviour and a visionary of the thinking machine started to believe that extraterrestrials were sending messages to him and that aliens had recruited him to save the world. He seriously believed this was so because, according to Nash himself, “the ideas I had about supernatural beings came to me the same way that my mathematical ideas did”. Nash was admitted to a psychiatric hospital in 1959 for involuntary treatment, and diagnosed with paranoid schizophrenia. According to Nash’s own words, there was no difference in the way he came to creative scientific ideas and how he came to delusions. However, he won a Noble prize because of the former and was treated as psychotic because of the latter.

Second, a Finnish woman, Anna Lappalainen, who was called by herself, other patients and nursing staff Princess, ended up in a psychiatric hospital in Kellokoski in the 1960s. She had a belief, considered by nursing staff a delusion, that she was a princess. She gave the other patients and the

10 See the DSM-IV-TR 2000, 821. I use the text revision (DSM-IV-TR) of the DSM-IV. For more about the definition of delusion, see chapter 2. The definition of delusion is the same in the DSM-V (2013, 819), which was released in May 2013, except the term “sustained” is replaced by the term “held”.
11 Bolton & Banner 2012, 89.
nursing staff in the hospital a role in her palace. Princess was treated by
electroshock and insulin shock therapy, and also a lobotomy was almost
carried out.14 Though the life of Princess was not just a happy game, her
delusions did not seem to represent a serious threat to others. Instead, they
even brought joy, and other patients who got a royal role in her delusional
system might also have felt a sense of self worth and meaning in their lives
during long term hospitalization.

However, Anders Behring Breivik, who carried out a bomb attack
and mass shooting in Oslo in 2011 on the grounds of his ideology, was not,
after considerable debate and two psychiatric evaluations, treated as psychotic
but was instead sent in prison. With an antisocial personality disorder and a
narcissistic personality disorder (which are not considered psychotic
disorders), Breivik was considered mentally competent to know what he was
doing and in that sense responsible for his attacks.15 When it comes to
psychiatric help, he can decide himself whether he wants treatment or not.

The fourth case concerns Tapani Koivuniemi and his followers in
the so-called Koivuniemi’s sect. Many members of the sect went on such a
strict diet that they not only lost weight but became undernourished after
Koivuniemi told them that it was God’s will that they do so. Some of the
members work in a company headed by Koivuniemi. They work a lot of
overtime and their salary is quite small considering how much time they work
and the education and skills the job requires. The children of the families
belonging to the sect are at homeschool.16 It seems that the Finnish state does
not prevent members from making such extreme choices as long as they are
not a threat to outsiders. It also seems that Tapani Koivuniemi may continue
his preaching, which seems to have harmful consequences for his followers.

Bolton and Banner suggest that a fundamental issue in dealing with
psychiatric delusions has to do with harm, namely, that delusional beliefs
“may imply significant risk of harm to self or harm to others”.17 However, it is
clearly not only the degree of harm that is significant in defining psychotic
delusions. Breivik seemed to harm others much more seriously than most of
the people who are diagnosed as psychotic. Moreover, members of
Koivuniemi’s sect also seem to harm themselves without being diagnosed as
psychotic. Thus, there is also something other than harm that is crucial in
defining psychotic views of reality.

A psychiatric diagnosis, especially the diagnosis of a psychotic
disorder, has several ethical implications. According to the narrowest
definition in psychiatry today, psychosis is diagnosed because of certain

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15 Wikipedia: Anders Behring Breivik.
16 Nousiainen 2010.
17 Bolton & Banner 2012, 89.
symptoms, namely, delusions and/or hallucinations, and the person does not think that there is mentally something wrong with them. A diagnosis of a psychotic disorder is usually required in order to allow a person to be given non- or involuntary treatment. Non- or involuntary treatment of psychotic patients is often seen as ethically problematic but still necessary in order to protect both the patient and other people. Therefore, non- or involuntary treatment is allowed in the mental health legislation of many (if not all) countries and in the ethical guidelines of psychiatry. Since delusions and hallucinations are defined as central symptoms of psychotic disorder, the evaluation of a person’s beliefs, experiences and behaviour is an important task when somebody is sent for non- or involuntary treatment. However, this evaluation reflects an asymmetrical power relationship: a psychiatrist evaluates the patient and his or her decision, based on this evaluation, has consequences for the patient.

It has been claimed that the diagnosis of a psychotic disorder implies that there is an ontological assault on the person’s self. Psychotic disorder has an effect on a person’s sense of self, essence and moral agency by affecting their thinking, mood and behaviour. Psychotic disorder implies that the person is probably not mentally competent to make decisions concerning their own life and treatment and that the person cannot be considered fully responsible. According to Fulford and Radoilska, there is a presupposition “that mental disorder in general and delusions in particular are forms of internal obstacles to autonomy”. Psychosis implies that there is a breakdown of intentional agency. In this way, the evaluation of a person’s beliefs, experiences and behaviour are fundamentally linked to the way in which we understand their sense of self and interpret their state of agency and how autonomous or free we think they are.

Psychotic disorder and psychotic diagnosis also have consequences in social life. Some of these consequences are influenced by the psychotic

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18 For more about psychotic diagnosis, see chapter 2.1. and its subchapters.

19 See, for example, Mielenterveyslaki 1990/1116, 8§; The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (PUN) 1991, Principle 16. The Mental Health Act and PUN use the concept of mental illness instead of psychosis. However, the concept of mental illness refers to psychotic disorders. See Heikkinen 2008, 689. For example the Recommendation no.rec(2004)10 of the Committee of Ministers to Members States concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder and its Explanatory Memorandum by Council of Europe (RCE) (2004, Articles 17-19) requires that a person who is sent for involuntary treatment has a mental disorder. However, according to the Explanatory Memorandum to the RCE (Articles 17:128, 18:140), involuntary placement and treatment are considered appropriate “with regard to certain types of mental disorder, for example psychoses or other severe mental disorders”.

20 See Laitinen 1996. 2.


22 Fulford & Radoilska 2012, 45, 50-51.
behaviour itself and are the reasons why the need for a diagnosis have arose in the first place. However, some consequences are followed by diagnosis and treatment. After being recognized and “labelled” as psychotic, the person may have difficulties in their social life, in finding romantic relationships, in employment and studies. A person’s place in an organization and, for example, in religious and other ideological communities may change when a reputation that they are psychotic spreads.

1.2. Unclear concept of freedom of belief and opinion

Individuals with psychosis seem to challenge human rights theory and practice concerning freedom of belief and opinion. On the one hand, evaluating beliefs and opinions is part of a diagnostic process. Beliefs and opinions have to be evaluated if mental health is to be protected since some beliefs and opinions, and the way in which a person lives according to them, imply that that there is a need for treatment. On the other hand, one of the purposes of the right to freedom of belief and opinion is to protect individuals whose ideas are not widely shared in society. Thus, it can be asked whether a diagnosis of a psychotic disorder with several ethical implications is a threat to a person’s freedom of belief and opinion or if such rights are violated in the process of diagnosis and by non- or involuntary treatment.

The psychotic individual’s freedom of belief and opinion is protected by legislation and several ethical guidelines. Firstly, by default, as a human being the psychotic individual has the right to freedom of belief and opinion in the same way as any other individual. Since these rights are human rights and fundamental rights, which belong to all people, they are also a psychotic individual’s rights.23

Second, legislation and ethical principles which guide psychiatry confirm that these human and fundamental rights belong to psychiatric patients as well.24 The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care accepted by United Nations (PUN=Principles of UN) declares that “every person with a mental illness shall have the right to exercise all civil, political, economic, social and

23 On human rights as universal rights that belong to every human being, see, for example, Henkin (1990, 2-3). Henkin writes: “Implied in one’s humanity, human rights are inalienable and imprescriptible: they cannot be transferred, forfeited, or waived; they cannot be lost by having been usurped, or by one’s failure to exercise or assert them.”

24 The Explanatory Memorandum to RCE (2004, Article 11) notices that the title of the RCE is not “the Recommendation for the protection of human rights...” but “the Recommendation concerning the protection of human rights...”. The use of the word “concerning” in the title makes clear that the general human right conventions protect the human rights of persons with a mental disorder, and that the RCE is not a comprehensive list of these rights.
cultural rights” as they are recognized in international human right covenants, such as the International Covenant on Civil and Political Rights (ICCPR). The Recommendation no.rec(2004)10 of the Committee of Ministers to Members States concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder and its Explanatory Memorandum passed by the Council of Europe (RCE= Recommendation of the Council of Europe) confirms that persons with mental disorder should be entitled to exercise all their civil and political rights. According to the RCE, it is mental health professionals’ fundamental obligation to protect these rights. The RCE also advises mental health professionals to receive training in protecting the civil and political rights of their patients.  

Thirdly, ethical principles and recommendations also prohibit discrimination. According to the PUN and the RCE, any form of discrimination on the grounds of mental disorder is prohibited. Thus, it seems it is prohibited to interfere with a patient’s freedom of belief and opinion solely on the grounds of a psychiatric diagnosis. Moreover, any kind of discrimination on the grounds of religion, or political or other opinion is prohibited.

Finally, according to legislation and ethical principles, the monitoring of psychiatric treatment should be arranged, which means that whether a psychotic patients’ freedom of belief and opinion is being respected should also be monitored. Moreover, a psychiatric patient has to be informed about his or her rights. Patients also have a right to make a complaint to an external body if they suspect that their right to freedom of belief and opinion has been violated.

These above rules and guidelines clearly show that a psychotic individual’s freedom of belief and opinion should be protected. Unfortunately, these rules leave the question about how freedom of belief and opinion should be understood and how this right should be valued among other rights

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26 RCE 2004, Articles 4, 11:2i; Explanatory Memorandum to the RCE 2004, Article 11:85.
27 PUN 1991, Principle 1:4; RCE 2004, Article 3:1. In addition, the RCE (2004, Article 4) refers to the civil and political rights of mental patients, as follows: “Any restriction to the exercise of those rights should be in conformity with the provisions of the Convention for the protection of Human Rights and Fundamental Freedoms and should not be based on the mere fact that a person has a mental disorder.”
28 This does not mean that it is not allowed to restrict a patient’s freedom of belief and opinion in order, for example, to protect his or her health and safety. For more, see chapter 3.3.
29 The PUN (1991, Application) declares: “These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.”
somewhat open. This vagueness of definition results in complex challenges since people with a psychotic disorder also have beliefs which have been defined as delusions. For example, should we accept that Anna Lappalainen had a right to believe that she is a princess, and should this right have been protected? If not, why? Or, was it a violation of John Nash’s freedom of belief and opinion that he was sent for involuntary treatment and medicated against his expressed wishes? If it was not a violation, why was Nash not considered to be an individual who had such rights? And if it was a violation, was there something else which was considered to be more important than the right to freedom of belief and opinion? In other words, was there something which justified the interference with his freedom of belief and opinion?

These kinds of questions turn out to be even more complicated if we look at the distinction between non-absolute and absolute human rights as presented in human rights theory. When it comes to freedom of belief and opinion, a distinction is made between the external dimension of the right to manifest one’s beliefs and opinions (forum externum) and the internal dimension of the right to adopt and hold them in one’s mind without interference (forum internum). While certain restrictions of the forum externum are considered justified in order to protect other people’s rights, the forum internum is defined as an absolute human right which should not be interfered with in any situation for any reason.\(^\text{31}\) In general it has been suggested that influencing involuntarily the “conscious or subconscious mind with psychoactive drugs” would violate a person’s absolute rights.\(^\text{32}\) If we applied this notion to psychiatry, it would follow that involuntary treatment by antipsychotic medication would be against a patient’s absolute human rights. However, this is not how human rights are understood in mental health legislation, ethical guidelines for psychiatry or psychiatric practice.

Since a psychotic individual’s freedom of belief and opinion is a complex matter and since the formulations concerning this in the legislation and ethical guidelines are confusing and conceptually conflicting, psychiatric nursing staff, and in the last resort, the states and organizations that are responsible for protecting human rights are in a problematic situation. They should respect and protect the psychotic individual’s freedom of belief and opinion even though it is unclear what is meant by this right. It is unclear what should be respected and protected and what kinds of interventions (if there are such) are against a patient’s absolute human rights.\(^\text{33}\)

\(^{31}\) Ojanen & Scheinin 2011, 416-419; Evans 2001, 68, 72-74; Scheinin, 2000, 5-6; Kortteinen 1996, 55; Tazhib 1996, 25-27, 87; Nowak 1993, 314-315; Partsch 1981, 214, 217. For more about this distinction, see chapter 2.2.3.

\(^{32}\) See Nowak 1993, 314.

\(^{33}\) Sone’s (1997, 223) conclusion is also confusing since she writes about a patient’s right to refuse antipsychotic drugs: “Until the concept of the right to refuse treatment is clarified, nurses and other participants in client care must protect their patients’ rights and interests.” How can nurses
Partly because of this lack of clarity but also partly because there are different opinions there has been considerable debates between and within different fields and these debates have not always been fruitful or helpful for patients. Even though Riittakerttu Kaltiala-Heino somewhat simplifies the matter, her description of the debates between lawyers and psychiatrists or between the medical modelist and legalist is still helpful about the problems found in such debates:

The medical modelists, adhering to the knowledge and expertise of the mental health professionals and paternalistic ideology want the involuntary psychiatric treatment to be solely a medical question so that the patient’s right to treatment will be best granted. The legalists, believing in civil rights and fairness and incorruptibility of the due process want the matter to be removed from the control of psychiatrists to be decided by the lawyers to avoid abuse of the powerless mentally ill.\textsuperscript{34}

The problem with human rights theory when it comes to the freedom of belief and opinion seems to be that it has developed without taking into account that some people are psychotic and suffer from delusions. It seems that the right to freedom of belief and opinion is said to apply to people with psychosis even though they have been ignored when the concept of freedom of belief and opinion was defined and when the theory of freedom of belief and opinion was developed. As a consequence there are two kinds of risks. First, if the right to freedom of belief and opinion is just applied to people with a psychotic disorder without considering whether it is ethically justified, it would lead in many cases to ignorance and malpractice. Kaltiala-Heino seems to refer to this risk when she notes that the legalistic model does not function in practice and may endanger the patients’ right to receive treatment. Second, if it is thought that the way in which the freedom of belief and opinion is defined does not seem to be ethically applicable when it comes to people with psychotic disorder, we may end up simply ignoring that right. Kaltiala-Heino even suggests that there is a risk that psychiatry will be abused if the medical approach is applied without outside monitors.\textsuperscript{35}

In this study I seek an answer to the question what would be the best way to understand freedom of belief and opinion given that some people are psychotic. In this respect the starting point of my study refers to the concept of empirical ethics presented by Jonathan Glover when he notes that there has to be a two-way interaction in ethics. Ethical principles guide practice, but practical dilemmas should also challenge one to develop principles as and when it is necessary. As Glover puts it: “ethical beliefs should also be revisable in the light of an empirical understanding of people

\textsuperscript{34} Kaltiala-Heino 1995, 19. See also Gutheil 1980, 327.
\textsuperscript{35} Kaltiala-Heino 1995, 19.
and what they do”. I suppose that the same idea can be applied to jurisprudence. The way in which human rights are understood has to be tested, and rights should be redefined if we notice that they are not applicable in real life.

1.3. Research questions and the purpose of the study

The purpose of this study is to seek a definition of freedom of belief and opinion which would allow this freedom to be seen as a human right for a person with psychosis. This study has four research questions: 1) How can the freedom of belief and opinion be understood as a human right? 2) In what kinds of discourses, concepts and presuppositions are the different views of freedom of belief and opinion based? 3) What aspects are relevant when the realization of and interferences with freedom of belief and opinion are considered in the case of an individual with psychosis? And finally, 4) How are views about freedom of belief and opinion challenged in the case of an individual with psychosis?

By seeking an applicable definition of the freedom of belief and opinion I intend to create a conceptual framework which can be used in understanding what kind of question is involved when it comes to a psychotic person’s freedom of belief and opinion. With the help of this framework the interdisciplinary discussion becomes clearer. This framework can also be utilized when legislation and ethical principles guiding psychiatric care are developed, when professionals and students of psychiatry are educated and when there are discussions with psychiatric patients about their rights. Moreover, the conceptual framework presented in this study challenges us to develop human rights theory concerning freedom of belief and opinion. Special interest is given to the core of freedom of belief and opinion, namely the right to the forum internum. Considering the individual with psychosis reveals challenges and conflicts in human rights theory which should be discussed further.

1.4. Material and method

It would seem sensible to seek a definition of freedom of belief and opinion which would also be applicable as a human right for a person with psychosis by using materials from different kinds of fields. Since the challenge is interdisciplinary in nature, so too is this study. Thus, the material of this study

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includes 1) legislation and ethical principles which guide psychiatric care, 37 2) human rights theory, legislation and conventions concerning freedom of belief and opinion, 38 3) textbooks considering psychiatric diagnosis, 39 4) discussions concerning the philosophy and ethics of psychiatry, 40 5) (political) philosophical discussions concerning freedom and human rights 41 and 6) studies and reports which concentrate on the views and experiences of patients with psychotic disorder. 42 From each group, I have


38 For example, the International Covenant on Civil and Political Rights (ICCPR 1966), which was adopted and opened for signature, ratification and accession by the General Assembly of UN in 1966 and came into force in 1976; the European Convention of Human Rights. The Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR 1950), which was signed by governments being members of the Council of Europe in 1950 and was amended by protocol No 11, which entered into force in 1998; Tahzib, Bahluyihi: G: Freedom of Religion or Belief. Ensuring Effective International Legal Protection (1996); Lerner, Natan: Religion, Secular Beliefs and Human Rights. 25 Years After the 1981 Declaration (2006); Partch, Karl Josef: Freedom of Conscience and Expression, and Political Freedoms (1981); Ojanen, Tuomas and Scheinin, Martti: Uskonnollinen ja omantunnon vapaus (PL118) (2011).

39 Especially the DSM-IV-TR. Diagnostic and statistical manual of mental disorders (2000), but also the ICD-10. Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines (1993). I have also used a Finnish Textbook PSYKIATRIA edited by Lönnqvist et al (2007). In the fine-tuning of my research process, I have added some notices from the DSM- V to the footnotes but this new edition was published too late for me to use it in my analysis.

40 To mention some examples: Bortolotti, Lisa: Delusions and other Irrational Beliefs (2010); Jackson, Mike & Fulford, K. W. M.: Spiritual Experience and Psychopathology (1997); Radden, Jennifer: On Delusion (2011); Stephens, G. Lynn & Graham, George: The Delusional Stance (2007) and Reconceiving Delusion (2004); Relevant articles from Psychiatric Ethics edited by Bloch & Green (2009) and articles published in Autonomy and Mental Disorder, edited by Lubomira Radoilska (2012). This material focuses on international discussions since there is not much relevant material in Finnish.


42 For example, Iso-Koivistö, Eeva: "Pois sieltä, ylös, takaisin" - ensimmäinen psykoosi kokemuksenä (2004); Kaltiala-Heino, Riittakerttu: Involuntary Psychiatric Hospitalization – A Comparison of Voluntarily and Involuntarily Admitted Psychotic Patient's, their Experiences of and Attitude to Coercion in Psychiatry (1995); Kuosmanen, Lauri: Personal Liberty in Psychiatric Care – Towards Service User Involvement (2009). From international material, for example, Wagner, Luciane C. & King, Michael: Existential Needs of People with Psychotic Disorders in
picked up both internationally relevant material and material which is relevant especially in Finland and also written in Finnish.\footnote{Pôrto Alegre, Brazil (2005).}

Each set of materials relevant to this study have their own particular concerns. The purpose of Human Rights Conventions, legislation and ethical principles is to ensure certain rights. They present certain principles but leave it quite open as to how they are to be interpreted and applied in actual cases. In the human rights literature concerning freedom of belief and opinion, deeper considerations and conceptual clarifications are presented and they are often based on legal cases. However, these considerations are not applied to cases of people with psychosis. Moreover, philosophical discussions concerning rights are not always recognized very well. Textbooks considering psychiatric diagnosis also pay attention to human rights issues but their main purpose is to present diagnostic criteria, help in the diagnosing process and give guidelines for suitable treatment. Discussions concerning philosophy and the ethics of psychiatry deal with interdisciplinary challenges between psychiatry, philosophy and ethics. Viewpoints concerning human rights and jurisprudence are also presented, as is the case in the political philosophical discussion concerning freedom, but human rights theory is seldom analysed in a way that juridical theory of human rights as found in international conventions and juridical cases is taken into account. There seems to be some kind of gap between philosophy (ethics included) and jurisprudence especially in the area of freedom of belief and opinion. Studies and reports concerning the views and experiences of patients with psychosis are not meant to be universal declarations about how everyone should understand such issues, but are expressions that shed light on what individuals with psychosis think about these matters.

Thus, there are three limitations concerning the material used in this study. First, none of this material addresses the particular issue studied here. Second, there are gaps between materials since they do not seem to take into account what is written in other fields. And third, the materials are very different in nature. Some of the texts are expressions of what certain individual have gone through. Some are instructions for mental health professionals which guide to do something and avoid something else. And some are philosophical texts.

\footnote{Since there are several fields, I probably haven’t been able to go through all the interesting materials available. The bibliography of the thesis presents all the materials I have used. However, some examples are mentioned in the notes in this chapter. It is worth noticing that I have not used neuro-biological research concerning psychotic disorders since as a social ethicist my competence in using that kind of research is very limited. There is one exception, namely, Sihltj Kapur’s Psychosis as a State of Aberrant Salience: A Framework Linking Biology, Phenomenology, and Pharmacology in Schizophrenia (2003), which is often referred to in discussions about the philosophy of psychiatry and seemed to be relevant to my topic.}
Seeking answers from a diversive set of material is, though challenging, still possible with a method of philosophical conceptual analysis as it is used in the discipline of social ethics. When this method is used, the focus is on the question to which the reseacher seeks an answer and he or she is open to the ideas that are presented in these materials and their points of view behind them. With this method I clarify the meaning of different kinds of concepts and claims, and the relationships between them. I also analyse the argumentation and underlying assumptions of such concepts and claims. Conclusions are drawn on the basis of this analysis. With the help of analysis it is possible to understand what is meant by the concept of freedom of belief and opinion, how it can be threatened in cases involving psychotic individuals and how – according to a range of views – the rights of patients can be properly respected.

In using this method, I take into account that not all the material was written with a philosophical analysis in mind. However, it is important to include such materials in my analysis. When one’s interest is not just in philosophical texts, but also in guidelines and people’s experiences, it is possible to find significant issues or observations in unusual and less studied contexts. In pursuance of this, a researcher may bridge problematic gaps between the various discussions encountered. When a researcher uses philosophical analysis as it is used in social ethics, he or she brings different fields, which not always discussed together into the discussion. This is challenging, but something which should be done. When it comes to experiences, practical views and guidelines, which are not always argued philosophically, the reseacher takes into account the nature of these texts and does not demand argumentation where it would not be reasonable to do so given the nature of those discourses. Instead, by using these texts, a researcher seeks a two-way interaction in ethics. Namely, practical dilemmas may reveal that there is a need to develop philosophically well argued views if they don’t take into account how things seem to be in practice and how people seem actually to behave. In this study, I will realize an interdisciplinary two-way interaction in human rights theory in the following way. Different views regarding freedom of belief and opinion are presented in general first mostly with the help of philosophical texts and human rights theory. After that these views are considered in relation to the issue of individuals with psychosis which, on the one hand, clarifies the discourses, concepts and presuppositions on which the different kinds of views are based and, on the other hand, reveals what kinds of problems or challenges are inherent in such views. After that we see whether the each view of freedom of belief and opinion “passed the test” and if it did not, where the problems were.
Then, I would like to make some comments on the title of the thesis: Freedom of delusion – Interdisciplinary views concerning freedom of belief and opinion meet the individual with psychosis. First, the main title “Freedom of delusion” does not claim that there is or should be such freedom. “Freedom of delusion” is a provocative expression which demonstrates the complexity of the concept of freedom of belief and opinion and relates the theory of freedom of belief and opinion to people with psychosis in a challenging way. The subtitle Interdisciplinary views concerning freedom of belief and opinion meet the individual with psychosis refers, first, to the idea that this study presents different views concerning freedom of belief and opinion. These views are interdisciplinary since materials from different kinds of fields are used in their elaboration. Second, the subtitle refers to the idea of a two-way interaction since it includes the idea that these views meet the individual with psychosis and are in this way “tested”.

I have written two scientific articles and one scientific text during my PhD project. My article “Is there a right to hold a delusion? Delusions as a challenge for human rights discussion” was accepted by the journal Ethical Theory and Moral Practice in 2012 and published in 2013.44 The content of chapter 2.2. is partly similar to that of this article. I have also presented preliminary analyses of my research subject in an article published in Sosiaalilääketieteellinen aikakauslehti in 201045 and in a text published in Dialogues in Philosophy, Mental and Neuro Sciences in 2011.46

1.5. The nature of an interdisciplinary approach

There has been quite a lot of discussion about the autonomy and self-determination of psychiatric patients and the ethics of non- or involuntary treatment. In Finland, for example, Jorma Laitinen, Riitta-Kerttu Kaltiala-Heino and Lauri Kuosmanen have considered these issues. At the international level, Autonomy and Mental Disorder (ed. Radoilska) presents current considerations about this controversial question regarding psychiatry. There is also research which concerns the relationship between religion and psychosis. Just to mention one example, the journal Philosophy, Psychiatry & Psychology had a special theme “Spiritual Experience and Psychopathology” in number 4.1 (1997). Also the abuse of psychiatry for ideological purposes has been researched by, for example, Paul Chodoff (2009). Bruce Winick has considered the involuntary treatment from the viewpoint of freedom of belief and opinion in his juridical analysis in The Right to Refuse Mental Health

44 See Stenlund 2013.
45 See Stenlund 2010.
46 See Stenlund 2011.
Treatment (1997). There has also been discussions concerning the right to refuse antipsychotic medication in the United States in the context of some juridical cases. The so-called antipsychiatric discussion has also referred to the conflict between involuntary psychiatry treatment and the freedom of belief and opinion.

However, the arena, where human rights discussions concerning the freedom of belief and opinion is brought together with the ethics and philosophy of psychiatry or discussions concerning psychiatric treatment, is amazingly limited. It seems that interdisciplinary research and discussion has not been interdisciplinary enough in this matter. Either the view and argumentation of psychiatry has not been considered properly (which seems to be the problem for Winick, as I see it) or there is a lack of analysis that takes human rights theory into account (which seems to be the problem for most discussions concerning the philosophy and ethics of psychiatry). When it comes to my research topic, I haven’t come across any research that connects the views presented in political philosophy, psychiatry and human rights theory before, at least not in this analytical and conceptual way. My purpose is to make such connections and make visible the hidden area between these disciplines regarding the complex issue of a psychotic person’s freedom of belief and opinion.

To sum up, there are three main reasons why I consider an interdisciplinary study to be important here. First, the complex issue of the psychotic individual’s freedom of belief and opinion reveals such inconsistencies in human rights theory (as I will demonstrate in more detail in chapter 2.2.) that it is necessary to analyse human rights theory together with other fields in order to find the roots of such inconsistencies and make visible what those inconsistencies actually consist of. Second, even though the fields of human rights theory, psychiatry and philosophy are linked with each other, it seems to be unclear how they are actually linked and where they differ from each other and why. Therefore, I want to create a path to see each approach in relationship with others. Moreover, I will shed some light on the background ideas which may be behind the different discourses. Third, debates between different fields have not always been helpful for patients. I agree with Kaltiala-Heino when she notes that protecting patients requires co-operation between different fields.47 I hope that my interdisciplinary study can serve this fruitful and helpful co-operation.

As John Sadler notes, doing interdisciplinary research has always proved to be an impossible profession since “there are risks on all sides”.48 I suspect that researchers and professionals who work in some of the discussion

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48 Sadler 2005, 11.
areas represented in this study will note that my analysis could have gone
deeper and wider into their own particular fields. I agree with them: it could
have, – if it wasn’t an interdisciplinary study – and it probably will in the
future. However, I will present how far I was able to get in this research
project and I hope that I have been able to make the hidden areas visible
enough to continue the journey. There are plenty of deeper discussions in each
field where people interested in this research topic can go. I also hope that I
have been able to reveal the problems and challenges that remain for further
consideration in all fields (especially on the field of human rights theory).

I am sure that my own identity as a social ethicist and a theologian
with some experience of diaconia (church social work) and mental health
work has helped me to recognize certain questions in my research and has
provided some competence in dealing with them. As a social ethicist, I am
interested in finding philosophical and ethical questions which are relevant for
the life, relationships, well-being and dignity of human beings. Even though
social ethics is close to practical philosophy and political philosophy, I think
that social ethics is even more open to interdisciplinary approaches, since its
interest is not only in philosophical texts and ideas but also other kind of
materials, such as diagnostical classifications, ethical guidelines and the
experiences of people, that are relevant objects for analysis.

As a theologian I am interested in beliefs, belief systems and their
role in human life. I am also quite familiar with beliefs which are not
necessarily “epistemologically rational”, not only as a theologian but also as
someone who has religious beliefs. I suppose that if my own experiences and
values were different I might have had different ideas. But I also suppose that
this is the case for each researcher since everyone holds some beliefs and
values.

I also suspect that my experiences in diaconia and mental health
work has influenced my research. First, my experiences have helped me to be
critical towards such antipsychiatric or philosophical views which seems to
over-romanticize “madness”. Second, I have had the opportunity to see how
challenging it might sometimes be to have philosophical or ethical reflections
in every day psychiatry and how difficult it may be to discuss beliefs with
patients in environments where “discussions concerning religion and politics
are forbidden”. Third, as a researcher who is also a diacon I am motivated to
choose my research topics so that I could use my skills to serve people who
suffer and who have been ignored.
1.6. Structure of my thesis

This study is divided in to two parts. The first part (chapter 2) is necessary since there are certain questions which need to be analysed before I can proceed to analyse different views of freedom of belief and opinion. In order to answer my research questions, I need first to clarify what it means to have a psychotic disorder and how psychotic and other exceptional views of reality are distinguished. I also need to analyse the status of delusions as beliefs, thoughts and opinions in philosophical and human rights discussions. I will clarify how freedom of belief and opinion is discussed in human rights theory and how the formulations presented seem to be in a somewhat fraught relationship with views and practices justified in psychiatry.

The second part (chapters 3, 4 and 5) presents three different views of freedom of belief and opinion and clarifies their applicability in the case of an individual with psychosis. There is a chapter for each view and the basic structure of these chapters is similar: First I elaborate the view of freedom of belief and opinion in general and after that I discuss that view in the context of an individual with psychosis. All of these chapters answer in their own way all the research questions.

In chapter 3, I discuss freedom of belief and opinion in the negative sense, which means that other people do not interfere technically or physically with an individual holding and manifesting his or her beliefs and opinions. In chapter 4, I discuss freedom of belief and opinion in terms of authenticity, which means the right to hold such beliefs and opinions which are really one’s own and the right to manifest them in a way that is in harmony with them. Chapter 5 views freedom of belief and opinion in terms of capability, which signifies that the individual is capable of choosing a way of life which he or she considers valuable and which is worthy of human dignity. In the end (chapter 6), I summarize the results of the analysis and present the conclusions.
2. *Psychosis as a challenge to freedom of belief and opinion*

In this chapter I will clarify the nature of psychosis as a challenge to freedom of belief and opinion, which is necessary before I can proceed to analyse different views of freedom of belief and opinion. In order to answer my research questions, I need first to clarify what it means to have a psychotic disorder and how psychotic and other exceptional views of reality are distinguished.¹ I will do that in chapter 2.1. by collecting different kinds of conceptions from psychiatric diagnostics and discussions concerning the philosophy of psychiatry and then combining them. Thus, I will create a model which takes into account several views concerning the nature of psychosis.

After clarifying the nature of psychosis, I need to clarify what kind of challenge to freedom of belief and opinion psychosis represents in the context of human rights discussion. In chapter 2.2., I will analyse whether delusions are treated as beliefs, thoughts and opinions in philosophical and human rights discussions. I first consider the debate in the philosophy of psychiatry which has discussed whether delusions are beliefs. After that I continue to explore, firstly, what kind of status delusions have in the definitions presented in human rights theory. Second, I present conceptual challenges in human rights theory when it comes to the question concerning the relationship between an absolute human right (*forum internum*) and in- or nonvoluntary psychiatric treatment. I will clarify how freedom of belief and opinion is discussed in human rights theory and how the formulations presented seem to be in a somewhat fraught relationship with views and practices justified in psychiatry.

2.1. *Distinguishing psychotic and other exceptional views of reality*

When we discuss the question of a psychotic individual’s freedom of belief and opinion, one central issue is how psychotic and other exceptional views of reality differ. We need to find out what is specifically characteristic of psychosis. First, psychotic views of reality should be distinguished from ideological, religious and cultural views of reality. Second, the distinction should be made between psychotic and other disordered, but not psychotic,  

¹ “View of reality” is a wide term which refers here to an individual’s way of understanding, experiencing and seeing him- or herself, the world, life and other people.
views of reality, such as views of reality which occur in the context of personality disorders. The first distinction concerns the borders of psychiatry: what views of reality should psychiatry deal with and what views should it not to deal with. The second distinction concerns an issue that psychiatry must deal with itself and involves different diagnostics: which views of reality should be treated as psychotic and which should be treated (if the person wishes to be treated) as something else.

Whether the person is defined as psychotic or not has significant consequences in the area of human rights. If the view of reality of an adult individual with normal or high intelligence is not considered psychotic that individual has a right to refuse (both psychiatric and somatic) treatment and this decision has to be respected regardless of the consequences. However, if a person is defined as psychotic, their right to self-determination is considered in a different way. Their refusal to have treatment is not necessarily respected and they are not necessarily considered as competent to decide about their treatment. Moreover, it seems that the legislation of most if not all countries allows doctors to treat an individual with a psychotic view of reality in ways (for example with involuntary antipsychotic medication) which would not be justified if the person’s view of reality was not defined as psychotic. In cases where people are not considered psychotic, other citizens, carers included, have to, in a more strict sense, let them act according to unusual and even harmful beliefs as long as no serious threat is posed to other people’s human rights.

The ethical guidelines and diagnostic manuals of psychiatry guide mental health practitioners to distinguish psychotic views of reality from ideological, religious and cultural views. It is stated in the PUN that the determination of a psychotic disorder should not be made on the basis of a person’s political, economic or social status or membership of a cultural, racial or religious group. The DSM-classifications state that politically,

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2 In order to prevent the spread of the dangerous disease force inoculations and isolations are juridically justified at least in Finland. See Tartuntatautilaki 2003/935, 12§, 13§; 2006/989, 15a§.
3 For example, according to Finnish Mental Health Act the adult person can be determined to nonvoluntary psychiatric treatment only if he or she is (or is assumed to be) psychotic. There are also additional criteria for nonvoluntary psychiatric treatment, but diagnosis of psychosis is a basic criteria which has to be always fulfilled. See Mielenterveyslaki 1990/1116, 8§. See also Fulford 2009, 62. For example, according to British Mental Health Act anyone with mental disorder could be in principal determined to involuntary treatment if they present a risk to themselves or others. However, in practice it is mainly people with psychotic disorder who are determined in such a treatment. Fulford & Radoilska 2012, 50.
4 It is of course allowed to interact with people with views which are not considered psychotic, for example, by questioning, debating and persuading. These are normal methods of interacting in a social world where we live in relationships with each other and have different opinions. But the justified measures of influence are more limited than in cases involving a person with a psychotic view of reality.
5 PUN 1991, Article 4:2.
religiously or sexually deviant behaviour, or conflicts between an individual and society, should not be diagnosed as mental disorders. The PUN expresses the same idea, as follows:

Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person’s community, shall never be a determining factor in diagnosing mental illness.

Diagnostic manuals also pay attention to the challenges in diagnosing when a psychiatrist is dealing with a patient from an other culture or subculture. According to the DSM-IV:

A clinician who is unfamiliar with the nuances of an individual’s cultural frame or reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual’s culture. For example, certain religious practices or beliefs (e.g., hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder.

However, invoking religion, ideology or culture is not as such an adequate way to “avoid” a diagnosis. The DSM-classifications note that even though political, religious or sexual deviance or conflict as such should not be seen as a symptom of mental disorder, in some cases deviance or conflict is a symptom of mental disorder, in some cases deviance or conflict is a

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6 DSM-V 2013, 20; DSM-IV-TR 2000, xxxi. One Finnish textbook on psychiatry follows this idea of the DSM-IV. This textbook stresses that behaviour which follows from conflicts between the individual and society or is defined as exceptional on a religious, sexual or political basis should not be seen as mental disorder unless it can be shown that the conflict is clearly a symptom followed from the disorder. In addition, this textbook notes that the border between normal and pathological is always relative and subject to agreement despite clearly expressed criteria of diagnosis. Lehtonen & Lönnqvist 2007, 27.

7 PUN 1991, Article 4:3. The RCE declares that a lack of adaptation to the moral, social, political or other values of a society, of itself, should not be considered a mental disorder. The Explanatory Memorandum to the RCE notices, moreover, that definitions of mental disorders should be in accordance with internationally accepted medical standards and refers to the misuse of psychiatric diagnosis in totalitarian societies: “This method of defining mental disorder aims to prevent idiosyncratic approaches to diagnosis. So-called “sluggish schizophrenia” is one example of such an idiosyncratic approach; it was a diagnosis applied under certain totalitarian regimes in the past but not recognised elsewhere in the world.” The Explanatory Memorandum to the RCE also refers to a particular principle of jurisprudence of the European Court of Human Rights and its judgement in the Winterwerp case. According to the principle, the detention of a person cannot be taken as permitted simply because his or her views or behaviour deviate from the norms prevailing in a particular society. RCE 2004, Article 2:2; RCE 2004, Explanatory Memorandum, Article 2:20, 26.

8 DSM-IV-TR 2000, xxxiv. In the context of mood disorders, the DSM-IV notices: “Culturally distinctive experiences (e.g., fear of being hexed or bewitched, feelings of “heat in the head” or crawling sensations of worms or ants, or vivid feelings of being visited by those who have died) must be distinguished from actual hallucinations or delusions that may be part of a Major Depressive Episode, With Psychotic Features.” DSM-IV-TR 2000, 353. See also the ICD-10 (1993, 65) which comments on the diagnosis of schizophrenia: “In evaluating the presence of these abnormal subjective experiences and behaviour, special care should be taken to avoid false-positive assessments, especially where culturally or subculturally influenced modes of expression and behaviour or a subnormal level of intelligence are involved.”
symptom of a dysfunction in the individual. Moreover, psychotic delusions may also have an ideological content. For example, when it comes to delusional disorder, the DSM-IV notes that “grandiose delusions may have a religious content (e.g., the person believes that he or she has a special message from a deity)”\(^9\) The DSM-IV also notes that a person experiencing a manic episode may have a delusion about “having a special relationship to God or to some public figure from the political, religious, or entertainment world”. Moreover, a person’s political and religious activity may increase in a manic episode.\(^11\) When it comes to cultural notions in the context of a major depressive episode, the DSM-IV notes:

It is also imperative that the clinician not routinely dismiss a symptom merely because it is viewed as the “norm” for a culture.\(^12\)

Thus, it seems that diagnostic manuals acknowledge the threat of misdiagnosing from two different sides. On the one hand, there is a threat that psychiatrists consider religious, ideological or cultural views of reality as symptoms of psychotic disorder. On the other hand, there is a threat that psychiatrists might consider symptoms of psychotic disorder as expressions of religious, ideological or cultural views.

Legislation and ethical guidelines for psychiatry imply that it is a psychiatrist’s task to distinguish between psychotic and other exceptional views of reality. Psychiatrists determine the psychosis by exploiting diagnostic criteria and medical knowledge when they talk with the patient and observe his or her behaviour and mental processes (including beliefs).\(^13\) The person whose view of reality is observed does not have any authority when it comes to deciding whether his or her view of reality is psychotic or not, though he or she could, at least with in certain limits, decide which of his or her beliefs he or she expresses and what kind of relationship he or she manifests towards them in discussions with the psychiatrist.

In the following subchapters, I will collect and present views concerning what is characteristic of psychosis and how psychotic and other exceptional views of reality differ. Since the legislation and ethical guidelines which guide psychiatry emphasize that any determination of psychosis should be made according to official medical manuals and criteria,\(^14\) I will present

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\(^9\) See the DSM-IV-TR 2000, xxxi; DSM-V 2013, 20.

\(^10\) DSM-IV-TR 2000, 325. See also the DSM-V 2013, 91.

\(^11\) DSM-IV-TR 2000, 357-358. See also the DSM-V 2013, 128.

\(^12\) DSM-IV-TR 2000, 353.


\(^14\) See, for example, the Oviedo Convention 1997, Article 4. The Declaration of Hawaii (1977, 7), states, that: “The psychiatrist must not participate in compulsory psychiatric treatment in the absence of psychiatric illness. If the patient or some third party demands actions contrary to
views which seem to be in accordance with the DSM-IV.\textsuperscript{15} However, this presentation is analytical and interpretative so that a philosophical discussion can be utilized in order to describe the nature of psychosis in more detail.

2.1.1. Psychotic disorders in diagnostic manuals

The current diagnostic manuals of mental disorders consider most mental disorders as syndromes. This means that each mental disorder has a characteristic group of symptoms which are linked together so that it is possible to know a disorder’s progress and prognosis. The approach in the DSM and ICD classifications is also descriptive, which means that they detail symptoms-based criteria for each mental disorder.\textsuperscript{16} Descriptive definitions of mental disorders, psychosis among others, ended up playing a central and official role in mainstream psychiatry when they were established in the third edition of the DSM (DSM-III).\textsuperscript{17}

The diagnostic classifications list several disorders as psychotic. The most common psychotic disorders are schizophrenia, substance-induced psychotic disorder, schizoaffective disorder, psychotic depression and bipolar I disorder.\textsuperscript{18} Diagnostic classifications also present specific criteria for each psychotic disorder.\textsuperscript{19} Despite these specific criteria, the term psychosis in diagnostic manuals refers generally to the presence of certain symptoms, namely, delusions and hallucinations.\textsuperscript{20} The DSM-IV defines delusion as “a scientific or ethical principles the psychiatrist must refuse to co-operate.”

\textsuperscript{15} I also refer in places to the new edition of the DSM-classification (DSM-V) and the ICD-10 classification, which is in use in WHO Member States (Finland included). See WHO, International Classification of Diseases (ICD). My main focus is, however, on the DSM since it is a leading classification in international research and education. See Lönnqvist 2007, 51.

\textsuperscript{16} Füldőr et al 2006, 36-37; Lönnqvist 2007, 48. According to Bracken (1999), Anglo-American descriptive psychiatry identifies its philosophical roots with phenomenology. However, this is done narrowly without acknowledging the rich and complex history of phenomenology. Berrios (1991, 2011) questions the supposed link between phenomenology and current psychiatry and claims that the philosophical roots of descriptive psychiatry lie in descriptivism.

\textsuperscript{17} See Heinimaa 2008, 30-31.

\textsuperscript{18} Perälä et al 2007.

\textsuperscript{19} For example, the symptoms of schizophrenia have been divided into groups of positive and negative symptoms. Positive symptoms signify a disordering of normal psychological functions. Positive symptoms have been divided into two dimensions: 1. psychotic symptoms that include hallucinations and delusions, and 2. disorganized symptoms that include disorganized speech and behaviour, and inappropriate expression. Negative symptoms signify a weakening or lack of normal psychological functions. Negative symptoms are, for example, impoverishment of speech, unwillingness, anhedonia and weakening of expression. Isohanni et al 2007, 77-79. The characteristics of a manic episode in bipolar I disorder are an abnormally and persistently elevated, expansive or irritable mood with for example inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas and increased involvement in activities that cause significant harm. DSM-IV-TR, 357; Isometsä 2007b, 196-201.

\textsuperscript{20} The DSM-IV-TR (2000, 297) defines the concept of psychosis, as follows: “The narrowest
false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary”. The DSM-IV divides delusions in to different subcategories according to their content. The person with a persecutory delusion, for example, believes that somebody is attacking, harassing, cheating, persecuting or conspiring against them. The symptoms of grandiose delusion are that one has inflated worth, power, knowledge, identity, or a special relationship to a deity or famous person. A delusional person may also experience being under the control of some external force. Sometimes delusions have a bizarre content, which means that a delusion involves a phenomenon that the person’s culture would regard as totally implausible.\(^{21}\)

Hallucination is, according to the DSM-IV, “a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ”.\(^{22}\) Hallucinations may affect all the senses, but paracusis, or hallucinations affecting hearing, are the most common. Usually an individual with paracusis hears speech as single words, phrases or whole sentences. For example, an individual with schizophrenia may hear a voice commenting on his or her behaviour or repeating his or her thoughts aloud. Sometimes individuals with schizophrenia hear two or more voices discussing them, threatening, insulting and accusing. One Finnish textbook for psychiatry notes that hearing these kinds of voices may seriously disturb an individual’s life and activity. It notes that hearing voices may even be dangerous, if for example the individual obeys commands given by such voices.\(^{23}\)

In this study the concept of delusion seems to be especially significant and as “a belief” attracts my main interest while hallucinations as psychotic symptoms occupy a secondary role. It seems that hallucinations are more “given experiences”, namely, experiences a person just happens to have,

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\(^{21}\) Other subtypes of delusions, like delusional jealousy, somatic delusions and delusions concerning thought insertion, are also mentioned in the DSM-IV. DSM-IV-TR 2000, 821-822. See also the DSM-V 2013, 87, 819.

\(^{22}\) DSM-IV-TR 2000, 823. The DSM-V (2013, 822) defines hallucinations as “a perception-like experience with the clarity and impact of a true perception but without the external stimulation of the relevant sensory organ”. See also the DSM-V 2013, 87-88.

\(^{23}\) Lönnqvist 2007, 55; Isohanni et al 2007, 78.
while in delusions the focus is on how an individual ascribes his or her view of reality. Thus, it seems meaningful to consider the right to freedom of belief and opinion primarily in relation to delusions. It also seems that delusions are conceptually more at the core of psychosis than hallucinations are. On the one hand, sometimes a person with psychosis does not suffer from hallucinations. On the other hand, people may experience hallucinations without being psychotic if they recognize them as hallucinations, which means that they have an insight into their pathological nature. The nature of psychotic hallucinations seems actually to return us to the concept of delusion since it is significant how an individual considers their hallucinatory experiences and what kind of meaning they gives to them. If a person believes that the source of their hallucinations is in the external world, this belief can be seen, from the viewpoint of psychiatry, as a delusion. The absence of insight into delusional beliefs’ pathological nature seems to be conceptually part of the concept of delusion since beliefs which the person him- or herself recognizes as “delusions” are something other than delusions. They are more like neglected ideas, imaginings, illusions or obsessions.

Even though delusions and hallucinations are considered in diagnostic manuals as central symptoms of psychosis, it is worth noticing that they are not, however, necessary symptoms of all psychotic disorders. In some cases delusions and hallucinations are not present, but disorganized speech, or disorganized or catatonic behaviour or negative symptoms, such as affective flattening, are listed as sufficient characteristic symptoms of psychosis. It actually seems that there is no one such necessary criterion for all psychotic disorders, which would be specific for psychosis. The only necessary criterion for all psychotic disorders, according to the DSM-IV, seems to be general “clinically significant impairment or distress”, which is presented as a necessary criterion for all kinds of mental disorders. However, this general criterion is not a sufficient criterion for psychosis or for any other mental

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24 See the DSM-V (2013, 87), which states that hallucinations are not under an individual’s voluntary control.
25 For example, Heinimaa (2008) seems to pay more attention to the concept of delusion than to the concept of hallucination in his study, which considers the concept of psychosis. See also Fulford & Radoilska (2012, 46), who claim that delusions are paradigm symptoms of psychotic disorders.
26 For example, according to the DSM-IV-TR (2000, 323, 327) and the DSM-V (2013, 90), hallucinations may be absent in a delusional disorder. If there are hallucinations present in a delusional disorder they are not prominent and are related to the delusional theme.
27 See, for example, Barnes et al 2011; Mental Health Foundation: Hearing Voices.
28 According to the DSM-IV, for diagnosing schizophrenia, delusions or hallucinations need not be present if two of the following, namely, disorganized speech, grossly disorganized or catatonic behaviour and negative symptoms are present. See the DSM-IV-TR 2000, 312. The DSM-V (2013, 99) requires that if delusions and hallucinations are absent, for diagnosing schizophrenia, disorganized speech has to be present in addition to grossly disorganized or catatonic behaviour, or negative symptoms.
29 See the DSM-IV-TR, 8.
disorder. It follows that two individuals with psychotic disorder do not necessarily share any of the same symptoms characteristic of psychotic disorder. All they share is the general criteria, and even if this is the case, one might be suffering from clinically significant impairment while the other might be suffering from clinically significant distress. This complexity implies that even though some symptoms are presented as conceptually central for psychosis, the core of the concept of psychosis is still in some sense undefined in diagnostic manuals.

The DSM-classification can be called as operational since its goal is to define and describe mental disorders in terms of simple, externally observable and often behavioural symptoms. The purpose has been, firstly, to ensure reliable diagnostic procedures across different settings and countries. Second, the role of aetiological assumptions in diagnostic formulations has been minimized in order to promote communication between professionals and research data. The goal has been to create a useful system for clinical practice, research and education. However, there is a debate concerning how well these DSM-classifications have been able to reach their goals and whether too serious problems are linked in those goals.

On the one hand, it has been claimed, that the DSM-classifications are informative and that they help to recognize and treat different disorders. Classifications also make research easier, and research in turn helps to develop criteria for defining different disorders. Moreover, diagnostic criteria ensure an open and critical discussion about diagnostics, which promotes the legal protection of both patients and professionals. On the other hand, the DSM-classifications have also been criticized. According to Heinimaa, criticism has often been based on “philosophically oriented arguments as to the incongruences of their premises and the dubious consequences of their application in either clinical or research settings”. For example, since a diagnosis is based on different criteria all of which do not need to be present,

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30 This is the situation, for example, when we are faced with a person with schizophrenia whose psychotic symptoms are disorganized speech and negative symptoms (and clinically significant impairment) and a person with substance-induced psychotic disorder who holds delusions and suffers from clinically significant distress. See the diagnostical criteria in the DSM-IV-TR (2000, 312, 342). See also the DSM-V 2013, 99.

31 See also Heinimaa (2008, 9) who considers the concept of psychosis as a psychiatric primitive which is “not amenable to an exhaustive definition in more elementary psychiatric concepts”. Laitinen notes that in psychiatry there is a temptation to dress up exceptions in order to find consensus. Laitinen 1996, 26-27. Emphasizing the conceptual importance of delusions in psychosis in spite of the fact that they are not a necessary criterion of psychosis might be a mark of this “dressing up”. However, there can also be disagreements between what official criteria state and what is claimed in discussions concerning the philosophy of psychiatry.


33 Lönnqvist 2007, 48-49.


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sometimes people with the same diagnosis do not share a single symptom characteristic of psychosis.\textsuperscript{35} People with the same diagnosis do not necessarily share the same aetiology, either.\textsuperscript{36} It has also been noted that psychiatric classifications are bounded in western ways of understanding.\textsuperscript{37}

From the viewpoint of this study, the problem with a definition of psychosis that is based strictly on diagnostic criteria is that it does not help to make a distinction between psychotic and other exceptional views of reality. The definition, which emphasizes symptoms, challenges us to debate what beliefs are psychotic delusions and what beliefs are something else, and what exceptional experiences should be defined as clinically meaningful hallucinations and which should not. It seems that a “symptoms centered” definition of psychosis does not succeed in reaching the deeper nature of psychosis. Moreover, the definitions given for the concepts of delusion and hallucination actually lead to a discussion of the deeper meaning of those concepts.

In the following subchapters, I will collect together different aspects which have been seen as meaningful when the distinction between psychotic and other exceptional views of reality has been discussed. The model which I present is, thus, my analytic interpretation, constructed with the help of the philosophical discussion about the principles presented in the DSM-IV. It is worth noting that none of the definitions or descriptions is universally accepted. Nevertheless this, certain features are often mentioned. Because my goal is to describe the model which is in accordance with official medical criteria, I won’t include definitions in my description which question the basic idea of making psychiatric diagnoses or add something very different to the definition of psychosis (like, for example, antipsychiatric views which claim that there is no such thing as schizophrenia). Excluding antipsychiatric views in this context does not mean, however, that I will not refer to them later in my study or that I will not consider the criteria presented in the DSM-IV critically.

If different viewpoints are collected together, it seems that psychosis manifests itself in aspects of irrationality, being unwell and alienation. I will suggest that the aspects of irrationality and being unwell

\textsuperscript{35} For example, when it comes to diagnostic criteria for schizophrenia, only two of the following characteristic symptoms are required: 1. delusions, 2. hallucinations, 3. disorganized speech, 4. grossly disorganized or catatonic behaviour, 5. negative symptoms. See the DSM-IV-TR 2000, 312. The DSM-V (2013, 99) requires that of these two at least one has to be delusions, hallucinations or disorganized speech, which does not change the fact that two people with the same diagnosis do not necessarily share a single psychotic symptom.

\textsuperscript{36} Lönnqvist 2007, 48.

\textsuperscript{37} This challenge is noted by the DSM-IV-TR (2000, xxxiv) itself. Even though, the classification has been and is regarded as useful all over the world, it is admitted that “the symptoms and course of a number of the DSM-IV disorders are influenced by cultural and ethnic factors”.

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include several characteristics, and that a psychosis occurs as at least one of them. I will show that there is a relationship between the irrationality, being unwell and alienation. However, when these aspects are conceptually separated it is easier to see what distinguishes psychotic views of reality from other exceptional views. On the other hand, with the help of this model it is easier to see where the grey areas are and where clear distinctions are difficult to make. I will also briefly discuss how different aspects of psychosis relate to the concept of freedom. However, deeper discussions concerning these relationships follow in chapters 3, 4 and 5.

2.1.2. Psychosis as irrationality

In the history of ideas and in current discussions concerning psychotic disorders it has been argued that the individual with psychosis has serious problems concerning rationality. The view which emphasizes the aspect of irrationality in psychosis is mostly rooted in philosophical discussion. However, psychiatric definitions of psychosis also reflect the aspect of irrationality.

I see three different characteristics of irrationality which are central when it comes to a definition of psychosis. The characteristic of “non-correspondence to reality” refers to the idea that psychotic beliefs are not in accordance with reality. The characteristic of “incomprehensibility” includes the idea that psychotic views of reality are not understandable to others. The third characteristic is “agential irrationality” and it refers to a psychotic person’s inability to endorse beliefs by offering good reasons in support of their content and by acting in a way which is consistent with and explicable by their content. My suggestion is that psychotic views of reality present themselves in one or more of these characteristics of irrationality. Moreover,

38 Radden (2011, xii) describes the connection between irrationality and psychotic delusions: “The strange notions entertained by madmen have consistently provided a foil against which the proper way to reason is recognized and defined. Delusion is a category shaped by these values, I think it can be shown, and the concept of delusion is saturated with ideas about how cognitive judgements are properly achieved. Moral values are also involved when we speak of the way delusions are held, and the actions stemming from them. But the values that are our initial concern here are epistemic, rather than moral. They involve evaluative judgements about how we believe and know.”

39 Another kind of categorization could be made and these characteristics could be called by different names. For example, when Bortolotti (2010) discusses the irrationality of delusions she makes a division between procedural rationality, epistemic rationality and agential rationality. I utilize the last concept used by Bortolotti, but in order to find expressions which would be more informative and distinctions which would be clearer I have decided to use other terms and divisions when I describe the other parts of irrationality. I hope that the terms I have chosen are sufficiently clear and that I will bring all the most relevant and popular arguments to the discussion.
irrationality occurs with a loss of insight, which means that the person does not see that there is something wrong with them. However, even though irrationality is a necessary requirement for a view of reality to be defined as psychotic, it is not a sufficient requirement since other views of reality may also be irrational.

It has been claimed that a psychotic person’s beliefs do not correspond to reality. When an individual’s beliefs correspond to reality, they are in accordance with external facts, with “how things really are”. In epistemology this viewpoint seems to refer to correspondence theory which states that a belief is true if it corresponds with facts. The background supposition of the theory is that beliefs reflect or present reality. Beliefs are considered true when they reflect or present reality “as it is”.

The view that psychosis is a non-correspondence to reality is mentioned in the DSM-IV when it notes that the term psychotic has previously been defined as a “gross impairment in reality testing”. The DSM-IV also refers to the characteristic of non-correspondence to reality when it defines delusions as false beliefs “based on incorrect inference about external reality”. When the ICD-10 describes one category of delusions due to schizophrenia as “completely impossible” it seems to refer to this characteristic of irrationality, as well. These “completely impossible” delusions involve, according to the ICD-10, religious or political identity, or superhuman powers and abilities. It is considered completely impossible, for example, that a human being could control the weather or communicate with aliens from another world.

One mark of correspondence to reality is that beliefs and opinions are well-supported and responsive to the available evidence. When it comes to psychosis, the problem in this area is seen, for example, in the definition of delusion presented in the DSM-IV, which notes that delusions are against “what constitutes incontrovertible and obvious proof or evidence to the contrary”.

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40 About correspondence theory, see Lammenranta 2006, 82.
41 See the DSM-IV-TR 2000, 297, 827. The concept of reality testing comes from psychodynamic tradition where it refers to differentiation between external (object world) and internal (self) representations. See Arlow 1969, summary. The Finnish textbook of psychiatry points out that the sense of reality as ability to distinguish our own world of ideas from external reality also in difficult life situations and in the middle of stress is fundamental in mental health. Lehtonen & Lönqvist 2007, 28.
42 DSM-IV-TR 2000, 821. See also the definition of hallucination in the DSM-IV: “A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ.” DSM-IV-TR 2000, 823.
43 See the ICD-10 1992, 78-79.
44 See Bortolotti 2010, 14.
45 See the DSM-IV-TR 2000, 821.
However, referring to the characteristic of non-correspondence to reality is also problematic for the definition of psychosis. Several challenges have been pointed out. First, the content of the delusional belief is not always about factual matters. A delusion may also have a religious, spiritual, ideological or metaphysical content, when, for instance, a patient says “I am God”, or it may describe an inner experience, when a patient says “I feel that it is not me who is thinking”. In these cases it is not necessarily helpful and may even be impossible for human beings to evaluate how such beliefs correspond to reality since no empirical evidence is available to validate such claims. Lisa Bortolotti asks, for example:

What type of experience would lend direct empirical support to the claim that Platonic forms exist or that every citizen should be treated equally?

According to Bill Fulford, most delusions are value judgements. The commonest and clearest examples of evaluative delusions occur in affective psychoses. For example, a person with psychotic depression may regard something trivial that they have done as wicked or evil. When this is regarded as delusional it is not because it is denial of the facts since the person really has done what they believe they have done. Instead, it is the way in which the person is evaluating the facts that seems to be delusional. Fulford presents an example of a patient with psychotic depression who had forgotten to give his children their pocket money and who believed that this was “the worst sin in the world,” that he was “worthless as a father” and that his children would be “better off if he were dead”.

Secondly, in some rare situations delusions actually correspond to reality. For example, a patient may have a delusion of infidelity if he or she has irrational reasons for suspecting that his or her partner is cheating on him or her even though the partner is, in fact, cheating. Fulford also notes how the “standard definition”, which considers delusions as false beliefs, leads to paradoxes and illustrates this point with a case where a patient had a hypochondrial delusion that he was “mentally ill”:

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46 Bortolotti 2010, 152; Edwards 1997, 53; Radden 2011, 95-98. This does not mean that non-correspondence to reality would be totally useless when dealing, for example, with religious beliefs since some of them involve issues where evidence is available. For example, as Edwards (1997, 53) notes in his example: “We cannot declare a Christian Scientist mentally ill for believing that a broken bone has been miraculously healed if indeed no fractures show up any longer on X-rays. However, if anyone for any reason insists that healing has occurred when the fractures are still showing up...then questions of sanity may be very legitimately raised and would be so raised even by Christian Scientists.”

47 Bortolotti 2010, 152.


49 Fulford & Radoilska 2012, 55; Fulford 2009, 64; Fulford 1994, 211-212; Radden 2011, 95. These kinds of cases seems to suggest that it is even more crucial for rationality that beliefs are well-supported and responsive to the available evidence than that they actually correspond to reality.
if the patient’s belief that he was mentally ill was false, then (by the standard definition) he could have been deluded, but this would have made his belief true after all. Equally, if his belief was true, then he was not deluded (by the standard definition), but this would have made his belief false after all. By the standard definition of delusion, then his belief, if false, was true and, if true, was false.50

Thirdly, Bortolotti points out that the “content of some delusional states makes it really hard to identify convincing evidence for their being false, and thus insulates them from rejection”. It would appear then that there is always some reason for continuing to believe in a delusional way since there is no argument which would convince the delusional person that they are mistaken. This is so because beliefs and experiences are linked. A person’s experiences provide evidence for the validity of their beliefs and vice versa, a person’s beliefs strengthen their conviction that their experiences are authentic.51

Fourthly, speaking about a sense of reality (or reality testing) as a lack of ability on the part of a psychotic person is problematic from an epistemological viewpoint. One Finnish textbook of psychiatry defines the concept of a “sense of reality”, as follows:

An ability to evaluate one’s external environment objectively and distinguish sensations that come from the environment from sensations caused by an inner impetus.52

From an epistemological viewpoint it is not necessarily possible to evaluate one’s external environment objectively. There is no unambiguous philosophical argument that allows us to think that we can find any information about reality as such. According to Kant, we don’t know anything about beings as such. Instead our representations of reality depend on our inner activity. It seems that psychiatric discourse does not take Kant’s idea into account, which has been revolutionary in philosophy.53

Moreover, it seems that when speaking about not corresponding to reality in the context of psychosis, it is unclear what characteristic of reality are being emphasized. On the one hand, as Fulford has noted, many delusions are value judgements. On the other hand, it seems that many different kinds of views are possible when it comes to so-called soft reality or soft facts (relationships, values etc.) without them being determined as psychotic. This is clear if we compare some personality disorders with psychotic disorders. For example, people with a narcissistic personality disorder understand themselves in relationship with other people in a way which others may see as

50 Fulford 1994, 212. See also Fulford 2009, 64; Fulford & Radoilska 2012, 55-56.
51 Bortolotti 2010, 138-140.
not corresponding to reality. The other question is whether values or feelings can be delusional. For example, a person with an antisocial personality disorder has a lack of empathy and may justify acts which others would see as so awful that the question arises as to whether the way in which this person sees other people corresponds to reality.\textsuperscript{54} There is also debate concerning the relationship between eating disorders and delusions, and it has been asked, for example, whether anorexic beliefs (for example, the belief that “I’m fat”) should be defined as delusions.\textsuperscript{55}

The second characteristic of irrationality which defines the nature of psychosis is the one I call here incomprehensibility.\textsuperscript{56} For example, Karl Jaspers considers delusions as incomprehensible by defining them as being incomprehensible, unreal and beyond understanding.\textsuperscript{57} Incomprehensibility can be seen as arising from the bizarre nature of some beliefs. According to the DSM-IV, delusions are bizarre “if they are clearly implausible, not understandable, and not derived from ordinary life experiences”. For example, a belief that “a stranger has removed a person’s internal organs and replaced them with someone else’s organs without leaving any wounds or scars” is defined as bizarre.\textsuperscript{58} It also seems that some value judgements can be seen as bizarre, and since it is not possible to evaluate whether value judgements correspond with reality, their bizarre nature is what makes them delusional.\textsuperscript{59}

Incomprehensibility can also be seen as incoherence in the way a person expresses themselves or as inconsistencies in a person’s web of beliefs. On the one hand, subjects with delusions may endorse “conflicting statements in the same stretch of conservation, where one statement implies the falsity of the other”, as described by Bortolotti.\textsuperscript{60} On the other hand, expressions may just be confusing so that even though single words, ideas or beliefs were understandable, the whole statement seems impossible to understand. The DSM-IV defines incomprehensible speech and thinking by noting that “words

\textsuperscript{54} The case of Anders Behring Breivik (who was diagnosed with an antisocial personality disorder and a narcissistic personality disorder) leads one to ask whether some values and goals are delusional. See chapter 1.1.
\textsuperscript{55} See, for example, Radden 2011, 34.
\textsuperscript{56} Radden 2011, 12. For the relationship between comprehensibility and meaningfulness, see Radden 2011, 58-77.
\textsuperscript{57} Radden 2011, 62. Radden (2011, 12) also refers to Wittgenstein when she describes the conception of delusions as incomprehensibility: “delusions are not to be understood as explained in terms of reason at all. Rather, they are the brute by-product of a disordered brain – brought about by causes, rather than reasons.” See also Heinimaa (2008), who analyses the concept of incomprehensibility in his thesis, which considers the concept of psychosis.
\textsuperscript{58} In contrast, nonbizarre delusions involve situations that can conceivably occur in real life (e.g., being followed, poisoned, infected, loved at a distance or deceived by one’s spouse or lover). DSM-IV-TR 2000, 324.
\textsuperscript{59} See the DSM-IV-TR (2000, 821), which states: “When a false belief involves a value judgement, it is regarded as a delusion only when the judgement is so extreme as to defy credibility.”
\textsuperscript{60} Bortolotti 2010, 63.
or phrases are joined together without a logical or meaningful connection”. Sometimes this incoherence is referred to as a “word salad”. In epistemology, this viewpoint seems to refer to coherence theory. According to coherence theory, a belief is true or justified if it is in a compatible relationship with other beliefs.

The DSM-IV lists disorganized speech as one possible symptom of schizophrenia. The DSM-IV also mentions flights of ideas as frequent symptoms of manic episodes and notes that it may lead to disorganized and incoherent speech. The person changes from one topic to another, for example, “while talking about a potential business deal to sell computers, a salesman may shift to discussing in minute detail the history of the computer chip, the industrial revolution, or applied mathematics”.

In the philosophy of psychiatry several cases have been discussed where the nature of psychosis as incomprehensibility or incoherence is clear. In one case a patient reported that she was dead and said, when asked, that dead people are motionless and don’t speak. Even though the patient acknowledged that her belief that she was dead was contradicted by her own ability to speak and move, she did not give up the delusion. In another case, a patient claimed, on the one hand, that her husband had died four years ago and, on the other hand, that this same husband was at the time a patient in the same hospital as herself.

However, some psychotic beliefs are not incomprehensible or incoherent. For example, the DSM-IV notes that it is common for people with delusional disorder to give special significance to random events. However, as the DSM-IV puts it, “their interpretation of these events is usually consistent with the content of their delusional beliefs”. It is also worth noticing that incoherence is not only a problem found in psychotic beliefs. Bortolotti points out that ordinary beliefs also fail to satisfy the demands of coherence and claims that such failing is qualitatively similar to cases of delusions.

The third characteristic of irrationality, which describes the nature of psychosis, is called here agential irrationality. According to Bortolotti, one criterion of rational beliefs is that the person can endorse beliefs by offering good reasons in support of their content and by acting in a way which is

51 DSM-IV-TR 2000, 824. See the example of the story of a patient which Iso-Koivisto (2004, 100-101) describes as being saturated by psychotic experience.
54 DSM-IV-TR 2000, 358.
55 See Bortolotti 2010, 64.
57 Bortolotti 2010, 77. Bortolotti writes about procedural rationality but it seems that the content of the term is similar to the content of the term coherence used here.
58 The term agential rationality has been borrowed from Bortolotti.
consistent with and explicable by their content. It has been noticed that people with delusions do not necessarily behave in a way which is in accordance with the content of their delusion.70

Louis A. Sass discusses schizophrenic patients’ tendency to engage in what he calls double-bookkeeping. According to Sass, patients are not mistaking the imaginary for the real. Instead they seem to live in two parallel worlds. One is consensual reality and the other is the “realm of their hallucinations and delusions”.71 Shaun Gallagher suggests that a person with delusions lives in two different kinds of realities, which are inconsistent with each other. A delusional person has an everyday shared reality, where they are able to feel the peculiarity of the delusion. However, they also have a delusional reality, where they are unable to distance themselves from their delusions.72

This tendency to double-bookkeeping, or living in two different kinds of realities, explains why a patient who claims that the nursing staff in a psychiatric hospital are trying to torture and poison them, still happily eat the food they are given. As Gallagher notes, the patient views doctors and nurses as poisoners in their delusional reality at the same time that they, in everyday reality, happily eat the food. This tendency also explains why the person “who asserts that the people around him are phantoms or automatons still interacts with them as if they were real”, as Sass reports when describing one case.73

When it comes to the distinction between psychotic and religious phenomena, Andrew Sims suggests that a person experiencing a religious experience “usually considers that the experience implies some demands upon his own behavior”.74 Perhaps usually, but not, however, always. A person with religious experiences and beliefs may have “two different realities”, an everyday reality and a religious one. For example, a person who believes that God has created him or her may feel that his or her life has no meaning or value. However, these kinds of inconsistencies between beliefs and feelings might be symptoms of agential irrationality, but only seldom are they referred to as psychosis. As Bortolotti notes, it is actually quite ordinary to hold beliefs

69 Bortolotti 2010, 14.
70 Bortolotti 2010, 164-166. See also, Radden 2011, 66-67. According to Bortolotti (2010, 175-178), reason-giving is also part of agential rationality. She defines reason-giving as a subject’s capacity to give good reasons in support of the content of her beliefs. Bortolotti makes a distinction between agential rationality and authorship. Whilst authorship of beliefs applies when the person “is able to endorse the content of her beliefs on the basis of what she takes to be her best reason” (refers to the person’s own reasons whether other people accept them or not), agential rationality requires good reasons in an epistemological sense, which means that other people should, at least to some degree, consider the reasons epistemologically justified.
72 Gallagher 2009, 260.
74 Sims 1997, 80-81.
which do not, however, guide one’s actions. For example, one study revealed that the great majority of students who disapproved of cheating did actually cheat.\textsuperscript{75}

Bortolotti also asks whether failing to act on a delusion should be seen necessarily as a sign that the individual with the delusion is not committed to the content of it. Namely, failures in acting may also reveal something about the person’s motivation. There are also delusions which have no clear “behavioural correlates”. For example, if a person believes that thoughts are being put into their mind from spaces in the air it is not clear how they are expected to act.\textsuperscript{76}

Moreover, in many cases delusions actually do guide an individual’s actions. It is even part of the definition of a delusion that it leads to action, namely, that it has some consequences which are considered negative. Bortolotti points out:

There is a sense in which all clinical delusions are manifested in behaviour: minimally, they are reported and are diagnosed as delusions partially for the negative consequences that follow from the subjects conviction that the content of the delusion is true.\textsuperscript{77}

In order to make a distinction between psychotic and other disordered views of reality, we need to specify that all characteristic of irrationality have to involve a loss of insight in order to be criteria of a psychotic view of reality. Fulford and Radoilska describe psychotic disorders as serious because:

"delusions and related symptoms by which they are defined are in turn characterized by a particularly profound disturbance of rationality called in descriptive psychopathology, ‘loss of insight’.”\textsuperscript{78}

Bill Fulford and Lubomira Radoilska point out that it is crucial for people with psychosis that they “fail to recognize that there is anything (mentally) wrong with them”. Loss of insight distinguishes psychotic disorders, for example, from obsessive-compulsive disorders. A person with psychosis may have, for example, a delusion of guilt if he or she believes without rational reasons that he or she is responsible for war in the Balkans. A person with obsessive-compulsive disorder may, instead, suffer from obsessions of guilt

\textsuperscript{75} Bortolotti 2010, 174. When we come to the area of moral conduct we also face a reality where people do not follow their own rules and fail to act in a way they claim to value. In the Christian tradition, this matter is understood from the viewpoint of the problem of sin. For example, it is written in St. Paul’s letter to Romans (7:15-17): “For that which I do I allow not: for what I would, that do I not; but what I hate, that do I. If then I do that which I would not, I consent unto the law that it is good. Now then it is no more I that do it, but sin that dwellth in me.”

\textsuperscript{76} Bortolotti 2010, 167.

\textsuperscript{77} Bortolotti 2010, 163-166.

\textsuperscript{78} Fulford & Radoilska 2012, 46. See also Bolton & Banner 2012, 87.
combined with compulsive checking if they themselves realize that there is really nothing to feel guilty about “any more than the next man”.  

Referring to all characteristics of irrationality, I suggest that exceptional beliefs and opinions are not psychotic if they are rational enough. For example, a person may have scientific ideas and theories which are not accepted by others. The person with these ideas and theories may suffer from a lack of social support and this may even make them feel unwell. However, they are not psychotic if their beliefs or opinions correspond to reality in the sense that they have proper evidence behind their claims, if they have a belief system which is coherent enough and if they act as if they really believe their ideas. I suppose that dissidents in the USSR who were diagnosed and sent for involuntary treatment had beliefs and opinions which were, in this sense, rational enough.

On the other hand, as I see it, mere irrationality is not sufficient for deciding that some views of reality are psychotic. Other views of reality can be irrational, too. When it comes to religious beliefs, Bortolotti notes:

Any Christian would agree that, in general, if the body of a dead man is not found in the tomb, it is more probable that the body were stolen than that the man resurrected from the dead. But this does not prevent Christians from endorsing the belief that Jesus resurrected from the dead and that his body was not stolen.

On the grounds of her analysis Bortolotti claims that irrationality alone is not the difference between psychotic beliefs (or attitudes) and beliefs which are not psychotic, and I deeply agree with her when she writes:

What makes delusions pathological? Whatever it is, it is not their being irrational, because the irrationality of delusions is not different in kind from the irrationality of everyday beliefs. Delusions are on a continuum with irrational beliefs, and you are likely to find them towards the “very irrational” end of the line, where the degree of irrationality tracks both how much they deviate from norms of rationality for beliefs and how many norms of rationality they deviate from.

Fulford & Radoilska 2012, 47. There may also be, of course, rational reasons for feeling guilty connected with compulsive checking, if the person, for example, fails to carry out his or her moral duties because they are wasting time on compulsive checking. It has also been claimed, for example, by Perkins & Parimala (1993) that insight is an extremely crude and arrogant concept since it requires that a person’s view about their illness follows the ideas of scientific psychiatry, and that other kinds of ways of understanding what is going on are not accepted.

What is rational enough depends on many factors. For further discussion of this, see chapter 2.1.5.

Bortolotti 2010, 121.

Bortolotti 2010, 259-260. Bortolotti (2010, 116) notes, for example, that “we all tend to be too conservative when asked to re-assess strongly held beliefs, and we are unlikely to modify such beliefs, even if convincing evidence against them becomes available. Further, we tend to revise more easily beliefs that are undesirable (e.g. negative beliefs about ourselves) and to maintain more strenuously beliefs that are desirable (e.g. beliefs that contribute positively to our self-image).” Bortolotti (2010, 152) also mentions religious beliefs as “a good example of mental states that play a role in people’s mental economies and influence people’s behaviour, but are not
There is definitely something important in the aspect of irrationality as a criterion of psychosis. It is most discussed in the philosophy of psychiatry and this aspect seems to describe some features of some psychotic interpretations. Moreover, sometimes irrationality is understood itself as a lack of freedom or as a lack of autonomy. For example, Rem B. Edwards defines psychosis as the loss of practical rational autonomy. Thus, the aspect of irrationality is especially important in this study since the link between seeing psychosis as a lack of rationality and freedom of belief and opinion merits further analysis.

Despite these ideas, I actually see the aspect of irrationality as the most questionable of the necessary requirements of psychosis presented in my model. I see it as a difficult and perhaps even impractical criterion for the purpose of making a distinction between psychotic and other exceptional views of reality. It seems that the criterion of irrationality might be theoretically important, but in practice two other aspects, namely, being unwell and alienation are more helpful. Thus, a philosophical discussion concerning psychosis as irrationality should be connected with a discussion of these other aspects.

2.1.3. Psychosis as being unwell

In the history of ideas and in current discussions concerning psychoses it has been argued that the psychotic individual has serious problems in terms of their wellbeing. This view seems to be most visible in discussions concerning the diagnostics and ethics of psychiatry. However, writers who are engaged in more philosophical discussions have also paid increasing attention to this aspect. The DSM-IV refers to the aspect of being unwell when it presents the general and necessary criteria for all mental disorders, namely, “clinically significant impairment or distress”. Thus, according to the DSM-IV, being

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84 It has also been questioned whether psychotic views of reality are irrational at all, by claiming that delusions are rational responses to exceptional experiences. Campbell (2001, 89) presents two different approaches towards the relationship between delusions and rationality. There is the rationalist approach which considers delusion as “a matter of top-down disturbance in some fundamental beliefs of the subject, which may consequently affect experiences and actions”. And there is the empiricist approach which considers delusion as “a rational response to highly unusual experiences that the subject has, perhaps as a result of organic damage”. However, Campbell himself questions the empiricist view.

85 See the DSM-IV-TR, 8. See also the DSM-IV-TR (2000, xxxi), which states that each mental disorder is associated with disability, with a significantly increased risk of suffering death, pain, or an important loss of freedom. Mental disorder is a wider concept than psychosis. However, since psychosis is a mental disorder, it is reasonable to mention this definition.
unwell is a necessary criterion for psychosis. I consider the aspect of being unwell by dividing it in to three characteristics. The characteristic of an unsound mind refers here to the idea that the person’s mind is disintegrated. The characteristic of incapacity includes different kinds of impairments and disabilities, and distress refers to the person’s own negative experience. My suggestion is that in psychotic disorder at least one of these characteristics is present.

The term unsound mind is sometimes used as a synonym for psychosis, especially in older texts. In this context I use the term in order to describe the idea that the psychotic person’s mind or self seems to be “disintegrated” in some way. It might be that since this characteristic is so close to the term psychosis, bringing it up does not shed any light on how to make a distinction between psychotic and other exceptional views of reality. However, some definitions of psychosis seem to lean on this characteristic of being unwell. For example, when the DSM-IV considers the different kinds of definitions of psychosis, it notes that “the term has been defined conceptually as a loss of ego boundaries”. Some studies have attempted to show that unlike in creative and religious states, in psychotic states the person suffers from psychic disintegration.

It seems that the term unsound mind has quite close ties with the term incomprehensibility, which I argued was an characteristic of irrationality. The term unsound mind, understood as disintegration, can be seen as describing the same phenomenon as the terms bizarre and incoherence do. However, when disintegration is discussed the focus seems to be on the evaluation of the person’s inner state, while the terms bizarre and incoherence focus on the way in which beliefs and expressions are visible to outsiders.

I call the second characteristic of the aspect of being unwell incapacity. It has been suggested that the person with psychosis often loses their capacity in several areas of their life. The DSM-IV refers to the characteristic of incapacity when it states that mental disorder may be associated with disability (namely, impairment in one or more important area of functioning) or with a significantly increased risk of suffering death. For example, when the DSM-IV describes the criteria of schizophrenia, it mentions that signs and symptoms such as hallucinations and delusions are associated with marked social or occupational dysfunction.

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86 DSM-IV-TR 2000, 827. One Finnish textbook of psychiatry seems to refer to the idea of a sound mind when it describes mental health as the psychic flexibility and ability to protect oneself from harmful factors in difficult situations. Lehtonen & Lönnqvist 2007, 28.
87 Radden 2011, 106.
88 DSM-IV-TR 2000, xxxi.
89 DSM-IV-TR 2000, 298, 312.
The characteristic of incapacity has also been noted as a criterion of psychosis together with irrationality by many debaters in discussions concerning the philosophy and ethics of psychiatry. For example, McKay et al note that deluded people “have come to hold a particular belief with a degree of firmness that is both utterly unwarranted by the evidence at hand, and jeopardises their day-to-day functioning”. Lisa Bortolotti suggests that irrational beliefs which are not delusions “don’t seem to exhaust the cognitive resources of the subject in the same way that delusions do”. According to Rem B. Edwards, psychosis involves “primarily an extreme and prolonged inability to know and deal in a rational and autonomous way with oneself and one’s social and physical environment”. Derek Bolton and Natalie Banner note that delusions may lead to disability, because “the person with a delusional belief may attempt to act in ways consistent with the belief but the action may fail because he is wrong about the way the world is”. Thus, the person is incapable of performing actions “that result in the intended consequences”.

Sometimes the characteristic of incapacity can be discussed using the terms impairment and a lack of positive outcome or positive effects, as done by Lu et al. Mike Jackson and K.W.M. Fulford also interpret the approach presented in the DSM-classification so that when a distinction is to be made between psychotic and other exceptional views of reality, the focus is on whether the consequences of view are positive or negative.

However, Jackson and Fulford point out that speaking about consequences is problematic because sometimes bad may come out of good experiences and vice versa. For example, “even benign spiritual experiences may lead, through self sacrifice (including martyrdom) for example, to reduced life and/or reproductive expectations”. On the other hand, “a successful computer programmer, for example, may be thankful for a paraplegia which prevented her from vainly pursuing a career as an athlete”.

According to Jackson and Fulford, it is, instead, meaningful to discuss the experiences themselves and ask whether they are empowering:

In the case of of pathological psychotic phenomena, there is a radical failure of action...In the case of spiritual psychotic phenomena, action is radically enhanced.

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90 McKay et al 2005, 315.
91 Borlotti 2010, 260.
93 Bolton & Banner 2012, 87-88.
94 Lu et al 1997, 76.
95 Jackson & Fulford 1997, 50.
96 Jackson & Fulford 1997, 52-54.
97 Jackson & Fulford 1997, 55. They clarify that it is not a matter merely of good or bad outcomes or consequences since “in the case of benign spiritual experiences...the consequences of empowerment were also benign. Good came of the experiences. In the case of malign spiritual
William James seems to consider both the experience itself and the consequences of it meaningful when he states that “it is the character of inner happiness in the thoughts which stamps them as good, or else their consistency with our other opinions and their service-ability for our needs, which makes them pass for true in our esteem”. However, James also notes that inner happiness and service-ability do not always agree.

What immediately feels most “good” is not always most “true”, when measured by the verdict of the rest of experience.  

The question about what role the consequences of the view of reality should play in the diagnosis of psychosis is significant when we consider manic episodes. According to the DSM-IV, one feature of a manic episode is an abnormally and persistently elevated and expansive mood, which is described as “euphoric, unusually good, cheerful, or high”. However, in these cases it is likely that the consequences are painful in spite of the individual’s elevated mood. The DSM-IV describes the consequences of manic episode:

Expansiveness, unwarranted optimism, grandiosity, and poor judgement often lead to an imprudent involvement in pleasurable activities such as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the person, even though these activities are likely to have painful consequences...The individual may purchase many unneeded items (e.g., 20 pairs of shoes, expensive antiques) without the money to pay for them. Unusual sexual behavior may include infidelity or discriminate sexual encounters with strangers. The impairment resulting from the disturbance must be severe enough to cause marked impairment in functioning or to require hospitalization to protect the individual from the negative consequences of actions that result from poor judgement. (e.g., financial losses, illegal activities, loss of employment, assaultive behavior). By definition, the presence of psychotic features during a Manic Episode constitutes marked impairment in functioning.

As I see it, if the consequences of beliefs or opinions are bad for the person’s capacity, they can be counted as a sign of psychosis under the aspect of being unwell. Otherwise, manic episodes could not be diagnosed as psychotic if in terms of wellbeing the experience itself had been “empowering” for the person. Thus, when it comes to incapacity, it seems that we need to consider the consequences, too. We can probably do so without diagnosing too many states as psychotic because there are other necessary criteria, namely irrationality and alienation, which should also be fulfilled before a diagnosis can be decided.

98 experiences the consequences of such empowerment could well be evil.”
99 James 1960, 37.
99 The mood of the individual in a manic episode may also be irritable. DSM-IV-TR 2000, 357.
100 DSM-IV-TR 2000, 358.
However, incapacity is not a necessary or sufficient characteristic of psychosis. The DSM-IV notes that historically functional impairment used to be the central characteristic in the definition of psychosis, but comments that this kind of approach was perhaps too inclusive and termed too many states as psychotic only because there was an incapacity to meet the ordinary demands of life.\textsuperscript{101} It is also noted that a psychotic individual’s capacity varies. For example, the DSM-IV notes that some individuals with delusional disorder are relatively unimpaired in their interpersonal and occupational roles. It is also noted that in general, social and marital functioning are more likely to be impaired than intellectual and occupational functions.\textsuperscript{102} It is also worth noticing that the ICD-10 does not require or emphasize the characteristic of incapacity in the same way that the DSM-IV does. According to Donna Dickenson and Bill Fulford, this feature of the ICD-10 means that, for example, very exceptional religious beliefs which are not associated with a lack of capacity could, at least in principle, be diagnosed as psychotic symptoms.\textsuperscript{103}

The third characteristic of being unwell is called here distress. This characteristic refers to a lack of subjective wellbeing, namely, in the person’s own experience everything is not fine. The DSM-IV lists present distress (e.g. a painful symptom) as one of the possible ways in which being unwell may occur. A “significantly increased risk of suffering death”, which is also mentioned by the DSM-IV, can also be understood as a mark of distress in some situations.\textsuperscript{104}

The characteristic of distress is also noted in the field of the philosophy and the ethics of psychiatry when discussing the nature of psychosis. According to Bortolotti, irrational beliefs which are not delusions seem less distressing than delusions do.\textsuperscript{105} When Edwards presents his definition of psychosis as a loss of practical rational autonomy, he includes the concept “undesirable” into the definition, which implies that some kind of suffering is included in the definition.\textsuperscript{106} Bortolotti refers to the psychologists Taylor and Brown, who claim that holding irrational self-serving beliefs is even a mark of good mental health. The mentally health person is able to distort reality in a direction that enhances self-esteem, maintains beliefs in personal efficacy and promotes optimistic view of the future.\textsuperscript{107} It is worth noticing that if the distress is caused by the delusion, the person involved does not think that there is something wrong with them. Holding a delusion as such is not

\textsuperscript{101} DSM-IV-TR 2000, 297. See also the DSM-IV-TR 2000, 827.
\textsuperscript{102} DSM-IV-TR 2000, 324.
\textsuperscript{103} Dickenson & Fulford 2000, 114.
\textsuperscript{104} See the DSM-IV-TR 2000, xxxi.
\textsuperscript{105} Bortolotti 2010, 260.
\textsuperscript{106} See Edwards 1997, 52.
\textsuperscript{107} Bortolotti 2010, 148. This view suggests that rationality is not a feature of mental health.
distressing, rather it is the ways how reality is perceived by the person with a delusion that is distressing. As Bolton and Banner put it:

As far as we can see, belief – having a belief – is not itself distressing or otherwise. What I believe to be the case may well upset me, be more or less catastrophic so far as I am concerned, but it is the facts in the world that I am upset about, not the fact that I believe it.108

The characteristic of distress also seems to be connected to discussions which focus on the question whether the individual’s experiences are empowering.109 When it comes to the distinction between psychotic and religious experiences, Andrew Sims suggests as one criterion that a religious experience is, unlike psychosis, a “personally enriching life experience”.110 However, some individuals with psychosis may feel fine and they do not suffer, at least not at every moment, during their psychotic episode. People with manic episodes are a good example of this since many of them enjoy an “abnormally and persistently elevated and expansive mood”.111

When it comes to the aspect of being unwell as a whole, the importance of this aspect is particularly clear when a distinction is made between exceptional spiritual beliefs and experiences, and psychotic disorders.112 Jackson and Fulford present, among others, the case of Simon. Simon is a forty-year-old senior black American professional from a middle-class Baptist family. As a response to a crisis at work Simon started praying at a small altar which he had built. During his prayers he discovered that the candle wax had left a “seal” on several pages of his Bible and had covered certain letters and words. Simon understood this to be a very beautiful sign and interpreted this event as a direct communication from God. He started to believe that he had a special mission from God.113

Later on, Simon received a series of revelations, mostly through images left in melted candle wax. For Simon, the images were clearly representations of Biblical symbols. The images signified, for Simon, that he had a special role in God’s plan. He believed that his colleagues were agents

108 Bolton & Banner 2012, 86.
109 See, for example, Jackson & Fulford 1997, 55.
110 Sims 1997, 80.
111 DSM-IV-TR 2000, 357. As I see it, even though the experiences of such individuals might be empowering and even though the person might feel no distress, the individual’s wellbeing cannot be fully separated from the consequences of the experiences if we also want to define manic episodes as psychotic. Therefore, I think it is also important to consider the consequences of the experiences, which I did when I defined the characteristic of incapacity. Thus, a person with psychosis does not necessarily suffer but in that case there are problems in terms of characteristic of capacity or they have an unsound mind.
112 See, Jackson & Fulford 1997, and the articles in the same volume which comment on their considerations.
of Satan and his career successes were evidence of God’s special favour. Simon believed that his mission was to unify true Christianity and true Islam. He carried photos of the images around with him and showed them to others. Most observers were not impressed and the ministers of his own religious community also considered them abnormal. Some of them had been openly suspicious when it came to the supposedly prophetic messages of the revelations. However, Simon consulted a professional “seer” and discussed his life events and decisions with him.\textsuperscript{114} Simon considered the revelations had been beneficial for his life. He claimed that they had encouraged him. He had high self-esteem, firm moral convictions and a strong sense of purpose in life. Moreover, he could work and his career flourished, at least for a year after the first revelations, and he even set up a new charitable institution.\textsuperscript{115}

Even though the way Simon formed his beliefs is in some other respects quite similar to the way psychotic beliefs are formed, Jackson and Fulford consider Simon’s experiences and beliefs as spiritual and they seem to do so because they were beneficial to Simon in the sense that Simon himself considered them to be supportive and benign.\textsuperscript{116} However, from the viewpoint of all the characteristics of being unwell presented in this chapter (including the consequences of experiences to capacity) it can be noted that Simon’s beliefs and experiences seem not to be psychotic.

The Simon’s case also illuminates the fact that other people’s being unwell is not a criterion in diagnosing psychosis.\textsuperscript{117} We don’t know whether Simon’s colleagues knew that Simon believed them to be agents of Satan or how this belief perhaps influenced the relationships and communication between Simon and his colleagues. However, even though Simon’s beliefs might have reduced the wellbeing of the people around him, this would not constitute a reason for diagnosing Simon as psychotic. We meet the same kind of situation when we consider people with narcissistic or antisocial personality disorder. Even though other people may suffer from their personality disorder, the people who cause such suffering are not considered psychotic for this reason.\textsuperscript{118}

\begin{itemize}
\item \textsuperscript{114} Jackson & Fulford 1997, 44-45.
\item \textsuperscript{115} Jackson & Fulford 1997, 46.
\item \textsuperscript{116} However, Jackson and Fulford note that favorable outcomes of experiences are also connected with factors such as preparation (Simon had a religious background which perhaps gave him an ability to make sense of his experiences), guidance (even though Simon’s religious community did not share his interpretations, he had contact with a seer who guided him) and giftedness or sufficient ego-strength to succeed. Jackson & Fulford 1997, 48, 51, 58. When Fulford & Radoilska (2012, 62-65) comment on Simon’s case, they discuss it in the context of non-pathological delusions.
\item \textsuperscript{117} The threat to other people’s health and safety may be one reason why a person with psychosis is prescribed non- or involuntary treatment. However, it is not a reason for diagnosing a person as psychotic.
\item \textsuperscript{118} When it comes to personality disorder, a disordered view of reality is also treated differently than
\end{itemize}
From the viewpoint of this study, it is interesting that being unwell can be seen in terms of a lack of freedom. For example, Fulford and Radoilska consider pathological delusions as “autonomy-impairing”, while non-pathological delusions (such as Simon’s beliefs, according to their point of view) are “autonomy preserving”. A lack of freedom and being unwell are linked, for example, in the DSM-IV’s list of possible features associated with mental disorder. In this context “a significant risk of an important loss of freedom” is listed together with disability and a significant risk of suffering death or pain. Thus, it seems that there is also a need to analyse the relationship between wellbeing (or mental health) and freedom in more depth.

2.1.4. Psychosis as alienation

In discussions concerning diagnostics and the ethics of psychiatry, it has been argued that psychosis signifies alienation or problems in terms of sharedness. Philosophical discussions highlight this from the viewpoint of epistemic community. Even though there are different ways to emphasize the aspect of alienation in psychotic disorder, unlike in the aspect of irrationality and in the aspect of being unwell, there seems to be no need to divide the aspect of alienation in to different kinds of characteristics.

The aspect of alienation refers here to the fact that other people do not share or accept the beliefs and opinions expressed by a person with psychosis. Diagnostic manuals and textbooks of psychiatry imply an aspect of alienation when they notice that mental disorders, psychosis included, occur in an individual. This means that it is not possible to diagnose a family, or for example, an ideological or religious community as a whole as suffering from a mental disorder. Even a shared psychotic disorder is always diagnosed in an individual. The DSM-IV requires in its criteria of a shared psychotic disorder that “a delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion”.

Diagnostic criteria for mental disorders note clearly that psychotic delusions are culturally inappropriate and not shared in the person’s

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in cases where a psychotic view of reality is in question. For considerations about values and their correspondence to reality, see chapter 2.1.2.

See Fulford & Radoilska 2012, 65. Fulford & Radoilska (2012, 66) state, that “effective intentional agency over time is the reference point when defining what goes wrong with delusions”.

See the DSM-IV-TR 2000, xxxi.

See the DSM-IV-TR, 2000, xxxi; Lönqvist & Lehtonen 2007, 14.

According to the DSM-IV, shared delusions occur typically in relationships between two people. However, sometimes a larger number of people share the same delusion. When one of the people is separated from the individual who has the primary delusion, that person’s delusion disappears sooner or later. DSM-IV-TR 2000, 298, 334.

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subculture.123 The DSM-IV includes in its definition of delusion that they are “firmly sustained despite what almost everyone else believes” and that the delusional beliefs are not “accepted by other members of the person’s culture or subculture”. In this definition, articles of religious faith, for example, are excluded from the definition of the delusion.124 The DSM-IV also pays attention to the fact that the delusional status of some beliefs and hallucinative status of some experiences depends on culture:

Ideas that may appear to be delusional in one culture (e.g., sorcery and witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God’s voice.)125

In addition, the way in which some delusions are described as bizarre seems to refer to the unshared nature of psychotic incomprehensibility. According to the DSM-IV, delusions are bizarre “if they are clearly implausible, not understandable, and not derived from ordinary life experiences”.126 Andy Hamilton seems to connect the characteristic of incomprehensibility with alienation by claiming that it is not just that delusions are not accepted by others but that other people do not even understand them.127 It is worth noticing that even though a person might not share their views as such with others they are not necessarily in a state of alienation if other people accept that what is going on is not pathological but, somehow, “normal”. So, even though other people do not have the same beliefs and thoughts as the person, they may share that person’s views by accepting them and understanding them. Thus, alienation does not refer to statistical abnormality but to abnormality as the “disapproval of others”.128 For example, thoughts connected to the process of sorrow are not necessarily shared with others in the sense that other people would have the same thoughts. For example, a person in grief over the death of a near relative may have experiences and beliefs that are similar to hallucinations and delusions. However, other people may accept what is going on. They do not think that

123 See, for example, one category of delusions due to schizophrenia in the ICD-10 (1992 78-79) and the way in which delusions due to delusional disorder are described (ICD-10 1992, 85).
125 Moreover, the DSM-IV continues: “In addition, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures that affects the logical form of verbal presentation.” DSM-IV-TR 2000, 306.
126 DSM-IV-TR 2000, 324. I considered bizarrerie of some delusions in the context of incomprehensibility (one of the characteristic of irrationality) in chapter 2.1.2.
127 Hamilton 2007, 220. To me Hamilton’s claim seems too strict since, it would appear, there are many delusions which are understandable to, but not accepted by, others.
128 See, for example, Edwards (1997, 51) who has noted the difference between disapproving and statistical normality when it comes to the definition of mental illness.
something is wrong with the person or that these experiences and thoughts are 
symptoms of a disorder, even though they might be exceptional.\(^\text{129}\)

The aspect of alienation is mentioned, for example, in the 
discussion concerning the distinction between psychotic and religious beliefs 
and experiences. For example, Andrew Sims notes that “religious experiences 
conform, in very general terms, with the subject’s religious traditions”\(^\text{130}\). 
According to Jennifer Radden, “religious ideas are less likely to be 
categorized as delusional when there is formal religious affiliation, because of 
the supportive social and cognitive frameworks it provides”\(^\text{131}\). Roland 
Littlewood even notes that sometimes “originally” delusions can be 
considered meaningful by other people to such a degree that they turn out to 
be shared beliefs, at least in religious communities. This might happen if a 
person who is already influential has delusions and hallucinations or if this 
influential person is only periodically psychotic and in between episodes his 
or her beliefs and experiences can be interpreted in a shared religious 
reality.\(^\text{132}\) According to Littlewood, “it is the emergent meaning for a 
community which determines whether psychosis becomes prophecy”. 
Psychosis turns into prophecy especially at times of crisis when the world 
seems to be unbalanced: “desperate times need desperate remedies”, as 
Littlewood puts it.\(^\text{133}\) On the other hand, often exceptional spiritual views of 
reality are recognized as psychotic in people’s own religious communities, 
which seems to be the case, for example, in the case of a novice nun who 
believed she was Mary Magdalene:

She was, she said, Mary Magdalene and was trying to do God’s work. She also had ‘all 
this poetry to write’. The nuns who came with her reported that she believed she was

\(^{129}\) It is worth noticing that such experiences and beliefs are restricted to a certain area of life. It is 
also possible that a person facing a life crisis reacts in a psychotic way, in which case other people 
might consider their reaction not be healthy.

\(^{130}\) Sims 1997, 81.

\(^{131}\) Radden 2011, 100.

\(^{132}\) Littlewood 1997, 67-69. Littlewood (1997, 69) points out that “illnesses like schizophrenia, which 
psychiatrist define on the basis of widespread and continuing personality changes with a serious 
loss of social competence, are unlikely to be subsequently integrated in this way. Toxic drug-
induced states, early psychosis, isolated psychotic episodes or phasic reactions like manic-
depressive psychosis, are more amenable to re-entry into the shared world, and thus may serve as 
an experiential model for others.”

\(^{133}\) Littlewood (1997, 71) considers the British anti-psychiatry movement as movement which also 
sought desperate remedies: “if we accept with R.D. Laing that the girl who says she is dangerous 
because she has an atomic bomb inside her is actually “less crazy” than a state which possesses 
nuclear weapons, then this is because we are so concerned about the possibility of nuclear war that 
we broaden our conventional conceptions of rationality of delusion. Doubts as to the value of 
technological course of society in the latter part of the twentieth century have led us to seek 
prophets from among the “ primitives” - from the madmen, the shamans, the children.”
writing a great mystical text but that her poetry, although showing some imaginative ‘flashes’, was rambling and largely incoherent.134

In some cases, the aspect of alienation is connected with a lack of reflectivity in social relationships. In this context, I understand reflectivity as an ability which the person with exceptional experiences and beliefs needs when facing other people who do not share them. In these situations the reflective person is able, to some extent, to distance themselves from their experiences, thoughts and ideas and is able to take other people into account. On the one hand, the person is able to be considerate and, on the other hand, the person is able to discuss their experiences and ideas with others in an empathic way.

Sims seems to suggest in his practical checklist for distinguishing between religious experiences and psychotic phenomena that the ability to be reflective refers to religious experience. According to Sims, it is suggestive of a religious experience:

1) that the person shows some degree of reticence to discuss the experience, especially with those he believes to be unsympathetic; 2) that the experience is described afterwards unemotionally, with matter of fact conviction, and appears “authentic”; 3) that the person understands, allows for and even sympathizes with the incredulity of others135.

Thus, it seems that a lack of these abilities might suggest that one should considered further whether it is a psychotic phenomena. However, a psychotic person may also be reflective in the sense described here and yet a lack of reflectivity does not as such mean that the person with exceptional experiences and beliefs is psychotic.

The aspect of alienation is deeply connected with epistemology and, thus, with the aspect of irrationality. This is clear, for example, in such expressions as “common sense”. According to Kant, whose conception of “objectivity”, correct judgement and sound understanding was based on intersubjective agreement, “madmen” were trapped by a merely subjective understanding because there had been a failure to check if their views were shared by others.136 Jennifer Radden considers delusions from the viewpoint of commonality:

With some bizarre and extreme delusions, the usual way of reasoning about ideas has been lost...Everyday assumptions point to the psychotic’s failure as a failure of commonality with the world of other perceivers and language users.137

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134 Fulford & Radoilska 2012, 57.
135 Sims 1997, 80.
136 Radden 2011, 8.
137 Radden refers in this context to Wittgenstein’s conception about language and writes: “he insists that an idiosyncratic “private language” could not be a proper language. Meaning and significance are tied to how words are used, and such use occurs within some linguistic community.” Radden 2011, 70. Wittgenstein’s idea about a language game can also be applied in evaluating the meaning.
Louis A. Sass argues that a subject with delusions refers by their experience to the private world when they report delusional states and do not engage with the real world.\textsuperscript{138} John Rhodes and Richard Gipps claim that delusions are recognized as delusions because they conflict with other people’s bedrock certainties. By this they mean that delusional people have a different foundation for their belief system compared to other people in the community. This is what makes communicating and understanding impossible.\textsuperscript{139} According to Lisa Bortolotti, beliefs which are less common are often considered puzzling and pathological. However, Bortolotti claims that just because a belief is does not mean that it is pathological. Any puzzlement there might be is, instead, the effect of the fact that the belief in question is more uncommon than other irrational beliefs.\textsuperscript{140}

It is possible to describe alienation from the viewpoint of “otherness”, in which case there is a critical attitude towards society, and the psychotic person is seen as a victim. However, otherness seems not to be a distinctive characteristic of alienation but more like a different kind of way of understanding the processes which are behind the phenomenon of alienation. According to this point of view, the community uses psychiatry in order to control and ignore phenomena and people who are considered deviant or dangerous.\textsuperscript{141} It has been claimed that psychotic individuals are identified with moral and social qualities that are not valued and that they have been described in a stereotypical way.\textsuperscript{142} Madness has been seen as the antithesis of what is valued and found sensible and even human.\textsuperscript{143} For example, Michel Foucault thinks it problematic that reasonableness and madness are separated from each other so that there is no longer a dialog between them. Foucault claims that in the modern world people no longer communicate with mentally ill people but have handed them over to psychiatrists. For their part, people

\begin{footnotesize}
of spiritual beliefs. Radden (2011, 97-98) notices that without understanding the “local” rules of the game (“theology”), it is impossible to know whether some spiritual claim should be understood, for example, as metaphorical.\textsuperscript{138} Sass, according to Bortolotti 2010, 118. Here Sass claims that the aspect of alienation is knitted with the characteristic of “not corresponding with a reality” (one characteristic of irrationality) since the “real world” is understood as shared and the psychotic (“unreal”) world is defined as private.\textsuperscript{139} Rhodes & Gipps 2008, 297-299. See also Bortolotti (2010, 194-197), who sees the threat that speaking about bedrock certainties which are not shared may lead to the view that delusional beliefs are radically discontinuous from false and irrational beliefs. Bortolotti points out that people with delusions still believe many things which other people also believe. Therefore it is questionable whether delusional beliefs are fundamental “framework beliefs”.\textsuperscript{140} Bortolotti 2010, 260.\textsuperscript{141} See Fulford, Thorton & Graham 2006, 17.\textsuperscript{142} Radden (2011, 14) refers, for example to the description by Du Laurens: “you’ll find nothing human there: he bites, he screams, he bellows with a savage voice, rolls burning eyes, his hair stands on end, he throws himself about and often kills himself so”.\textsuperscript{143} Radden 2011, 2, 14-15.
\end{footnotesize}
with mental illness communicate with society only through intermediaries that are considered reasonable. Thus, psychiatry is a monologue by reason about madness. According to Foucault, reason has subjugated that element of truth which lies in non-reason.\textsuperscript{144}

The view which emphasizes that alienation is a necessary aspect of psychosis can be questioned by the claim that psychotic disorder can also be shared in a community. For example, according to Andy Hamilton, culture-wide delusions are not necessarily impossible:

Collective hallucinations have resulted in collective delusion, for instance when troops in battle report that angels appeared from the clouds and fought on their side.\textsuperscript{145}

Jennifer Radden suggests that some delusions are even the results of a process in which the deluded person is influenced by groups of people. She writes about ideas which spread like contagions.\textsuperscript{146} However, it seems that this approach is somewhat different to that found in definitions in psychiatric diagnostic manuals concerning shared delusion disorder. While Radden also considers spreading of ideas, diagnostic manuals require that the person with shared delusion disorder is closely connected to the person with the primary delusion. It seems that the diagnostic criteria avoid any suggestion that some widely shared beliefs could be defined as delusions.\textsuperscript{147} It is interesting that the DSM-IV does not even admit the possibility that shared delusions could occur in individuals who live in the same ideological community. The examples of shared delusions given in the DSM-IV refer to families, but nothing is said about, for example, close religious groups.\textsuperscript{148} It is also worth noting that in the age of the Internet it is quite possible to find people in some other part of the world who share very imaginative views about the world and accept exceptional ideas that seem to be, however, psychotic.

\begin{footnotes}
\footnote{Foucault 2005, xi-xiv.}
\footnote{Hamilton 2007, 220.}
\footnote{Radden 2011, 79.}
\footnote{Compare Radden 2011, 78-93 and the DSM-IV-TR 2000, 332-334. To use the word delusion when the spreading of ideas and beliefs are described is one way that so-called neo-atheistic critics approach religions. For example, Dawkins (2007, 26-28), speaks about “god delusion”, claims that atheism nearly always indicates a healthy mind and refers to Robert M. Pirsig who states “When one person suffers from a delusion, it is called insanity. When many people suffer from a delusion it is called Religion”.}
\footnote{If the criteria of shared delusional disorder were to be applied to close religious groups, it would be argued that if a member was separated from the community his or her beliefs – if they were delusions – would disappear sooner or later. See the DSM-IV-TR 2000, 298, 334. However, there would have to be strong indications of shared delusional disorder before it would be justified to separate someone from their religious group. Moreover, even though the beliefs of the separated individual might change, this does not necessarily mean there was a shared delusion. One explanation might be that without the support of his or her religious community and without the teachings of the religious leader the member just lost his or her faith, especially, if this happens rather “later” than “sooner”.}
\end{footnotes}
In spite of these challenges, I consider the aspect of alienation as a necessary criterion of psychosis. If it was not a necessary criterion of psychosis, a Christian, for example, who, on the one hand, believes that Jesus was resurrected from the dead (which Bortolotti describes as an irrational belief\(^{49}\)) and, on the other hand, is really distressed by the possibility of ending up in hell (so, this person suffers), might be diagnosed as psychotic. I suppose that ultimately shared beliefs which mostly cause suffering and incapacity cannot exist. They just cannot survive. However, people who share their beliefs with others may have as individuals problems, or they may go through a spiritual process, which reduce their capacity or result in them suffering. They may need spiritual counselling but it would be a sign of overmedicalization if they were diagnosed as psychotic. Therefore, I consider alienation as an important criterion of psychosis. However, the borders of sharedness should be discussed further in order to understand better what is defined as alienation and what is not. I will consider the relationship between shared delusions and manipulation or brainwashing in chapter 4.2.3.

The importance of the role of sharedness can be seen, for example, in a case concerning an exorcism-resistant ghost possession reported by Anthony Hale and Narsimha Pinninti.\(^{150}\) They had a patient who was a 22-year-old unemployed Hindu Indian male. He had lived in Britain with his family since the age of six. Recently, he had committed several crimes and had ended up in prison. However, the patient claimed that he had committed the crimes because he was under the control of a ghost. He said that his problems with the ghost had started when he was eleven. His aunt, who was jealous of the success of his family, gave him cursed rice to eat. The patient said that the ghost of an old woman possessed him, took control of his body and voice, and rendered him powerless while it made him do wicked things. The patient said that a fog, which he saw drifting towards him, was a warning of imminent possession. After that the ghost entered him through his nose and mouth. The patient said that he felt fear, anger and guilt during the possession.\(^{151}\)

The parents of the patient had consulted local religious leaders and finally had sent him to holy places in India where he was exorcised by a Hindu priest. Later the patient had also asked for help from the Muslim peer and finally from a Christian priest. The psychiatrists who wrote the article treated the patient as psychotic but were disturbed by a telephone call from the prison chaplain. The chaplain had not believed before that it could be a real possession in question but now he had seen a possession by a ghost with his own eyes. He had seen a cloud and the face of a dead woman and he got the

\(^{49}\) See Bortolotti 2010, 121.

\(^{150}\) Hale & Pinninti 1994.

\(^{151}\) Hale & Pinninti 1994, 386-387.
impression that this was the woman that the patient had told him about. The
chaplain said that similar reports had been received from frightened cellmates.
Since the belief concerning ghost possession was now quite widely shared
with others, the writers of the article now questioned whether it was a
psychotic disorder. However, since exorcism had not been helpful, they
continued the treatment with medication, which seemed to help the patient.\textsuperscript{152}
Hale and Pinninti come to quite interesting conclusions where they try to
combine a culturally sensitive approach towards ghosts with western
psychiatry. Their claim is that antipsychotic medication may relieve symptoms
of exorcism-resistant possession.\textsuperscript{153}

In Antti Pakaslahti’s comments on the case, he notes more
information is necessary. There is much about the case that we don’t know.
Hale and Pinninti describe the possessions by leaning on the reports of the
patient and the chaplain. However, it is unclear whether the patient’s family
shared the patient’s view about the existence of the ghost, although the way
they sought spiritual help and did not turn to western psychiatry gives the
impression that they believed that there was a ghostly possession. Pakaslahti
also pays attention to the fact that Hale and Pinninti do not define possession
even though the term has different kinds of meanings in different cultures.
Moreover, Pakaslahti notices that the patient was capable of studying and
living independently and could arrange the pilgrim to India which implies that
there was not a serious lack of capacity as is usually the case, for example,
with schizophrenia.\textsuperscript{154} However, since the patient was suffering, there was a
problem in the aspect of wellbeing, and thus, the criteria of psychotic disorder
would have been clearly fulfilled if the patient’s view of reality had not been
shared. However, the aspect of alienation is not a sufficient condition of a
psychotic view of reality, as we saw in the case of Simon presented in the
previous chapter. So called irrational and unshared views of reality are not
psychotic if the person has no serious failures in the aspect of wellbeing.

There seems to be a certain tension between alienation and the
freedom of belief and opinion. Unlike irrationality and being unwell, which
have been seen as as a lack of freedom, the aspect of alienation seems to
demand freedom of belief and opinion. There is a special need for freedom of
belief and opinion especially when the individual’s view of reality is not
shared in the community. At the same time, it is the community which
determines the borders of these rights, and the aspect of alienation as a
necessary criteria of psychosis is actually used as one argument when borders
of the freedom of belief and opinion are drawn. Given the tension between
alienation and freedom of belief and opinion, we face the power of the
\textsuperscript{152} Hale & Pinninti 1994, 387.
\textsuperscript{153} Hale & Pinninti 1994, 388.
\textsuperscript{154} Pakaslahti 2006, 48-51.
community as the fundamental border drawer. Even though the purpose of the freedom of belief and opinion is to protect individuals with exceptional views of reality, in the last resort, it is other people who accept some individuals with certain exceptional views as people worth protecting and ignore other individuals with some other, less acceptable exceptional views of reality.

2.1.5. Values-based definition of psychosis on a continuum with other kinds of views of reality

The purpose of this study is not to present my own definition of psychosis. However, we need to have an idea about whose freedom of belief and opinion will be analysed here. Therefore I have brought together the aspects of irrationality, being unwell and alienation in order to have a hypothetical model of psychosis for my study. The model which I have created on the grounds of the analysed material suggests that psychosis occurs as serious irrationality (with loss of insight), as being seriously unwell and as serious alienation, while other exceptional views of reality are restricted to one or two of these aspects. This is to say that each of the aspects of irrationality, being unwell and alienation are necessary but that none of them alone is a sufficient condition for diagnosing a psychotic view of reality. However, manifestation of some characteristic of each aspect is enough for that aspect to be regarded as present – the person need not manifest all the characteristics of all the aspects. For example, a person fails to be rational if he or she is agentially irrational even though there might not be serious failures in the other characteristics of corresponding to reality and incomprehensibility. The following picture presents this model of psychosis:

<table>
<thead>
<tr>
<th>Irrationality (with loss of insight)</th>
<th>AND</th>
<th>Being unwell</th>
<th>AND</th>
<th>Alienation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-corresponding to reality OR/AND</td>
<td></td>
<td>Unsound mind OR/AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomprehensibility OR/AND</td>
<td></td>
<td>Incapacity OR/AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agential irrationality</td>
<td></td>
<td>Distress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This model may have some limitations. I have already considered the problems and challenges presented by the aspects of irrationality, being unwell and alienation in chapters 2.1.2., 2.1.3. and 2.1.4. However, when these aspects are brought together, as I have done, more problems occur. Namely, my suggestion draws borders between irrationality, being unwell and alienation which might be regarded as too artificial. I am aware that all of the described aspects are in relation with each other. The aspect of irrationality and being unwell are connected since psychological well-being seems to require rationality, at least in some degree. Moreover, as Derek Bolton and Natalie Banner note, a person with delusions is incapable of performing actions that result in the intended consequences if that person has an incorrect view about the way the world is. The aspects of irrationality and alienation also have common areas. If a person fails seriously in terms of rationality, it is unlikely that other people share their beliefs and it is likely that the person is seen as an “other”. Discussions concerning common sense and epistemic community seem to refer to the idea that rationality is connected with shared ideas. The aspect of being unwell and the aspect of alienation overlap, as well. If a person cannot share his or her ideas with anybody it is questionable if he or she is able to preserve capacity. Moreover, what is considered “agential success”, as Bill Fulford and Lubomira Radoilska call it, depends on what outsiders consider desirable, at least if agential success is understood in conventional terms:

To put it crudely, an agent is successful on this view in so far as he or she manages to secure the kind of goods that are generally considered as enviable by his or her society or social group.156

Bolton and Banner describe it, as follows:

The person with delusional beliefs is also disabled from the point of view of other people, insofar as acting in accord with those beliefs is incompatible with behaviour we normally expect, such as giving priority to self-care, shopping and eating, conversation, and so on.157

Because the different aspects overlap, the distinction between them is quite theoretical. In practice it may be difficult or even impossible to find cases where a person fails seriously in any two aspects without failing seriously in the third aspect, too. For example, even though in the case of

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156 Fulford & Radoilska 2012, 66-67. Fulford & Radoilska also present two other options for understanding agential success. In a particularist interpretation, the focus is on the goals which the agent endorses. A universalist interpretation takes into account both “an agent’s plan brought to fruition” and “the plan itself”, which “has to be worth undertaking in a sense that cannot be fully reduced to the agent’s endorsement”. Fulford & Radoilska see all interpretations as problematic. For more details, see Fulford & Radoilska 2012, 66-70.
Simon it was emphasized that he did not have serious failures in wellbeing it has to be noted that he actually had a relationship with a professional peer, which shows that he did not totally manifest the aspect of alienation, either. When it comes to the case of the exorcism-resistant ghost possession, we need to take into account Pakaslahti’s notion: the patient, actually, had the capacity to study and live independently, which suggests that his failures in the area of wellbeing were not perhaps very serious, even though he was suffering.

The complexity of the model which I have suggested also becomes clear in the following questions and considerations. For example, what if Simon had some mental disorder like anxiety disorder or depression, which was not a psychotic disorder but would still influence his well-being? Is it likely that he would have still avoided being diagnosed as having a psychotic disorder? How is it possible to make a distinction between a depressed person who has exceptional spiritual experiences and a person with psychosis? How so we know whether being unwell is connected to psychotic disorder or whether it is connected to some other factors in the person’s mental health or life situation? Or, if we think about political dissidents who probably may have suffered and been incapable in many areas of life in a situation where their ideology was seen as a threat to the community: How is it possible to evaluate whether their ideology is rational enough if we do not share their views?158 Or, if we are faced with a genius, how able are we to evaluate their rationality if we are not geniuses ourselves? For example, how could an outsider evaluate the ideas of John Nash,159 which, ultimately, turned out to be delusions?160

It is also worth noting that since everyone fails to some degree concerning the aspects of rationality,161 wellbeing and sharedness, we should speak, on the one hand, about a sufficient degree of rationality, wellbeing and sharedness and, on the other hand, about serious failures in these areas. Thus, we face the problem of where to draw the border between sufficient and insufficient and serious and not serious.

Serious failures in the area of some aspect requires, at least, that these failures are significant both in duration and the severity of

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158 See also Fulford & Radoilska (2012, 67) who point out the threats of conventionalist understanding of agential success by noting that it “may offer a platform for the resentment of majorities by inadvertently allowing them to discredit unpopular conceptions of the good and penalize dissenters”. They mention political dissidents of former USSR who were diagnosed with mental disorder as examples of this.

159 About John Nash, see for example, Wikipedia: John Forbes Nash, Jr.

160 My thanks to Ville Päävänsoalo, who pointed out the problem of evaluating the rationality of beliefs of geniuses.

161 See, for example, Radden (2011, xiv), who notices that normal reasoners and rational agents are imperfect reasoners and rational agents. She writes: “They are prone to any number of reasoning biases, for example, engendering flawed judgement”.

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impairment. Exceptional views of reality also need to cover sufficiently large areas of the person’s life and they have to be significant for the person. If the person believes, for example (the example is purely theoretical), that one flower pot in his window is green even though other people see that it is black, the belief is bounded so narrowly and the connections with other and usually more meaningful areas of life are so narrow that serious failures in the area of rationality cannot usually occur. To be defined as psychotic requires that such failures are quite holistic. Andrew Sims refers to this characteristic in his practical checklist for making a distinction between religious experiences and psychotic phenomena, by suggesting that when psychosis is involved there are “other recognizable symptoms of mental illness in other areas of life; other delusions, hallucinations, disturbance of mood, thought disorder and so on”.163

When the border between a psychotic view of reality and other exceptional views of reality is drawn the difficult challenge is that there are different ways to be psychotic, and the nature of delusions varies, as well.164 Radden notices that delusions differ to each other in several ways, and presents a list:

- their degree of congruence with the patient’s other beliefs, actions, moods and attitudes;
- relative complexity of the themes involved; their duration – as fleeting thoughts, long-lived, enduring convictions, or recurrent and episodic belief states; and, finally, their apparent origin, as endogenous, or the result of social contact.165

Therefore, it is impossible to make conclusions about the nature of psychosis in the light of one, two or three cases. Moreover, since in some cases the person with psychosis does not manifest delusions at all, or at least delusions are not recognized to be present, the gamut of psychoses is even wider than the gamut of delusions, and I am not sure how well my model covers the nature of psychoses without delusions.166

When we look at other exceptional views of reality, which are not, however, defined as psychotic, we must admit that they vary, as well. In addition, the person may exhibit more than one exceptional view of reality. It

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162 See Edwards 1997, 54. Diagnostic manuals also require a certain duration before a diagnosis can be given.
163 Sims 1997, 80.
164 See Radden 2011, 18, 35-36.
165 Radden 2011, 18.
166 See chapter 2.1.1. The aspect of rationality in particular is difficult here. In cases where a patient has negative symptoms and catatonic behaviour (which are held to be symptoms in the DSM-IV when diagnosing schizophrenia) and, for example, does not express their beliefs verbally, it might be difficult to say whether their behaviour is rational. However, the patient may not manifest much rationality either, at least not so that other people understand the message and share his or her view, whatever it may be. In the DSM-V the problem seems to be milder since in cases where delusions and hallucinations are absent, disorganized speech is a necessary criteria for diagnosing schizophrenia, and disorganized speech seems to indicate irrationality. Compare the DSM-IV-TR 2000, 312 with the DSM-V 2013, 99.
is also important to notice that even though a person is psychotic they may still have exceptional experiences and beliefs which are not, however, psychotic. Even though a dissident might suffer from psychosis, this does not mean that their ideology as such is delusional. Or, the person with psychosis may have exceptional spiritual experiences which are, however, “healthy”.

One explanation for why it is so difficult to make a clear conceptual distinction between psychotic and other exceptional views of reality is that there is no definition for psychosis which covers what psychosis is about. Markus Heinimaa claims that “psychosis is a psychiatric ‘primitive’, not amenable to an exhaustive definition in more elementary psychiatric concepts”.  

I am aware that ultimately we may not be able to say what psychosis is about. We may get close by using certain definitions and descriptions but the final nature of psychosis might be impossible to define or describe. In spite of that, I think that we need some kind of definition of psychosis. Even though it might not be possible to define psychosis completely, I think we should seek a definition which is as good as possible. Since psychosis is required before an adult person with normal or high intelligence can be prescribed involuntary or nonvoluntary psychiatric treatment, it should be possible to discuss this diagnosis with the help of some concepts. A definition is needed for the sake of the legal protection of both patients and psychiatrists and for public discussions concerning psychiatry, psychiatric treatment and the ethics of psychiatry. The definition must also be useful and understandable outside the psychiatric context for use in multidisciplinary research, as well. Therefore, although there are problems with my hypothetical model, I think it serves its purpose.

My hypothetical model has certain benefits which makes it relevant and useful for my study. Firstly, the model takes into account many different kinds of views concerning psychosis and, therefore, I consider it suitable for a multidisciplinary study. I want to utilize a model which is understandable for people who come from and work in different fields. Secondly, I hope that it is possible to communicate the basic idea of the model to people who do not have an academic education in psychiatry or philosophy. This is especially important because I wish that as many people as possible who use mental health services or who have been treated as psychotic will be able to understand the model and discuss it. Thirdly, the model is quite inclusive and open for further development, which means that characteristics which are not mentioned in my version can be added to it, at least if they fit some of the aspects of irrationality, being unwell or alienation. This model is also compatible with definitions presented in official manuals for psychiatric

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168 There are also debates about whether psychosis “exists” at all.
diagnostics, since features of each aspect are mentioned in such manuals. Fourthly, it seems to me that a model that emphasizes several aspects will be more successful in defining psychosis than definitions which emphasize, for example, just one aspect or characteristic. At the same time, while my model includes many different definitions of psychosis and considers them relevant, it also emphasizes other aspects. For example, I believe that the aspect of irrationality is relevant and meaningful in defining psychosis. However, I do not believe, that the aspect of irrationality alone is able to describe psychosis as satisfactorily as a model where other aspects (being unwell and alienation) are also emphasized.\(^\text{169}\)

When definitions of psychosis are discussed and when the distinction between psychosis and other kinds of states is debated, there are two different kinds of “meta-conceptions” of how psychosis relates to other states. According to the categorical model, psychosis is a categorically different state than other states. According to the continuum model, the difference between a psychotic state and other states is a question of degree.\(^\text{170}\) With my model I come out for the continuum model of psychosis.

Which model is chosen seems to influence the way in which the distinction between psychotic and other views of reality is thought about and what kinds of differences between them are looked for. If one accepts the categorical model, the “grey areas” between psychotic and other exceptional views of reality challenge us to make a stricter analysis which helps us to

\(^{169}\) It seems to me that the aspect of irrationality is, actually, the most questionable of the aspects presented in my model. It is easy to find examples which show that the aspects of being unwell and alienation are central when psychosis is defined. The reason for that might be that these aspects are clearly apparent in discussions concerning psychiatric diagnostics and the ethics of psychiatry. They are also easier to evaluate. Evaluating rationality or irrationality is more philosophical and is therefore a more difficult task for people who make distinctions in practice. It might be easy to claim that some kind of view of reality is irrational but it is far more difficult to explain why it is so. Still, I assume that the aspect of irrationality (with loss of insight) is important when the distinction is made between psychotic and other exceptional views of reality (in particular between psychosis and other mental disorders). However, it cannot be emphasized alone without taking the aspects of being unwell and alienation into account and without emphasizing the role of other aspects as much as the role of irrationality. The problem in philosophical discussion seems to be that the aspect of rationality is emphasized separately from other important aspects. As I see it, this leads to problems since not all irrationality is psychotic. So-called normal thinking and believing may also be irrational. Therefore, other aspects are also fundamentally important when psychosis is defined.

\(^{170}\) Radden 2011, 40-44. Bortolotti (2010, 259) seems to give some support to the continuum model at least in the area of rationality (as she understands the content of rationality) since she claims that “there is considerable continuity between delusions and beliefs”. Moreover, she writes: “For each delusion, I’ll give you a belief that matches the type if not the degree of irrationality of the delusion”. (In Bortolotti’s text the concept of belief refers to beliefs which are not delusional ones).
place these views in the right category. If one accepts the continuum model, certain unclearnesses and the existence of “grey areas” are acceptable.  

I am aware that values play a central role in the model that I have presented. We face the value of wellbeing and discuss what is accepted by others. Moreover, the idea that there should be an insight into illness “requires accepting certain normative ideals of health”, as Jules Holroyd puts it, and “offers an extremely limited index of the way a person understands their distress and disturbance”, as Perkins and Parimala note. Some debaters in psychiatry see values as a problem. For example, George Vaillant seems to consider descriptive psychiatry as relatively successful in avoiding value judgements when it defines psychosis. According to Peter Jepsen, only the biomedical model offers value-neutral concepts of health and disease when mental health problems are discussed. In these discussions, values are seen as a problem in psychiatry and creating a value-neutral system is understood as a goal which would also ensure the scientific status of psychiatry.

However, I don’t see this value-ladenness as a problem. Instead, I think it is important to admit the role of values in the definitions and models which define psychosis or other mental disorders. We cannot escape values in psychiatry and, therefore, we should not even try to do so. We should, instead, acknowledge the meaning of values. With this notion I join the tradition of philosophy of psychiatry which has been called values-based practice. Fulford et al acknowledge that the value-ladenness of the diagnosis of psychotic disorder may seem to be a danger when the issue is looked at from the viewpoint of the traditional medical model:

From the perspective of the traditional science-based ‘medical’ model, the claim that values are important in diagnosis as well as treatment, may seem to involve a radical,

\begin{footnotesize}
\begin{enumerate}
\item Values play a significant (though not necessarily acknowledged) role in both models. However, if the categorical model is chosen the meaning of values may sometimes be forgotten once the different categories have been created, if they are taken as self-evident and value-neutral. In the continuum model, the meaning of values might be easier to acknowledge because the existence of grey areas reminds us that diagnoses are value-laden.
\item Holroyd 2012, 152, 159; Perkins & Parimala 1993, 233.
\item According to Vaillant, defining mental illness is relatively value free when compared to defining mental health: “Mental illness, after all, is a condition that can be reliably defined, and its limits are relatively clear. In contrast, mental health seems to lie more in the domain of value judgement than of science. For example, mental illness can be defined as the presence of selected symptoms, but mental health is something more than the absence of symptoms.” Vaillant 2003, 1373.
\item Jepsen 2011. See also Jepsen according to von Troil 2012, 15. In the discussion followed by the lecture Jepsen admitted that the bio-medical model is not perhaps completely value-neutral but since the other models are even more value-based they are worse than the bio-medical model.
\item About values-based practice, see, for example, Fulford, Thornton & Graham 2006, 585-608. About values and psychiatric diagnosis, see Sadler 2005. See also von Wright (1963, 41-62), who considers medical goodness and the concepts of health and illness as varieties of goodness.
\end{enumerate}
\end{footnotesize}
even subversive, departure from the aspirations to scientific ‘objectivity’ on which the
authority of health-care professionals has traditionally been taken to rest.\textsuperscript{176}

According to Fulford et al, the traditional medical model considers
diagnosis as purely scientific, which means that both the classification of the
diagnosis and the diagnosis process are understood as value-free. Freedom
from values is also demanded from them. Even though it might be admitted
that there are ethical questions in medicine, those questions are kept outside
the process of diagnosis. However, Fulford et al claim that this kind of
approach towards diagnosis is untenable, since diagnosis is unavoidably
value-laden even when it is properly grounded on facts. Psychiatric diagnosis
is based on both science and ethics. The value-ladenness of diagnosis is,
according to Fulford et al, a radical conclusion from the viewpoint of the
traditional medical model.\textsuperscript{177} When it comes to the bio-medical model which,
for example, according to Jepsen, defines psychosis in a (relatively) value-free
way, Fulford et al argue:

all human experience and behaviour must have a basis ‘in the brain’. Yet all too often the
discovery of a brain basis for some particular characteristic of experience or behaviour is
taken to be equivalent to proving that it is a disease...The spectacle of barristers waving
brain scans around in court to prove that their client was ‘not responsible’ is more and
more a reality.\textsuperscript{178}

Moreover, as Fulford et al notice, brain imaging research cannot distinguish
between people who have a psychotic disorder and people who have certain
kinds of spiritual experiences. Thus, when neurologically psychotic
experiences arise in normal and non-pathological contexts, it seems, that it
would be consistent from the viewpoint of the medical model to diagnose
these experiences as illnesses together with schizophrenia and other forms of
psychosis.\textsuperscript{179}

According to Fulford et al, the approach that invokes neurological
or biological “evidence” to avoid value-ladenness, has two presuppositions.
Firstly, mental illness is perceived as a problem, and, secondly, physical
illness is not. Therefore, if physical evidence is found of mental illness, it
becomes more like physical illness and turns out to be less problematic or
completely unproblematic. Mental illness becomes a brain disease.\textsuperscript{180}

\textsuperscript{176} Fulford, Thorton & Graham 2006, 565.
\textsuperscript{177} Fulford, Thorton & Graham 2006, 565, 571. Fulford et al (see 2006, 571-578) consider possible
arguments against their value-laden model of diagnosis but find them unconvincing.
\textsuperscript{178} Fulford, Thorton & Graham 2006, 575.
\textsuperscript{179} Fulford, Thorton, & Graham 2006, 600.
\textsuperscript{180} Fulford et al notice this kind of presupposition in the thinking of Szasz, Kendell and Reich. Even
though they disagree with each other about mental disorders’ status as diseases, they agree about
the arguments concerning why some forms of mental illness would be regarded as a disease and
others not. Reich, for example, who criticized psychiatric abuse in the Soviet Union, suggests that
more objective diagnostic criteria would solve the problems concerning abuse. He thinks that
According to Fulford et al, all medical diagnoses are value-laden. However, the value-ladenness of psychiatric diagnosis is more obvious and also more problematic than that of other medical diagnoses, because psychiatry is concerned with areas of life where individuals’ values differ from each other more. People usually agree more about values concerning other medical diagnosis than psychiatric ones. If the variety of values connected to psychiatric diagnosis is not admitted, there is, according to Fulford et al, a danger that abuse will occur in the form of imposing values: one group’s or individual’s values are imposed on another’s.

Fulford et al have noticed that the value-ladenness of psychiatry has been seen as a negative thing, which questions the justification of an entire branch of medicine. They disagree, however, with this approach and claim instead that acknowledging the value-ladenness of psychiatry is the starting point for a more positive approach in psychiatry: it challenges psychiatry to work with values. They believe that acknowledging the role of values in psychiatry protects from abuse. According to them, misdiagnosis is not as great a danger as the inability to realise the presence of values in all diagnostic practice.

To sum up, I have presented in this chapter that a view of reality is psychotic if it is seriously irrational (with loss of insight), occurs with being seriously unwell and is unshared by other people. I will utilize in my study this values-based definition of psychosis, which is on a continuum with other kinds of views of reality.

### 2.2. Delusions as beliefs, thoughts and opinions

Making a distinction between psychotic and other exceptional views of reality is fundamental when it comes to questions concerning a psychotic individual’s

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better science would solve the ethical problems of psychiatry. Fulford et al call this kind of approach a fact-only-model and suggest that a fact+value-model would be better. They note, for example, that the problem in the Soviet Union was not the diagnostic criteria, since at the same time in the west broad if not broader criteria for schizophrenia were used. Fulford, Thorton & Graham 2006, 588-591.

Fulford, Thorton & Graham 2006, 577-578. In Finnish discussions, Laitinen (1996, 19-20) has pointed out, on the one hand, that in psychiatry the main interest of clinical research are mental processes like thoughts, feelings, desires, motives and so on while in somatic medicine the interest is in biological mechanisms and physiological relations between organic systems. On the other hand, in psychiatry the way in which the patient expresses their mental processes also depends on the person who is evaluating these processes and the relationship between the patients and the evaluator.

Fulford, Thorton & Graham 2006, 578.

Fulford, Thorton & Graham 2006, 586.

Fulford, Thorton & Graham 2006, 601.
freedom of belief and opinion. By making this distinction, we define which condition and thus which individual challenges us to seek a tenable view of freedom of belief and opinion in this study. I have answered this question in chapter 2.1.

The other question is, how freedom of belief and opinion is understood as a psychotic individual’s right. Acknowledging on the grounds of my analysis presented in chapter 2.1. that the border between psychotic and other exceptional views of reality is sometimes difficult or, in some cases, even impossible to draw, in chapter 2.2. (and also later on), I continue with the supposition that the person whose condition challenges us to seek a tenable view of freedom of belief and opinion is diagnosed with a psychotic disorder. In the following chapters the goal is to clarify how freedom of belief and opinion could be understood after such a diagnosis.\footnote{\textsuperscript{185}}

In chapter 2.2., I present my analysis concerning the status of delusions as beliefs, thoughts and opinions, first in the philosophy of psychiatry and then in human rights theory. I will also consider the relationship between the use of involuntary antipsychotic medication and an absolute dimension of freedom of belief and opinion, namely, the \textit{forum internum}. I show how delusions challenge human rights theory since it seems to be conceptually unclear whether there is a right to hold a delusion.

\subsection*{2.2.1. Philosophical debate concerning the status of delusions as beliefs}

The nature of delusions and psychosis (or in the history of ideas, so-called madness), has always inspired philosophical discussion. During the last two

\footnote{\textsuperscript{185} The other way to describe the different viewpoints presented in chapters 2.1. and 2.2. is to see them as representing different presuppositions concerning the status of delusions as beliefs. According to Stephens & Graham (2004, 236), when delusions are considered to be beliefs the main interest is “whether, when, and how delusory beliefs differ from normal, non-pathological beliefs”. However, more recently growing attention has been given to the question “whether delusions are beliefs of any sort”; as Stephens & Graham put it. As I see it, the presuppositions of these different approaches are not necessarily different, at least not always. Even though the concept of belief might be used when describing delusions, it can still be emphasized that delusions are different kinds of beliefs than other beliefs. Very often the two discussions mentioned by Stephens & Graham consider the same features of psychotic interpretations (or attitudes or beliefs or whatsoever), namely, irrationality, being unwell and alienation (even though the discussion which questions whether delusions are beliefs at all seems to concentrate mostly on the aspect of irrationality). So, it seems, that the fundamental question in both discussions is what distinctions there might be between psychosis and “something else” and whether delusions are called beliefs or not.}
decades, the discussion concerning psychotic delusions has, if anything, grown.\textsuperscript{186} One theme of the debate is the status of delusions as beliefs.\textsuperscript{187}

Traditionally delusions have been considered as beliefs, which can be seen, for example, in the definitions provided in diagnostic manuals. The DSM-classifications define a delusion as “a false belief based on incorrect inference about external reality”.\textsuperscript{188} However, the status of delusions as beliefs has been questioned in philosophical discussion. The reason for this is that delusions have been considered as irrational on the grounds of their content or the way in which they are formed. Scholars interested in the philosophy of psychiatry have claimed that delusions are, for example, “empty speech acts”, “imagination” or “stances” rather than beliefs. It seems that this kind of suggestion has a lot in common with approaches which emphasize irrationality as a central feature of psychosis.\textsuperscript{189}

German Berrios denies that delusions are beliefs and suggests instead that delusions are empty speech acts. According to Berrios, delusions are speech acts because they have a form, a purported content and course. As speech acts, delusions are, nevertheless, empty because their informational content does not refer to the world nor to the self, as other speech acts do. Berrios seems to mean that delusions are irrational in two senses. First, they do not correspond with an external reality. According to Berrios, one sign of this irrationality is that delusions are not responsive to evidence, whilst beliefs are.\textsuperscript{190} Second, Berrios also claims that delusions tell us nothing about the person’s internal reality:

They are not the symbolic expression of anything. Its ‘content’ is but a random fragment of information ‘trapped’ in the very moment the delusion becomes crystallised. The commonality of certain themes can be explained by the fact that informational fragments with high frequency value also have a higher probability of being ‘trapped’.\textsuperscript{191}

Berrios seems to mean that there is no point in trying to understand the delusional person by analysing his or her delusions since they don’t tell us anything about the delusional person’s self.

Gregory Currie, Ian Ravenscroft and Jon Jureidini claim that delusions are imaginings. The basis for this claim is the supposition that people aim to have a consistent belief system. Therefore, if a belief is inconsistent with one’s other beliefs, a person rejects it or reconsiders their belief system as a whole. However, people sometimes seem to adopt delusions

\textsuperscript{186} See, for example, Radden 2011; Heinimaa 2008; Sass 1994.

\textsuperscript{187} See, for example, Bortolotti 2010; Hamilton 2007; Bayne & Pacherie 2005; Currie & Ravenscroft 2002; Currie & Jureidini 2001; Berrios 1991.

\textsuperscript{188} DSM-IV-TR 2000, 821; DSM-V 2013, 819.

\textsuperscript{189} See chapter 2.1.2.

\textsuperscript{190} Berrios 1991, 6, 8, 12.

\textsuperscript{191} Berrios 1991, 12. For a critique of Berrios’s suggestion, see Bortolotti 2010, 118-121.
which are not consistent with their belief system. If delusions are imaginings, it would, according to Currie, Ravenscroft and Jureidini, explain why people adopt delusions in spite of such inconsistencies. Namely, the imaginings a person has may be inconsistent with their beliefs. According to Currie and Jureidini:

imaginations are not apt to be revised in the light of evidence; the whole point of imagining is to enable us to engage with scenarios that we know to be nonactual. Thus, imaginings seem just the right things to play the role of delusional thoughts; it is of their natures to coexist with the beliefs they contradict, to leave their possessors unwilling to resolve the inconsistency, and to be immune to conventional appeals to reason and evidence.

According to Currie and Jureidini, a delusional individual fails to recognize that delusions are imaginings and therefore mistakenly considers them as beliefs:

we usually know straight away and without reflection that this is a belief and that is an imagining. The explanation for our ability to identify beliefs must appeal to sub-personal capacities, and it is, on our account, this sub-personal capacity that is damaged in cases of delusion.

Lynn G. Stephens and George Graham suggest that a person with delusions is in a delusional stance. They describe a delusional stance as a special and complex higher-order attitude towards lower-order states, thoughts and attitudes. Stephens and Graham clarify their idea by an example:

we think that even a deluded patient might have an accurate appreciation of the character of her first-order attitudes. She might believe that she believes that the sky is falling, and this second-order belief might be true. She does believe that the sky is falling. Second, we do not think that the second-order attitude characteristic of delusions is best understood simply as a second-order belief. Indeed, we think that the second-order state involved in delusion is complex. So, we prefer to see the higher order state as a ‘stance’...the subject may adopt the delusional stance towards any of a variety of different first-order states. The deluded subject may be first-order believing that the sky is falling, or merely first-order considering the proposition that the sky is falling, or vividly first-order imagining (without believing) that the sky is falling.

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194 Currie & Jureidini 2001, 162.
196 Stephens & Graham 2007, 202. Stephens & Graham develop their idea about delusions on the grounds of Currie’s thought. They follow Currie’s hierarchical approach to delusions but develop its details. Currie considers delusions as second-order beliefs: the person believes that he or she believes something (as a first order belief). However, this something, this first-order belief, is not, according to Currie, a belief, but an imagining. Stephens & Graham follow Currie’s idea about a hierarchy of first-order and second-order systems. However, they claim that the second-order belief is not a belief, but a stance, and first-order imaginings can also be beliefs. Stephens & Graham 2007, 201.
Stephens and Graham list the major components of a delusional stance. When they do so, the issues concerning irrationality seem to be central, especially if we are interested in how delusions might differ from (non-pathological) beliefs. First, the mark of a delusional stance is, according to Stephens and Graham, that the person experiences the content of delusion as an act of thinking, on their part. Stephens and Graham themselves note that “this feature of self-identification or self-represented personal possession does not distinguish delusions from normal or non-pathological second-order attitudes”. This dimension is important, because it distinguishes delusions from “various other pathological (or at least, abnormal) ways of viewing one’s first-order thoughts.” Second, the person with a delusional stance resists changing a lower-order thought which is challenged, for example, by evidence to the contrary. This component seems to clearly concentrate on an evaluation of rationality. Third, a person with a delusional stance does not have, according to Stephens and Graham, insight concerning the lower-order thought which is the object of the delusion. This means that the person in a delusional stance does not think that something is wrong with them.\(^{197}\)

However, it seems to me that the third component is based on the fact that the content of a first-order thought does not correspond to reality or it is otherwise considered irrational. It seems meaningful to bring up the loss of insight because of the content of the first-order thought. People with no delusions have “loss of insight” as well, because no insight is needed in these cases. Bringing loss of insight up seems to ensure that the person with delusions is committed to their first-order thoughts as is the person with no delusions. So, it seems that loss of insight may be an interesting component when a distinction between different kinds of pathologies is made but it does not solve the problem of distinguishing between pathological and non-pathological stances, since people with either one of these stances do not consider themselves ill or irrational. So, it seems this point becomes meaningful only if we are interested in the rationality of first-order thoughts. Therefore, even though Stephens and Graham try to discuss stances or higher-order attitudes instead of lower-order states, thoughts and attitudes, they seem not to be able to describe the delusional stance without discussing lower-order states, thoughts and attitudes and without discussing their rationality. Thus, it seems that the philosophical discussion about the status of delusions as beliefs returns to the discussion concerning the irrational nature of the psychotic view of reality.\(^{198}\)

\(^{197}\) Stephens & Graham 2007, 203-209.

\(^{198}\) When Stephens & Graham discuss stances it seems, at first, that they bring the discussion on to a “higher level”. Before the debate was about whether delusions understood as “first-order attitudes” are beliefs. In this debate many arguments against a doxastic approach towards delusions are presented but they all seem to face a problem since they either narrow the definition
Views which question the status of delusions as beliefs on the grounds that they are not rational, have been challenged. According to Tim Bayne and Elisabeth Pacherie, “Currie’s claim about consistency appears to be implausibly strong” since people’s “cognitive behaviour does not always meet the normative standards that it ought to”. For example, self-deception and the partial encapsulation of belief are, according to Bayne and Pacherie, common phenomena.

Lisa Bortolotti also opposes the claim that delusions are not beliefs because they are irrational. Bortolotti admits that delusions are often irrational. She claims, however, that beliefs need not be rational to be defined as beliefs. By referring to examples from prejudices and self-deception to religious beliefs, Bortolotti describes how beliefs are often not rational. She refers to the psychological literature on human reasoning, which shows that

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Bayne & Pacherie 2005, 171. Bayne & Pacherie also claim that the way Currie, Ravenscroft and Jureidini describe the nature of beliefs and imaginings is inconsistent and unclear. Bayne & Pacherie (2005, 169) point out, on the one hand, that: “Currie and Ravenscroft suggest that imaginings and beliefs are generated in very different ways. Sometimes they say that imaginings are actions – they are doings – whereas beliefs are not actions, they are things that happen to us. In other places they make the weaker claim that imaginings are autonomously generated, whereas beliefs are formed “in response to perceptual information, or by inference from other beliefs we already have.” On the other hand, Bayne & Pacherie (2005, 170) note that Currie & Jureidini (2001, 159) claim, that: “It is characteristic of imaginings to be more easily triggered by comprehension than is belief.” On the grounds of these notions, Bayne & Pacherie (2005, 170) ask: “How could it be true both that imaginings are autonomously (voluntarily) generated and that they are more easily triggered by perceptions than beliefs are?”

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Bortolotti divides the concept of rationality in to three aspects, which she calls procedural rationality, epistemological rationality and agental rationality. According to Bortolotti, procedural rationality requires that beliefs are well-integrated in a system with other beliefs or intentional states. Beliefs are epistemologically rational if they are well-supported by and responsive to the available evidence. Agental rationality is when a person endorses beliefs by offering good reasons in support of their content, and by acting in a way that is consistent with and explicable by their content. Bortolotti 2010, 14.
most people fall prey to systematic mistakes in deductive, statistical and probabilistic reasoning and often exhibit dissonant attitudes. Bortolotti also points out that mistakes in causal reasoning are common. People put too much emphasis on the temporal order of events, they have a conservative bias in the assessment of scientific theories and judge the intentionality and voluntariness of actions in an irrational way. People also hold prejudices even if they are presented with evidence to the contrary. Moreover, ordinary beliefs are often self-serving; people emphasize and remember the events which put them in positive light more easily while those which put them in a negative light are more likely to be forgotten or neglected. Bortolotti also refers to a study which revealed that students seemed to be concerned about the dangers of unprotected sex but did not think that the dangers applied to them in the same way as they applied to everyone else.\footnote{Bortolotti 2010, 77, 121, 124, 146-153, 172-173.}

First, when it comes to the question of whether delusions are beliefs, I defend the claim that most of them are.\footnote{Since there are so many different kinds of delusions, it is possible that some of them are better defined as, for example, attitudes or feelings.} As I see it, the concepts of “epistemologically justified belief” or “rational belief” and the concept of “belief” should be distinguished. It would be questionable to claim, for example, that a person who thinks that Jesus was resurrected from the dead, does not hold a belief.\footnote{Hamilton suggests that there are both psychotic and non-psychotic delusions (such as self-deception and wishful thinking), and neither of them are beliefs. However, he notes that the concept of delusion can also be used in a metaphorical sense when the intention is to reject some “real beliefs”, such as religious and political beliefs. Hamilton mentions that, for example, the Catholic belief that the bread and wine in the Eucharist are converted into the body and blood of Christ is a delusion only in this metaphorical sense. Hamilton notes, first, that “[d]elusion is not simply a groundless framework principle that one does not accept; to call something a delusion is to imply that it is more than a simple error. It is essential to distinguish delusions, especially psychotic cases, from mere mistaken belief”. Hamilton 2007, 217-218. However, it seems unclear why, for example, the Catholic belief about the Eucharist could be seen as a mistaken belief instead of being a delusional non-belief, which is more than a simple error. It seems that the fact that some beliefs are shared by a community is important in evaluating whether it is a mistaken belief or a delusional non-belief that is in question. Hamilton (2007, 219) himself also brings this up: “The status of non-psychotic delusion bears on the question of whether delusion is something that is not accepted by others in one’s culture or subculture”. Second, Hamilton (2007, 217-218) considers religious beliefs as illusions, namely, as something that the person wishes to believe. However, if we follow the way in which the belief status of delusions is questioned, it seems consistent to question the belief status of religious beliefs by claiming that they are not beliefs but illusions, instead. It is also worth noting that religious beliefs are not always “positive” things that the person wants to believe. For example, religious people can be afraid that their children will end up in hell. They wish that God will lead their children to heaven but believe that they will go to hell (for example, because they do not believe in Jesus Christ). Should we think that these people secretly wish that their children will end up going to hell? Third, it seems that Hamilton’s distinction between illusions, non-psychotic delusions and psychotic delusions is inconsistent or at least unclear. Namely, he writes about the difference between non-psychotic and psychotic delusions: “Non-psychotic delusions, I will argue, fall within the sphere of reasons broadly}
the group of “beliefs”, even though they might not belong to the group of “epistemologically justified beliefs” or “rational beliefs”.

Second, I want to emphasize that irrationality as such does not make a belief delusional. We cannot capture the nature of delusion by only discussing the aspect of irrationality, as some debaters in the philosophy of psychiatry seem to do. Their demand for sufficient rationality is so ideal and high that too many beliefs are considered delusions. It would appear, on this reasoning, that everyone who holds beliefs which are not epistemologically justified would be labelled delusional. I would rather call them just (partly) irrational. Psychotic irrationality, instead, accompanies being unwell and alienation, as I argued in chapter 2.1.

Bortolotti notes that the question concerning the status of delusions as beliefs is meaningful when it comes to issues concerning human rights and the ethics of psychiatry. It has been claimed, for example, that having beliefs is a necessary condition for autonomous agency. Even though human rights discussion is also connected with philosophy, it is worth noting that there are differences between philosophical approaches and the approaches presented in human rights discussions. If we applied the views of epistemology directly to human rights discussions, the result would be strange since we might end up arguing that freedom of belief does not concern religious beliefs if they are not epistemologically justified beliefs. Thus, it seems that the philosophical discussion about epistemologically justified beliefs and the human rights discussion concerning the kinds of beliefs people have a right to hold are two distinct debates. It seems that the human rights discussion is less concerned about whether beliefs are rational and more about the meaning of beliefs for people who hold them. Human rights are not rules for academic philosophers but rights of ordinary people. Therefore, we also need to analyse the human

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204 Bortolotti 2010, 1, 3, 7. Bortolotti (2010, 3) presents some examples of how the question of delusions’ belief status is connected with ethical and human right issues: “characteising subjects with delusions as intentional agents capable of forming beliefs and acting on them would impact significantly on current debates about their ethical standing in clinical and forensic settings, and the suitability of different types of psychiatric treatment. Should delusional reports be listened to with attention? To what extent should choice of treatment be offered to subjects with delusions when several options are available? Should personal autonomy and responsibility be attributed to subjects whose behaviour shows a commitment to the content of their delusional reports?”
rights discussion in order to understand better the status of delusions in the context of human rights.

2.2.2. The status of delusions in human rights definitions

In this study the concept of freedom of belief and opinion includes all the individual’s rights which concern believing and thinking and which are defined as human rights\textsuperscript{205} in 1) the International Covenant on Civil and Political Rights (ICCPR) of the United Nations and in 2) the Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) of the Council of Europe.\textsuperscript{206} Freedom of religion, belief, opinion, conscience, thought and expression are all mentioned in these international covenants.\textsuperscript{207}

The ICCPR and the ECHR consider the individual’s freedom of belief and opinion in two sections. At first, these rights are considered in the context of the freedom of religion, conscience and thought (in this context the freedom of belief is also mentioned). According to article 18 of the ICCPR:

1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.\textsuperscript{208}

The formulation in the ECHR is similar with the formulation in the ICCPR. Article 9 of the ECHR notes:

\textsuperscript{205} In chapter 2.2.2, I follow a nominal definition of human rights. According to this definition, human rights mean the rights that are protected in constitutions and in covenants of human rights. See Karapuu 1999, 62.

\textsuperscript{206} I will also consider the view of Finnish legislation in footnotes. Freedom of belief and opinion is considered in The Constitution of Finland (Suomen perustuslaki 1999/731). It was adopted in 1999 and entered into force in 2000.

\textsuperscript{207} See the ICCPR 1966, Articles 18-19; the ECHR 1950, Articles 9-10. I have chosen to speak about freedom of belief and opinion in order to refer to both articles in the ICCPR and in the ECHR. Belief is mentioned in the ICCPR, Article 18 and in the ECHR, Article 9, and opinion in the ICCPR, Article 19 and in the ECHR, Article 10. Choosing the concept of belief is meaningful since there is already a discussion concerning the status of delusions as beliefs. However, I also wanted to refer to a concept which refer to ideas, thoughts and attitudes which are not necessarily expressed to others. This is also one reason why I chose also the concept of opinion from the constellation of these rights.

\textsuperscript{208} The ICCPR 1966, Article 18:1-2. Article 18:4 also states that: “The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to ensure the religious and moral education of their children in conformity with their own convictions.” The ICCPR 1966, Article 18:4.
Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.209

Secondly, the rights concerning the individual’s freedom of belief and opinion are considered in the context of the freedom of opinion and expression. The ICCPR notes in article 19 that everyone shall have the right to hold opinions without interference.210 The ICCPR also states:

Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.211

In the ECHR, freedom of belief and opinion is considered in article 10, as follows:

Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers.212

As a human right an individual’s right to freedom of belief and opinion is inherent in the view that every individual has human dignity which the individual need not earn and which he or she cannot lose. This dignity is something which we are all supposed to have to the same degree, just because we are human beings.213 It is, however, more complicated to say what this dignity actually means, to what kind of conclusions it leads and why people have such dignity (if they do).214 The idea of human rights and the idea of human dignity have developed mainly hand in hand through a long and rich history of ideas. In addition to the traditional Christian answer which invokes

209 The ECHR 1950, Article 9:1. The Constitution of Finland (Suomen perustuslaki 1999/731, 11§) also acknowledges the freedom of religion as a fundamental right. However, the formulation differs from the formulations used in the ICCPR and the ECHR since it declares that: “Everyone has the freedom of religion and conscience. Freedom of religion and conscience entails the right to profess and practice a religion, the right to express one’s convictions and the right to be a member or decline to be a member of a religious community. No one is under the obligation, against their conscience, to participate in the practice of a religion.”


211 The ICCPR 1966, Article 19:2.

212 The ECHR 1950, Article 10:1. The Constitution of Finland (Suomen perustuslaki 1999/731, 12§) states: “Everyone has the freedom of expression. Freedom of expression entails the right to express, disseminate and receive information, opinions and other communications without prior prevention by anyone.”


214 Some philosophers and ethicists have claimed that human dignity is useless and vague concept which can be described by other concepts, such as autonomy or rational agency. See Barlan 2012, 2; Rosen 2012, 4-7. See also Sen (1985, 132-133), who notes that it is difficult to provide a moral theory which gives an adequate foundation for human rights.
the idea that humans are created in God’s image, the idea of human dignity also refers to different human capacities, such as consciousness and the ability to think, not being completely determined and being the creator of one’s own norms and values, which is also what is often meant when someone is said to be autonomous. Immanuel Kant in particular emphasized that a human being’s free will and rationality was the basis of human dignity and autonomy, though there is a long history of these ideas which extends as far back as Antiquity’s Stoics. Moreover, as Yechiel Michael Barilan describes, the idea of human dignity is rooted in solidarity and compassion, which are emphasized in intuitionist phenomenology. According to this view, humanity is something that human beings recognize and feel in each other.²¹⁵

When it comes to human rights which protect believing and thinking they have been seen as fundamentally important in society, because they protect the individual as an autonomous thinker and believer, but also because they protect free public political and societal discussion and free communication, which are considered the basis of a democratic society. Moreover, human rights which protect believing and thinking are not only considered important in themselves, but also because of their role in protecting other human rights.²¹⁶

In discussions concerning human rights, freedom of belief and opinion is classically seen as belonging to the groups of civil and political rights (CP rights). Human rights are often divided into three generations. CP rights constitute the first generation. Economic, social and cultural rights (ESC rights) belong to the second generation of human rights. The third generation of rights refers to collective rights like the right to peace or the rights of minorities. Sometimes a fourth generation of rights is also distinguished to signify the rights of nature.²¹⁷ CP rights are separated from ESC rights, for example, in the UN’s covenants signed in 1966, since CP rights and ESC rights are protected in different documents. The same kind of distinction is used in the Council of Europe because the European Convention of Human Rights and the European Social Charter are separate documents.²¹⁸

I will now clarify whether the definitions of religion, belief, a matter of conscience, thought or opinion also include delusions. One difficulty is that there are no official definitions for the concepts of religion, belief,

²¹⁵ Barilan 2012, 28-30, 46, 81, 84, 87, 90-91; Nordenfelt 2003, 103-105. On the common history of ideas about human rights (especially freedom of belief and opinion) and human dignity, compare, for example, Barilan (2012) with Stenlund (2009).
²¹⁷ The other possibility to categorize the rights is to divide them into four groups, as follows: The first group consists of freedom rights and legal protection, the second group includes ESC rights, the third group consists of equality rights, while the fourth group includes right to participate. Ovey & White 2006, 5-6; Karapuu 1999, 70-73; Perusoikeuskomitean mietintö 1992, 50-51.
conscience, thought and opinion. However, some definitions have been presented in the human rights discussion because of their significance for juridical philosophy or their relevance for case law. The status of delusions can be considered in the light of this discussion.

In human rights discussion, the controversial concept of religion refers to such beliefs which consider the existence of superior or supernatural beings and a relationship with these beings often called God. Even if a delusion referred to a God or to something as divine, it would be erroneous to define it as religious in the sense of religion as defined in the context of human rights. Unlike delusions a religion is shared in and by a community. Juha Seppo argues:

Despite the personal nature of religion, it is not just a private matter but involves a common, institutional, social and cultural dimension as well.

Beliefs are of a more individual nature than religions. The concept of a belief is wider than the concept of a religion also in the sense that it includes not only different theistic creeds but also such beliefs as agnosticism, atheism and rationalism. There are also, for example, political, philosophical and social beliefs. Since delusions typically are of an individual nature and their content varies, can they be defined as beliefs?

In the discussion concerning human rights, it has been noted that not every kind of opinion or idea can be defined as a belief in the same way that the concept of belief is used in the context of human rights. Ovey and White express this idea as understood in the European tradition by saying that a belief must “attain a certain level of cogency, seriousness, cohesion and importance”. Natan Lerner states:

Belief has been defined legally as a “conviction of the truth of a proposition, existing subjectively in the mind, and induced by argument, persuasion, or proof addressed to the judgement.”

Sometimes delusions may be part of the person’s wider ideology and thus not just isolated ideas without any link to other beliefs. They may also be understandable in the sense that an outsider can follow the logic of the beliefs and can understand their place in the belief system as whole. In spite of this it seems that belief status in terms of human rights may be denied on

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219 Lerner 2006, 5.
220 “Uskonto ei henkilökohtaisesta luonteestaan huolimatta ole yksityisasia, vaan uskonolla on myös julkinen, institutionaalinen, sosiaalinen ja kulttuurinen ulottuvuutensa.” Seppo 2003, 11. Translation by Mari Stenlund. It is a matter of debate whether some religions actually are shared delusions. See chapters 2.1.4 and 4.2.3. for more details.
221 Seppo 2003, 11.
222 Lerner 2006, 7.
223 Ovey & White 2006, 302. See also Campbell and Cosans v. United Kingdom 1982.
224 Lerner 2006, 7.
cases of delusions. For example, the case of Pretty v. The United Kingdom reveals how the European Court of Human Rights has interpreted the borders of the concept of belief. In this case Diane Pretty, who suffered from motor neurone disease, wanted to commit suicide with the assistance of her husband. Therefore, her solicitor asked the Director of Public Prosecutions (DPP) to give an undertaking not to prosecute the husband if he assisted his wife to commit suicide. The DPP refused to give undertaking, which Diane Pretty considered to be a violation of her freedom of belief. The case could raise questions concerning potential restrictions of freedom of belief. However, the court ended up in defining the concept of belief by arguing that not all opinions or convictions (like the views concerning assisted suicide) constitute the kind of beliefs that are protected by the freedom of belief. By claiming that Diane Pretty’s view was not a belief, the court stated that invoking the freedom of belief could not be used in her argument against the DPP.225

The approach is different in the United States. Unlike the European approach, which emphasizes the coherence of a belief and is oriented to its content, the American approach concentrates on the functional role of a belief. Based on the ideas of the German-American theologian Paul Tillich, the Supreme Court of the United States has recognized that beliefs are those thoughts or ideas that give meaning and orientation to people’s lives. Therefore, for something to qualify as a belief, the person who claims to hold it must be able to show that they have a concern or a deep motivation that is ultimate, fundamental and cannot be compromised.226 Sometimes delusions can be so important and meaningful for the individual that it is meaningful to ask whether they can be said to be ultimate concerns of the person. Even though belief status in terms of human rights may be denied, at least in many cases, it may be asked whether some delusions could be defined, in the American tradition, as beliefs.227

Human rights conventions also protect the freedom of conscience. Sometimes the concept of conscience is understood as parallel to the concept of belief, especially when it refers to beliefs that are not religious. The concept is understood in this way for example in the Finnish constitution which lists “freedom of religion and conscience” as a fundamental right.228 In this sense it is questionable whether delusions can be defined as matters of conscience in the same way that it is questionable whether they can be defined as beliefs.

Sometimes the concept of conscience refers instead to the moral attitudes and decisions of the individual. According to Karl Josef Partsch, the

225 Ovey & White 2006, 303; Pretty v. The United Kingdom 2002.
227 For a critique of the American definition for the concept of belief, see Evans 2001, 63.
228 Ojanen & Scheinin 2011, 416; Suomen perustuslaki 1999/731, 11§.
concept of conscience refers to all morality in the personal sphere.\textsuperscript{229} If understood in this way, some delusions might be defined as matters of conscience. According to the DSM-IV, a delusion sometimes involves a value judgement which can be recognized as a delusion because it “is so extreme as to defy credibility”.\textsuperscript{230} As personal and internal matters these kinds of delusions might be matters of conscience. However, the definition of the concept of conscience seems to be very unclear. Therefore it is questionable whether the concept includes some delusions.

According to the Covenant provision of the ICCPR, the concept of opinion refers in particular to convictions concerning secular, civil and political matters.\textsuperscript{231} The interpretation adopted by the European Court of Human Rights requires that expressed opinions have something to do with facts. Even value judgements which cannot be proved, should have a sufficient factual basis. This view arose in a context where defamation was being discussed.\textsuperscript{232} It is worth noting that this requirement applies to opinions that are expressed. Therefore, statements are valid when it comes to the question of whether the person has a right to express his or her delusions in public.\textsuperscript{233} It can be asked whether principles utilized in the context of the freedom of expression might also be applied when the concept of opinion is defined and whether it is required that an opinion as such (even though it might not be expressed) should have, at least, a slim basis in fact. However, it seems that in the case of defamation there has been a need to restrict expressing such opinions which may damage somebody else. Thus, statements of the European Court of Human Rights seem to focus on how freedom of expression should be restricted in order to protect the rights of others. They do not seem to offer a definition of opinion as such.

\textsuperscript{229} Partsch 1981, 214.
\textsuperscript{230} DSM-IV-TR 2000, 821.
\textsuperscript{231} Partsch 1981, 217.
\textsuperscript{232} Ovey & White write, that: “The Court makes a critical distinction between value judgements and statements of fact. Value judgements cannot be proved. A requirement, in defamation proceedings, that a defendant prove the truth of a value judgement will violate his right to freedom of opinion, protected by Article 10. However, that does not mean that defendants can express any opinions, no matter how damaging, without any evidence to support them. Even value judgements will require, at the very least, a slim basis in fact. Factual statements, on the other hand, are susceptible of proof. In general, it will be reasonable, in the interests of protecting the rights and reputations of others, to require defendants in defamation proceedings to prove the truth of factual statements that they have made.” Ovey & White 2006, 326. See also the Case of Lingens v Austria 1986 and Dichand and others v Austria 2002.
\textsuperscript{233} Since it seems to be the case that value judgements are more protected than expressions dealing with factual matters, it might be that publicly expressing a delusion along the lines of “my problems are caused by Satan who has stolen my neighbour’s soul and now influences my life spiritually through him” might receive more protection than a delusional expression like “my neighbour has blown up the door of my house”.

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When it comes to the definition of an opinion as such, Carolyn Evans seems to suspect that when we discuss the right to hold opinions silently in the mind, these opinions must concern “religious or other important issues” (whatever the term “important” means in this context, it seems to be some kind of requirement for the opinion to be so treated). On the other hand, since freedom of expression is protected in the ICCPR (article 19:2) with respect to “information and ideas of all kinds” it implies that the broad expression about “all kinds” also applies to the concept of opinion since freedom of opinion is protected in the same article (19:1). The difference between external expressions and internal opinions is that the first one is allowed to restrict (for example, in cases concerning defamation), but the latter is not. Thus, it seems, that even though the expressed opinions should have something to do with facts, opinions held in the mind do not necessarily need to do so. From this it seems to follow that at least some delusions might be opinions. They might be included in the inclusive formulation about “information and ideas of all kinds” at least if they concern secular, civil and political matters. For example, a delusion that one is being persecuted seems to fulfil the criteria presented for the concept of opinion.

The human rights definition of the concept of thought also seeks to be as inclusive as possible. The Covenant provision of the ICCPR stated that, compared with the concept of opinion, which refers more to secular matters, the concept of thought may be used especially in connection with faith, creed and religion. Bahiyiyih G. Tazhib seems to interpret the ICCPR in such a way that any conceivable kind of thought should be understood as thought in a discussion concerning freedom of thought. Tazhib describes the concept of thought in the context of human rights:

It appears that freedom of thought applies to every conceivable kind of thought on any subject an individual might have.

Tazhib also describes the scope of freedom of thought in ICCPR:

The exercise of freedom of thought is not limited to the sphere of religion. Therefore, the Committee clarified in the first sentence that the right to freedom of thought, conscience and religion encompasses freedom of thought “on all matters”.

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234 Evans (2001, 68) argues: “the Court has emphasized the importance of freedom of religion or belief, in particular at the level of the internal, individual conscience. It has not, however, given much consideration to the content of the freedom. At the most basic level, it could be considered simply the right to hold opinions silently (on religious or other important issues) without interference by the State.”


236 See Nowak 1993, 339-342.


238 Tazhib 1996, 313.

239 Tazhib 1996, 312.
Partsch also presents this inclusive notion when he discusses the terms “thought”, “conscience” and “religion”. According to Partsch, these concepts cover together “all possible attitudes of the individual toward the world, toward society, and toward that which determines his fate and the destiny of the world, be it a divinity, some superior being or just reason and rationalism, or chance”.²⁴⁰ It seems that, if not all, at least most delusions fit in to these categories of “every conceivable kinds of thoughts” and “all possible attitudes of the individual” at least if they concern faith, creed and religion. For example, such a grandiose delusion as a person claiming to have a special divine identity, seems to be included in the concept of thought.

The border between an opinion and a thought conceptually is not clear and their meanings overlap. Both an opinion and a thought have an internal and private nature.²⁴¹ They are both defined as inclusive and as wide as possible. Therefore, if previous definitions are taken seriously, it seems that many, even if not all, delusions should be defined as opinions or thoughts in the context of human rights. Moreover, some delusions might also be matters of conscience, or even beliefs. Probably the writers elaborating these definitions have not had the particular issue of delusions in mind. However, if we look at the definitions given, it is difficult to avoid the view that especially the concepts of opinion and thought together cover most delusions.²⁴²

2.2.3. Delusions and the absolute right to hold opinions and thoughts

In human rights discussion, the freedom of belief and opinion has been divided in to an absolute and a non-absolute dimension. The first is an internal and private dimension and the latter is an external and public dimension of the freedom of belief and opinion.²⁴³

The external dimension of the freedom of belief and opinion consists of the individual’s right to express and manifest his or her beliefs and opinions and to live according to them. The external dimension of the freedom of belief and opinion also includes a person’s right to live and act in a relationship with others who have the same beliefs and opinions. Thus the

²⁴⁰ Partsch 1981, 213. See also Scheinin (2000, 6), who refers to Partsch’s definition.
²⁴² See also Winick (1997, 162), who writes in the American context, as follows: “Thoughts deemed ‘disordered’ would seem no less entitled to First Amendment protection.”
²⁴³ Making this kind of distinction between the external and internal dimension is philosophically problematic. Moreover, the borders between internal and external are not clear. However, since this distinction is presupposed in both human rights conventions and human rights discussion I utilize it and lean on it.
external dimension of the freedom of belief and opinion is a public matter. Sometimes this external dimension is called the *forum externum*, especially in the context of the freedom of religion and belief.\textsuperscript{244}

The *forum externum* is non-absolute right, which means that it can be limited in certain situations.\textsuperscript{245} According to the ICCPR, the freedom of expression may be subject to certain restrictions which are provided by law and are necessary for the respect of the rights or reputations of others or for the protection of national security, public order, or public health or morals.\textsuperscript{246} When it comes to the freedom of religion and belief, the ICCPR declares:

Freedom to manifest one’s religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.\textsuperscript{247}

It is unclear how wide the internal dimension of freedom of belief and opinion – sometimes called the *forum internum* – should be. Despite differing opinions on other matters concerning the borders of the *forum internum*, human rights theorists seem to share at least the view that this dimension signifies the freedom to hold thoughts and opinions “in one’s mind”. The internal dimension of the freedom of belief and opinion is a private matter.\textsuperscript{248}

The internal dimension of freedom of the belief and opinion is an absolute right, which means that it should be not restricted in any situation for any reason. For example, so called brainwashing is defined as absolutely illegal.\textsuperscript{249} When it comes to the freedom to hold opinions, the ICCPR declares: “Everyone shall have the right to hold opinions without interference”. The ICCPR states no excuses for this article.\textsuperscript{250}

According to Natan Lerner, the three freedom rights, namely, the freedom of thought, conscience and religion, do not taken individually have a

\textsuperscript{244} Ojanen & Scheinin 2011, 416; Kortteinen 1996, 55; Tazhib 1996, 26-27, 87; Partsch 1981, 214, 217.

\textsuperscript{245} Ojanen & Scheinin 2011, 418-419; Tazhib 1996, 26-27.

\textsuperscript{246} The ICCPR 1966, Article 19:3.

\textsuperscript{247} The ICCPR 1966, Article 18:3.


\textsuperscript{250} ICCPR 1966, Article 19:1. The position of the *forum internum* as an absolute right is interesting from the viewpoint of the debate about belief-control. There is disagreement about whether or not belief-formation is voluntary or not and in what respects an individual controls what beliefs he or she holds. I thank Dan-Johan Eklund for bringing this discussion to my attention. For more on the ethics of belief, see Chignell 2010. When it comes to the *forum internum*, it could be argued that if the individual cannot form his or her beliefs (or thoughts and opinions) voluntarily he or she cannot be responsible for them. If this is the case it could also be asked whether we can discuss the freedom to hold them.
similar weight as legal notions. In the context of this claim, Lerner seems to refer to the idea of the *forum internum*:

Freedom of thought and freedom of conscience can be considered more philosophical than legalistic. Both freedoms emanate from the most internal and intimate sphere of human existence. Freedom of conscience can sometimes be legally violated or restricted. Freedom of thought, on the other hand, can only be violated or affected by complicated and sophisticated means of acting upon the human mind.\(^{251}\)

It seems that inclusive definitions of an opinion and a thought in human rights theory are possible because freedom of opinion and freedom of thought are connected only within the dimension of the *forum internum* (if opinions and thoughts are not expressed or manifested). Theorists may have come to the conclusion that a person has the right to have any opinion or thought whatsoever in his or her mind because an opinion or a thought that is only in one’s mind cannot pose a threat to other people and cannot therefore be in conflict with the rights of others. For example, Martin Scheinin notes:

States have not considered it difficult to allow their citizens the freedom to think. The difficulties start when we come to the right to express one’s conviction, the right to organize as a community in order to promote a religion or belief and the right to act in accordance with one’s conscience even in cases where a domestic legal system seems to require uniform behaviour irrespective of the different convictions held by individuals. The real problems concerning freedom of thought, conscience and religion do not concern the nucleus of the right itself, the freedom of the *forum internum* or an inner state of mind, but issues that relate also to other human rights.\(^{252}\)

I concluded chapter 2.2.2. by noting that the concepts of opinion and thought are defined in human rights discussion in such a way that they also seem to include most delusions. Earlier in this chapter, I noted that the freedom to hold opinions and thoughts is defined in human rights discussion and international human rights covenants as an absolute human right, which should not be restricted in any situation for any reason. Even though it seems to be unclear what is really meant by the *forum internum* and what this absolute right protects, these views presented in human rights theory seem to imply that the person might have – if human rights definitions and formulations are understood literally – an absolute right to hold a delusion.

It also seems that this literal interpretation of the definitions and formulations of human rights is not in clear conflict with the standard justifications which are presented in human rights theory when the reasons for freedom of belief and opinion to be protected in the first place are discussed.

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\(^{251}\) Lerner 2006, 8. See also Evans 2001, 52. It seems that the *forum internum* could be defined as a moral philosophical starting point for freedom of belief and opinion. However, its nature is somewhat mere theoretical since rights are meaningful only in social contexts, in relation to others.

\(^{252}\) Scheinin 2000, 5-6.
Freedom of belief and opinion is seen as fundamentally important in society, firstly, because these rights protect the individual as an autonomous thinker and constitute the basic conditions for each individual’s self-fulfilment. Second, freedom of belief and opinion has been seen as protecting free public political and societal discussion and free communication, which are considered fundamental to a democratic and pluralistic society. Moreover, it has been recognized that freedom of belief and opinion also has a significant role in the protection of other human rights.\textsuperscript{253} It can be, and should be, questioned whether holding delusions serves an individual’s self-fulfilment, whether they are needed in society or whether they constitute any kind of ground for other human rights. However, it seems that in the tradition of human rights the standard justifications mentioned are especially highlighted when it has been necessary to defend the manifesting of ideas which “offend, shock or disturb”.\textsuperscript{254} It does not seem self-evident that delusions are totally different to such ideas, or if they are, this is not stated clearly. If it was the case that standard justifications of freedom of belief and opinion conflicted with the conclusion that there is an absolute right to hold a delusion, this conflict would in itself challenge us to develop human rights definitions and formulations concerning freedom of belief and opinion. The need for such a development is an issue to which I will return during this study.

However, if we follow the literal interpretation of definitions and formulations which seem to suggest that there is an absolute right to hold a delusion, we end up by asking whether the use of involuntary antipsychotic medication is justified. Since the aim of antipsychotic medication is to relieve or remove the symptoms of psychosis (delusions included),\textsuperscript{255} it would appear that the exercise seeks to influence brain activity and, in this way, opinions and thoughts (namely delusions). For example, Manfred Nowak lists “influencing of the conscious or subconscious mind with psychoactive drugs” as one of the means which interferes with an individual’s spiritual and moral existence.\textsuperscript{256}

However, mental health legislation and the ethical principles which guide psychiatric care do not consider the use of involuntary antipsychotic

\textsuperscript{253} Korteinen 1996, 32; Ovey & White 2006, 300-301, 319-320. In utilitarian liberalism it has been argued that an individual’s freedom of belief and opinion is important because it promotes the reaching of true beliefs. For more about Mill’s idea, see chapter 3.1.1.

\textsuperscript{254} See, for example, Dichand and Others v. Austria 2002.

\textsuperscript{255} See, for example, Partonen et al (2008, 727) who note that the goal of the use of antipsychotic medication is to relieve a patient’s delusions, hallucinations and other symptoms of psychosis, relieve anxiety caused by psychotic symptoms and nervous or otherwise exceptional behaviour and prevent relapses of psychosis. They also mention that antipsychotic medication has an important role in the treatment of psychotic disorders.

\textsuperscript{256} Nowak 1993, 314. Nowak does not consider the cases of psychotic patients, thus it is unclear what he thinks about involuntary antipsychotic medication as a psychiatric treatment.
medication as an act which violates the *forum internum*. Instead, involuntary antipsychotic medication is not only used in practice, but the use of it is allowed in the mental health legislation of many (if not all) countries and in international ethical guidelines. For example, the PUN notes that involuntary treatment may be given if the following conditions are satisfied:

( a ) The patient is, at the relevant time, held as an involuntary patient;
(b ) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient’s own safety or the safety of others, the patient unreasonably withholds such consent; and
(c ) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient’s health needs.257

The use of involuntary antipsychotic medication is defended for therapeutic and ethical reasons. My purpose is not to question these reasons or to claim that these practices are unethical. Instead, I point out that there is ambiguity and tension in human rights theory. On the one hand, it seems to follow from the definitions and formulations presented in the discussion concerning freedom of belief and opinion that there is an absolute right to hold a delusion. On the other hand, it seems that this is not how things are understood when a psychotic patient’s treatment is involved. Accusations about violating absolute human rights have been presented in antipsychiatric discussion258, but it seems that the tension between the use of involuntary antipsychotic medication and the *forum internum* is mostly either ignored or not acknowledged in the wider discussion.

The European legal tradition appears not to present legal cases, at least not on the international level, based on the question whether the use of involuntarily antipsychotic medication violates the patient’s right to the *forum internum*. Cases tried in the United States, on the other hand, show that the inconsistency between a patient’s right to the *forum internum* and the practice of involuntary antipsychotic medication is acknowledged. However, the inconsistency cannot be said to be solved since the juridical cases manifest the same ambiguities and tensions that are visible in the theoretical human rights discussion.

In the 1980s and 1990s there were juridical cases in some state and lower federal courts in the United States concerning involuntary and intrusive therapies. In these instances the courts stated that the use of psychosurgery, electroconvulsive therapy and psychotropic medication (including antipsychotic medication) violates a person’s freedom of thought, freedom of

258 See, for example, Gosden 1997; Szasz 1990, 563.
belief and freedom of mind or right to mental privacy. Psychotherapy and other verbal techniques have been considered less intrusive, because as slow therapies they allow the patient to keep his or her mental privacy and either accept or reject the change.\textsuperscript{259} However, other kinds of legal cases can also be found in the United States. For example, in Massachutes, drug-treatment was justified by emphasizing the importance of being free from psychosis.\textsuperscript{260} In addition, the case of Osheroff concerned a malpractice suit against psychiatrists who treated a patient (who had refused medication before) by psychotherapy. According to the court’s judgement, the psychiatrists failed, among other things, to treat Osheroff’s psychotic depression with appropriate biological measures.\textsuperscript{261} So, it seems, that it is far from clear how the various human rights of psychiatric patients should be understood and valued.

Additionally, in the case of Rennie v. Klein, referenced by Bruce Winick, the United States Court of Appeals seems to consider antipsychotic drugs that may have permanently disabling, undesirable effects (often discussed as side-effects) as problematic. Moreover, the Court notices that, even though the patient had a right to refuse such medication, the state may, in emergency situations, “override that right when the patient is a danger to himself or others”.\textsuperscript{262} These notions reveal that the tension between the individual’s right to the \textit{forum internum} and the use of involuntary antipsychotic medication is still unresolved. First, speaking about permanent undesirable effects is not the same thing as speaking about influencing opinions or the thought process. Second, if a right may be overridden in cases of emergency the right cannot be called absolute.

More recent legal cases in the United States also show that the use of antipsychotic medication is not seen as a violation of the \textit{forum internum}. There have been cases where criminal defendants with a psychotic disorder have refused the antipsychotic medication which had been considered necessary to restore his or her competency to stand trial. In the context of these cases (e.g. Sell v. United States), the “liberty interests” have invoked.\textsuperscript{263} In some cases (e.g. the case of Washington v. Harper) the “liberty-interests” have been highlighted because the antipsychotic medication has mind-altering properties.\textsuperscript{264}

However, it is unclear when the focus of the wide concept of “liberty-interests” is on the mind-altering undesirable effects of antipsychotic

\textsuperscript{259} Winick 1997, 145-136, 171-176, 210-212.
\textsuperscript{260} Guthiel 1980, 327.
\textsuperscript{261} For more about Osheroff’s case, see, Malcolm 1986 and Robertson 2005. See also chapter 3.2.1.
\textsuperscript{262} Winick 1997, 211, note 176; see Rennie v. Klein, Opinion of the Court, 1.
medication, which might question the defendant’s right to a fair trial, and when the focus is on the possibility that the medication’s influence on brain activity might “change” a person’s opinions and thoughts and could be, for this reason, a problem from the viewpoint of the forum internum. The other question is whether “liberty interests” are applicable only when the person is competent to decide about his or her treatment even though he or she would not be competent to stand trial.

Moreover, at the conclusion of these cases the court has set out the conditions in which the use of involuntary antipsychotic medication is legal. If the use of involuntary antipsychotic medication was seen as violating the person’s right to the forum internum there could be no conditions or no situations where it was legal. In the case of Sell v. United States the court skirted, according to Debra Breneman, the deep philosophical questions about “mental illness and its appropriate treatment, including implications regarding free thought, individual autonomy, and the connection between mind and body”. Breneman claims that “failing to acknowledge the existence of these issues and their implications for the Court’s decision seems to trivialize the rights of the mentally ill”. Human rights theory is quite unclear when it comes to such questions as does the forum internum protect the person holding the thoughts and opinions with certain contents (in his or her mind) or does it protect the process whereby the person develops thoughts and opinions. It has been suggested that the concept of thought refers to a process while the concept of opinion is the result of this process. Since there is an absolute freedom of thought and an absolute freedom to hold opinions it seems that the forum internum might protect both the process and the result.

However, human rights discussion seems to concentrate on evaluating the contents of beliefs, thoughts and opinions and the meaning of those contents for the people who hold them. When we look at the way in which human rights are expressed, we see that they discuss beliefs and opinions in the sense that they have a certain content and which reside in the person’s mind. They are like independent entities which a person may say out loud, write in a newspaper, come into their mind and even neglect them. These

266 See Justice Stevens (1990) who, while invoking fundamental rights, seems to suppose that the person is competent: “There is no doubt, as the State Supreme Court and other courts that have analyzed the issue have concluded, that a competent individual’s right to refuse such medication is a fundamental liberty interest deserving the highest order of protection.”
268 There is also the other way to describe the differences between the concept of opinion and thought. According to other distinction, the concept of opinion refers especially the convictions in secular, civil and political matters while the concept of thought may be used especially in connection with faith, creed and religion. See Nowak 1993, 339; Partsch 1981, 217.
entities influence a person’s activity, they can be invoked and so on. The reason for this focus in human rights discussion might be that the contents of beliefs and opinions are easier to evaluate than the thinking and believing processes involved. For other people thoughts are expressions of thinking and beliefs are expressions of believing. However, it might be that believing and thinking as processes should be protected first and the results (beliefs and opinions) should be protected only secondarily. Unfortunately, human rights discussion, which is focused on the contents of beliefs and opinions, seems to concentrate on this secondary area. The challenge that delusions present for the theory of freedom of belief and opinion, however, reveals the need to clarify whether there are some kinds of requirements concerning what kinds of believing and thinking processes are worth protecting.

When it comes to psychosis, it has been suggested in the discussion concerning the philosophy of psychiatry that the interest should not be in the content of delusions but instead in the process through which delusions develop. According to these views, it is not the content but the form which makes the delusion. The central question is not what the delusional person thinks and believes but instead how he or she thinks and believes. However, diagnostic manuals which consider psychotic disorders from the viewpoint of symptoms avoid addressing the aetiology of psychosis. The reason for this is that there is no consensus about the processes which lie behind delusions. The question is, then, whether it is possible to find such a consensus in human rights theory, either. Moreover, it can also be asked whether the abilities needed by an individual for believing and thinking are worth protecting more than the believing and thinking processes are. I will discuss the possibility of understanding the forum internum in the sense of protecting certain abilities from interference in chapters 3.4.4. and 5.4.2.

However, in so far as the question concerning the psychotic individual’s freedom of belief and opinion is as acute as it seems to be now and in so far as there is a lack of discussion about how delusions challenge human rights theory concerning the freedom of belief and opinion, it would appear that the human rights discussion does not properly take into account the situation of psychotic people. As for understanding what it means to be a human being, then this is quite narrowly confined to people who are competent adults who can decide about issues for themselves as long as they only concern themselves. Thus, human rights discussion mainly concerns


270 See Lönnqvist 2007, 48-51; DSM-IV-TR 2000, xxxiii. There are some exceptions. The DSM-IV states that substance-related psychotic disorders, such as cannabis-induced psychotic disorder or amphetamine-induced psychotic disorder, “are judged to be due to the direct physiological effects of a substance”. See the DSM-IV-TR 2000, 16-17, 338.

271 Compare the criticism of social contract theories from the viewpoint of people with disabilities
cases concerning the borders of freedom of expression (cases about hate speech, among others) and cases of religious rights (for example the question about wearing the Islamic headscarf, the right to do missionary work and the right to avoid military service because the religion concerned forbids it).

Even though people with delusions are an exceptional challenge, as human beings they should not be forgotten in the discussion concerning the freedom of belief and opinion.\textsuperscript{272} First, it is important that people, whatever their views may be are not ignored when it comes to treatment which concerns them. Second, people with psychotic disorder should have the right to participate on their own part in society and they may even have something important to say.\textsuperscript{273} Moreover, the ambiguity and tensions in understanding these rights may also weaken some delusional people’s trust in the protection offered to them by the law if they, on the one hand, enjoy certain rights and yet, on the other hand, do not enjoy them. People with delusions also have a right to know about their rights. This right is not realized if it is unclear how rights should be understood. However, at the deepest level, the problem is that certain human rights are defined in such a way that some human beings are ignored. The question then arises whether the borders of humanity are drawn too strictly when these rights are discussed and when they are defined. For example, is the way the \textit{forum internum} is defined (in all its unclearness) meaningful or should we develop the theory of freedom of belief and opinion (including the view of the \textit{forum internum}) so that people with psychosis are better taken into account? As I see it we need a theory of freedom of belief and opinion which includes all human beings.

In the following chapters, I will analyse this ignored question of the psychotic individual’s freedom of belief and opinion by presenting three

\footnotesize{presented by Nussbaum (2006, 98): “Children and adults with mental impairments are citizens. Any decent society must address their needs for care, education, self-respect, activity, and friendship. Social contract theories, however, imagine the contracting agents who design the basic structure of society as “free, equal, and independent,” the citizens whose interests they represent as “fully cooperating members of society over a complete life.” They also often imagine them as characterized by a rather idealized rationality. Such approaches do not well, even with severe cases of physical impairment and disability. It is clear, however, that such theories must handle severe mental impairments and related disabilities as an afterthought, after the basic institutions of society are already designed. Thus, in effect, people with mental impairments are not among those whom and in reciprocity with whom society’s basic institutions are structured.”}

\footnotesize{\textsuperscript{272} One explanation for why psychotic people have been somewhat forgotten or ignored in the discussion concerning freedom of belief and thought may be that people who suffer from psychosis are considered as human and inhuman at the same time. Even though psychotic people are officially human beings, attitudes towards them might partly account for the way they have been forgotten and ignored. See Iso-Koivisto 2004, 32.}

\footnotesize{\textsuperscript{273} According to Häyry, the task of applied ethics is to seek such solution for ethical problems which so many members of community as possible could accept with rational reasons. Häyry 1994, 32. However, the problem here is who are considered as members of the community and, when problems concern with minority, do people who belong to minority have sufficiently power in deciding process.}
different pictures of these rights. The way in which the concept of freedom is understood influences the way freedom of belief and opinion as a human right is interpreted. I will discuss the psychotic individual’s freedom of belief and opinion first, as negative sense. From this viewpoint, freedom of belief and opinion is realized when other people do not interfere in technically and physically concrete ways with an individual’s believing and thinking and manifesting his or her present beliefs and opinions. However, this classical view is challenged by two different kinds of views. If freedom of belief and opinion is understood in the terms of authenticity, the focus is on the person’s inner state, and the question is whether the beliefs and opinions which they hold and the manifestations based on them are really their own. From this viewpoint, the forum internum is interpreted differently than in the context of freedom in the negative sense. Third, it has been pointed out that it is crucial for freedom of belief and opinion what the person really is able to do and be. Thus, freedom of belief and opinion can be understood also in terms of capability, which signifies that the individual is capable of choosing a way of life which he or she considers valuable and which is worthy of human dignity.

Different consequences of different viewpoints are clearly visible especially in the case of the psychotic individual. Thus, as I see it, the question about psychotic people’s freedom of belief and opinion serves as a positive challenge which helps to develop the theory concerning freedom of belief and opinion further. Since freedom of belief and opinion should be the right of all human beings, the challenge presented by people with psychosis will help us to understand better what actually is being protected for all of us.
3. The psychotic individual’s freedom of belief and opinion in the negative sense

The legislation and ethical guidelines which guide psychiatry clearly state that the psychotic individual’s freedom of belief and opinion should be protected. However, it is not clear how the concept of freedom should be understood and how freedom of belief and opinion should be valued in relation to other values and human rights. The challenges and tensions presented in chapter 2.2, reveal that it is anything but clear how, for example, we should understand the forum internum as an absolute right and how we should consider the use of involuntary antipsychotic medication from the viewpoint of freedom of belief and opinion. Therefore, clarification is needed, in particular, because the way in which freedom of belief and opinion is understood and how these rights are valued influence the way in which the person with psychosis is treated in practice.

When I seek a view of freedom of belief and opinion which is also relevant as a human right for a person with psychosis, I come across discussions concerning self-determination, autonomy, competence, authenticity and paternalism. These general discussions deliberated in political philosophy and the philosophy and ethics of psychiatry offer both conceptual tools and material for my analysis here. However, these discussions are messy. Sometimes the same terms are used but different meanings are given to them. Sometimes the same issues are defined by different kinds of terms. Sometimes the same arguments lead to different solutions. Sometimes the same solution can be defended in many different kinds of ways. Even though the same meaning might be given to the concept of freedom, opinions differ when it comes to the question of how freedom should be valued in relation to other values and rights. Moreover, even though there is plenty of general deliberations concerning autonomy, freedom and so forth, the view of legal human rights, and in particular, the legal concept of freedom of belief and opinion including the forum internum, is usually absent.

It depends on the view of freedom how questions related to self-determination, autonomy, competence, authenticity, paternalism, and finally, protecting the psychotic patient’s freedom of belief and opinion are understood and what kinds of arguments are presented to justify the decisions concerning treatment (especially non- or involuntary treatment of people with psychotic disorder). In this study I distinguish between three different views in the concept of freedom. I will analyse the psychotic individual’s freedom of belief and opinion in the negative sense, in terms of authenticity, and in terms

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1 See chapter 1.2.
of capability. I have chosen these views since it seems that they are the most obvious and clear in discussions concerning human rights and the rights of psychotic individuals. However, it is worth emphasizing that in this study I am interested only in views of freedom which are meaningful when we want to understand freedom of belief and opinion as a human right of all human beings. This means that I will discuss freedom of belief and opinion in a juridical sense, although my approach is interdisciplinary and seeks help understanding the meaning of human rights from several disciplines. However, since the point is to develop a theory of freedom of belief and opinion for juridical use, such views of freedom which cannot be applied in the human rights discussion are excluded from the analysis.\(^2\) However, some of these excluded views are mentioned when I draw the borders of the views of freedom which I have chosen for analysis and explain what freedom does not mean, according to these chosen views.

What makes freedom an individual’s right is that it is connected with the duty of others not to interfere or/and their duty to promote it.\(^3\) Moreover, this duty of others is not any kind of moral duty. It is a juridical, or legal, duty. If others fail to live up to this duty there is a juridical punishment for them. Thus, there is a conceptual distinction between moral and juridical duties, though failures to live up to juridical duties are also often considered moral failures (for example, murder, sexual abuse and so forth). However, not every action which might be considered moral failure is juridically sanctioned (infidelity and lying in personal relationships, among others). People may treat themselves in different kinds of horrible ways without doing something illegal. On the other hand, right is not just something which would be nice and good for people. They are not “mere gifts or favors, motivated by love or pity, for which gratitude is the sole fitting response”, as Joel Feinberg puts it. Instead, “a right is something a man can stand on, something that can be demanded or insisted upon without embarrassment or shame.”\(^4\)

Despite the fact that some writers emphasize the differences between concepts like self-determination, autonomy and freedom, in this study I will utilize all these concepts when I analyse the different views of freedom without making a distinction between them and without defining one concept as a sub-concept of the other. Since my aim is to describe views of freedom (which could be autonomy or self-determination, as well) in order to understand what freedom of belief and opinion means, it does not matter what

\(^2\) For example, religious views about “true freedom” (such as, “Jesus makes you free”) are excluded since they cannot as such serve as views of freedom in the context of human rights even though they might be views of freedom which one can hold under the concept of freedom of belief and opinion.

\(^3\) See Feinberg 1973, 58.

\(^4\) Feinberg 1973, 58.
terms are used if the views behind the terms are similar. I have chosen to use
the term freedom, because that is the term which is used when discussing the
human right called “freedom of belief and opinion”. Otherwise I could speak
about autonomy or self-determination, as well. However, I will also use terms
other than freedom in contexts where I refer to materials where some other
term is used.

In chapter 3, I present how the psychotic individual’s freedom of
belief and opinion is understood when we understand the concept of freedom
in the negative sense. I also clarify what kinds of discourses, concepts and
presuppositions the view of freedom of belief and opinion in the negative
sense is based on and what kinds of challenges we face when we apply this
view in the context of an individual with psychosis.

3.1. The concept of negative liberty

In this subchapter I define the concept of negative liberty and consider the
requirements for it and interferences with it. In the end I describe what
freedom of belief and opinion in the negative sense means. The purpose here
is to consider the concept of negative liberty and freedom of belief and
opinion in the negative sense in general. I will proceed to apply the view to
the context of individuals with psychosis in later subchapters.

3.1.1. Definitions of negative liberty

Freedom in the negative sense, or negative liberty, means that other people do
not interfere\(^5\) technically or physically with an individual. According to this
point of view a person is free when nobody prevents that person to be and do
what he or she could otherwise be and do. In his famous essay *Two concepts
of liberty*,\(^6\) Isaiah Berlin describes negative liberty as the area within which the
subject is or should be left to do or be what he or she is able to do or be,
without interference by other persons. According to Berlin, the individual is

\(^5\) I use the term interference as a wide term which includes fundamental interventions to the core
area of humanity as well as limitations and restrictions which partly interfere but also leave some
other areas untouched so that an individual may still act on them. It depends on the issue which
terms are most suitable.

\(^6\) Berlin does not distinguish between the terms liberty and freedom. I also use the terms freedom
and liberty as synonyms. I use the term liberty especially in the contexts where I discuss freedom
in the negative sense, but in other contexts I use the term freedom, unless the material to which I
refer uses the term liberty. For the etymology of the term liberty, see Online Etymology
Dictionary: Liberty, which states that the term liberty comes from the Latin word *libertatem* which
means freedom, condition of a free man, absence of restraint and permission.
free to the degree to which no man or body of men obstructs his or her activity. Therefore, negative liberty means the area within which the individual may act without the interference of others. Berlin sums it up, the wider that area is, the wider is the individual’s freedom.  

Freedom in the negative sense has sometimes been discussed as external autonomy, self-determination or the right to self-determination. For example, Tom L. Beauchamp describes autonomy from the viewpoint of freedom of constraint when he states that, “autonomy of action should not be subjected to control by others”. The history of the word autonomy also leads to this kind of approach, as described by Joel Feinberg:

When one nation is the colony of another, it is not said to be free until it gains its independence. Formerly, it was governed from without; now it is governed from within. Hence, freedom in this sense, and independence, and self-government all come to the same thing.

When Feinberg defines different aspects of freedom he describes “political freedom” or “liberty” as “the absence of that one special kind of constraint called coercion, which is the deliberate forceful interference in the affairs of human beings by other human beings”.

When we define negative liberty, we refer to the external by speaking about external autonomy or about freedom from external coercion. When the discussion concerns an individual’s right, a distinction between external and internal is usually drawn so that external factors are understood as factors whose origin is outside the individual’s body and mind. The factors described as internal, refers, instead, to factors whose origin is within an individual’s body and mind. This kind of distinction between external and internal aspects of self and reality is problematic since there is no consensus about where the border between external and internal dimensions should be drawn or whether such a border exists at all. Being aware of the difficulties in drawing borders between what is inside and what is outside “the individual’s body and mind”, I will still use the distinction between external and internal, since these concepts are broadly used and it is hard to find better concepts for describing certain aspects of freedom and interferences with it. However, I

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8 According to Beauchamp, autonomy is not only freedom of constraint in the external sense. He also describes other dimensions of autonomy. However, the concept of autonomy as freedom from external constraint is also part of his definition. Beauchamp 2009, 33-34. See also Rauhala (1998, 86-87), who describes the right to self-determination by referring to John Stuart Mill’s principles and the concept of negative right.
10 Feinberg 1973, 7.
11 See Feinberg (1973, 12-13), who writes that “external” refers to restrictions of freedom that are outside the individual’s own body and mind, and “internal” refers to restrictions of freedom, whose origin is in the individual’s body and mind.
will return to this problematic border between external and internal aspects of self and reality in later chapters.

It is also characteristic of negative liberty that its realization (as well as any interference with it) can be technically and physically verified, which means that the state of freedom is something very concrete. Freedom in the negative sense is realized when there is a lack of clear obstacles to it laid by other people.\(^{12}\) In addition to the absence of technically and physically verified restrictions, negative liberty also requires juridical permission to do something, or in other words, the absence of a juridical duty. In this latter meaning a person is free in issues where he or she has no (juridical) duty to do or not to do something.\(^{13}\)

Even though freedom in the negative sense is connected with the absence of frustration by referring to the idea that a person may do what he or she wants without constraints, the absence of frustration itself does not mean, however, the same as freedom, not at least in the sense of negative liberty. Berlin points out that if freedom meant that one could do what one wants then an individual could become, through some kind of psychological process, more free if he or she stopped wanting to do everything that is not possible.\(^{14}\)

Moreover, as Feinberg notes, if somebody wants, for example, to vote for a certain person and then is coerced to vote for that person, that voter cannot be said to be free, even though he or she was not frustrated, but did do what he or she wanted to do and nobody had prevented him or her from doing so. Still, because the individual was prevented from voting for somebody else, because no choice is available, he or she is not considered to be free. Thus, it seems that freedom in the negative sense means that nobody prevents an individual from having all those alternatives that he or she would otherwise have. In this sense a free person has the possibility to change his or her mind and do something else without interference from other people.\(^{15}\)

In a certain sense, freedom was understood in the negative sense already by Democrats of Ancient Greece, which becomes evident, for example, through Plato’s criticism of democracy.\(^{16}\) Thomas Hobbes, who considered freedom as the individual’s natural right, understood freedom in the negative sense when he described it as “the absence of external

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\(^{12}\) However, the border between, so-called, concrete obstacles and not-so-concrete obstacles is unclear and grey. I will also return to the question concerning these unclear areas in later chapters.

\(^{13}\) See Feinberg 1973, 17-18, 56.


\(^{15}\) Feinberg 1973, 5-7.

\(^{16}\) Plato describes freedom, conceptualized by democrats, as living as one likes. According to Mulgan, freedom as living without external interference of others was considered a political concept. However, in Ancient Greece, the focus was not on the rights of the individual, but on the utility of the community. Mulgan 1984, 13, 17-18, 23.
impediments”. However, negative liberty has classically been the main interest of philosophical and political liberalism. Liberalism can be seen as one of the philosophical grounds for the theory of human rights. In deontological liberalism, which is also called Kantian liberalism further to Immanuel Kant’s conception of freedom, freedom is understood as an intrinsic value which is connected with humanity. Kant’s conception of freedom is, however, wider than the conception of negative liberty since Kant connects freedom with the individual’s morality and rationality. Anyway, when it comes to the concept of freedom in a political context, Kant strongly defends the conception of negative liberty. Even though Kant claims that being free is to follow the universal moral law, which is reachable by reason, he also points out that the state should not seek this kind of freedom for its citizens. In addition to the goal’s impossibility, since no system cannot coerce the individual to be free in the sense of morality and rationality, it is also dangerous, because it would lead to despotic coercion.

According to Kant, the political system which maximizes the individual’s freedom in the negative sense prepares the best way to secure the individual’s freedom as morality and rationality. Moreover, Kant’s principle which orders that the individual should be treated as end instead just as mean requires that the individual’s freedom to act should be respected as far as possible. This means that the task of the political authority is to allow all its citizens to be equally free so that they can try to find the happiness that each person seeks. John Rawls, who developed social liberalism on the grounds of Kantian liberalism, considers each individual’s right to maximal freedom the main principle of justice. Thus, in deontological liberalism, the individual’s negative liberty has been understood as the grounds of justice.

In utilitarian liberalism, freedom has been seen in addition to its intrinsic value, also in terms of its utility. According to John Stuart Mill, the most famous utilitarian liberalist, freedom is necessary for finding the truth, and truth contributes, for its part, to utility. Mill claims that different kinds of opinions and lifestyles are welcomed and it’s good if people decide to follow their own opinions and lifestyles in practice, because only then is it possible to test whether that opinion and lifestyle is valuable and whether it helps to find the truth. Moreover, Mill believes that not being free is contrary to human nature. The coerced individual gets bored, while freedom increases the

17 The definition of freedom is in Leviathan, Ch. 14 and is specified in Ch. 21. Raphael 1984, 29-30.
20 Kant does not mean that all kinds of lifestyles bring happiness to the individual, but he claims that coercing somebody to accept a lifestyle that might bring happiness is unacceptable paternalism. Taylor 1984, 114-116.
individual’s ability and develops his or her mind. Thus Mill considers freedom a precondition of progress in the life of the individual as well as that of society.\footnote{Mill 1948, 11-12, 24, 27, 54-55, 67-71, 76-78, 119.}

In the discussion concerning human rights, the conception of negative liberty refers to the classical way of understanding the meaning of civil and political rights (CP rights) of which freedom of belief and opinion is one. CP rights have been traditionally considered negative rights. This means that they have been thought to protect the individual from government officials intruding into an individual’s life. The individual’s negative rights impose an obligation on government officials not to interfere with the individual’s freedom. According to this view, the individual’s freedom grows as the state’s intervention in his or her life decreases.\footnote{However, the current interpretation is that an individual’s negative freedom also obliges the state to act so that other people would not interfere with the individual’s freedom. Perusoikeuskomitean mietintö 1992, 50-52; Karapuu 1999, 78.}

\subsection{3.1.2. Interfering with negative liberty}

Negative liberty is restricted, when the state, an other person or other people prevent or restrain an individual from doing what he or she could otherwise do. Preventing makes the individual unfree to that degree to that preventing is related. When the person is not totally prevented, but restrained, his or her freedom is constricted.\footnote{See Berlin 2005, 169; Feinberg 1973, 9.} According to Feinberg, political freedom or liberty is understood as the absence of force. Feinberg divides force in to two main forms. First, it is direct forcing or preventing (prodding with bayonets or imprisoning). Second, force is threat of harm clearly backed up by the power to enforce which means that the person has some kind of choice but has to consider whether he or she pays the price for making the costly choice. According to Feinberg, “threats are like burdens on a man’s back, rather than shackles, or bonds, or bayonets. They make one of his alternatives more difficult but not impossible”.\footnote{Feinberg 1973, 7-8.} When freedom is discussed in the negative sense it seems that it is mainly the use of direct force and prevention which is understood as a restriction of freedom.\footnote{However, the border between direct an indirect force and between situations where there is a choice and situations where there is not, is not clear.} Juridical duties\footnote{Since negative liberty requires the absence of a juridical duty, juridical duties are defined as restrictions of freedom.} seem to be the only type of threat of harm which is counted as a restriction of negative liberty.
Even though it might be possible to break the law which defines some kind of duty to the individual, it is still seen as a restriction of negative liberty.

When we speak about freedom in the negative sense, not everything that makes it difficult for an individual to reach what he or she wants, like poverty, sickness or a challenging residential environment, are considered restrictions of freedom. Only restrictions which involve the coercive power of other human beings are counted as restrictions of an individual’s liberty. This means that restrictions of negative liberty are external. They “come from outside a person’s body-cum-mind”, as Feinberg expresses it. Moreover, restrictions of negative liberty seem to be positive (barred windows, locked doors, pointed bayonets), not negative (lack of money, lack of transportation, lack of weapons). 28

Understanding freedom in the negative sense does not require one to think that freedom should not be restricted. Vice versa, most thinkers who defend understanding freedom in this sense, 29 also present accepted reasons for restricting freedom. The most obvious reason for restricting negative liberty is the protection of other people’s rights. We cannot live in anarchy, which Feinberg defines, as follows:

The anarchistic principle, in short, would be workable only in a world in which human desires and choices, through a miracle of preestablished harmony, could never conflict. In our own world, where conflict and rivalry are ineradicable facts, “complete liberty for all” on the anarchist formula would mean greater freedom for the strong than the weak, and no very stable freedoms for anyone. 30

According to Kant, the individual’s freedom should be restricted only if it comes in to conflict with other people’s freedom. 31 When John Stuart Mill wants to maximise the individual’s freedom, he also brings up one necessary reason for the restriction of freedom, which is protecting other

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28 See Berlin 2005, 169; See Feinberg 1973, 9, 12-13. According to Feinberg (1973, 12-13), restrictions can be, on the one hand, internal or external: “External constraints are those that come from outside a person’s body-cum-mind, and all others constraints, whether sore muscles, headaches, or refractory “lower” desires, are internal to him.” On the other hand they can be negative or positive. While positive constraints are things which occur, negative constraints are absences, the lack of something. It follows that there are internal positive constraints (headaches, obsessive thoughts, compulsive desires), internal negative constraints (ignorance, weakness, deficiencies in talent or skill), external positive constraints (barred windows, locked doors, pointed bayonets) and external negative constraints (lack of money, lack of transportation, lack of weapons).

29 For example, Berlin (2005, 171-172) seems to recommend the concept of freedom or liberty in its negative sense. According to Berlin, in this sense, freedom means freedom, not some other good things, like happiness, justice or equality. While freedom is just freedom and not something else, it is possible to notice that it is not the only good thing which people wish to have in their lives. Therefore, in some situations an individual’s freedom can be in conflict with other “goods”, and it is possible that sometimes the other “goods” are prioritized over freedom.

30 Feinberg 1973, 23.

people’s rights. According to Mill, the individual’s own good is not, however, the reason for restricting his or her freedom. This is how maximum degree of freedom is protected for everyone. Freedom cannot be unlimited, because in an anarchistic society only strong people have freedom while others do not. However, according to a liberal point of view, the individual should always have a minimum amount of freedom and, therefore, some areas of freedom should stay unlimited. Otherwise the individual’s nature is denied and his or her essence is negated.\footnote{Mill 1948, 11-12, 24, 27, 54-55, 67-71, 76-78, 119. See also, Rauhala 1998, 86-87. Berlin (2005, 173) notes that there is no consensus on what kind of area of an individual’s freedom should be unlimited. See also Sen (1985, 136) who, when arguing for a wider view of freedom (discussed in this study in terms of capability), notes that “it must be sometimes right to violate deliberately someone’s negative freedom to bring about the prevention of a more serious violation of the negative freedom of someone else”.}

Most thinkers who defend understanding freedom in the negative sense, also accept so-called weak or justified paternalism.\footnote{It depends on the writer what term is used for acceptable paternalism.} It has been thought that people who lack of competence need a paternalistic intervention which restricts their freedom but which is justifiable since they cannot decide themselves what is best for them. For example, even though Mill is generally against paternalism, he still seems to think that it is acceptable to restrict the freedom of certain people for their own good.\footnote{See Mill 1948, 12, 82, 93, 119. See also Rauhala, 1998, 86-87.} I will consider the questions concerning competence and paternalistic restrictions of freedom in more depth later in chapter 3.4.

\subsection*{3.1.3. Freedom of belief and opinion in the negative sense}

Understanding the freedom of belief and opinion in the negative sense is in accordance with the classic understanding of these rights. Freedom of belief and opinion has been considered a political right which obligates the state and other people in negative sense. The only positive obligation of the state is to ensure, by jurisprudence and, if needed, by juridical punishment, that people do not impose on each other’s freedom of belief and opinion.\footnote{See Karapuu (2011, 81; 1999, 79-81), who states that negative freedom includes juridical freedom (freedom from intrusion by the state), and freedom from other people’s intrusions. Juridical freedom obligates the state only in a negative sense, but negative freedom, as a wider concept, also obligates the state in a positive sense so that the state has to ensure that other people do not impose on each other’s business. See also Sen (1985, 136), who claims that “valuing negative freedom must have some positive implications” and describes the situation where somebody is about to molest an other person and where the outsider is under a positive obligation to do something to stop this. As I see it, from the viewpoint of negative liberty, the positive obligation of the state to ensure that other people do not impose on each other’s business might well lead to the idea that it is a positive legal obligation of citizens to act in these kinds of emergencies in order to}
According to this model, freedom of belief and opinion means that other people do not interfere in technically and physically concrete ways with an individual’s believing and thinking. In addition, this view requires that other people do not prevent the individual from manifesting his or her beliefs and opinions. The individual may believe and practise his or her present beliefs and opinions, but on the other hand, the person need not believe or practise some beliefs, if that is what he or she wants at the time. When freedom of belief and opinion is understood as negative liberty, the primary suspected threat to the individual seems to be the state and mainstream opinions which might prevent, by restrictive legislation or forcible means, minorities and individuals from believing and thinking as they wish and from manifesting their beliefs and opinions.

According to this point of view, freedom of belief and opinion can be restricted if an individual by practising his or her beliefs or opinions endangers other people’s rights. This approach is clearly seen in current human rights theory and human rights documents, since freedom of belief and opinion (or, to be more precise, the dimension of the forum externum of it) can be restricted when the purpose is to protect other people. However, since the freedom to hold thoughts and opinions in one’s mind (the forum internum) is considered the core area of the right, it is not justified to interfere with it in any circumstances.  

It is clear that there is no right to endanger the life and security of other people. However, when we come to the area of people’s mental wellbeing it is more unclear how we should understand and define the idea that other people’s right may restrict someone’s freedom of belief and opinion. One question is whether restrictions of freedom of belief and opinion are justified in order to prevent other people’s mental distress. Feinberg notes that “hurt feelings” is such a minor product that they cannot be a justified reason for restricting somebody’s freedom. However, sometimes the mental hurt caused by other people’s way of exercising their freedom leads to a mental breakdown, and preventing a mental breakdown would be a justified reason for restricting other people’s freedom. This means, that so-called

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37 Feinberg considers the concept of harm as the invasion of an interest, as hurt, as offence and as nonbenefit. Feinberg 1973, 27-28. Feinberg (1973, 29) presents a harm principle which states that the only reason for restricting the freedom of someone is in order to prevent harm to others. However, “state power may not be used against one person to benefit another”. 

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psychological abuse or assault, which may occur, for example, in ideological communities, should be juridically punishable.\textsuperscript{38}

However, the view that psychological abuse constitutes a restriction someone’s freedom of belief and opinion seems quite unclear. To what extent should people in exercising their freedom of belief and opinion take into account the vulnerability of other people? Should people always consider when they say or teach something whether there is somebody somewhere who might have a mental breakdown because of what they have said or taught? How far we can assume that expressions of opinions in the course of teaching, for example, is the fundamental reason for mental breakdowns? For example, somebody might have a mental breakdown because his girlfriend has left him. However, this cannot be a reason for restricting the girlfriend’s freedom to leave him. In the same way, we can ask whether mental breakdowns which might occur in ideological and religious communities should be seen as a reason for restricting freedom of belief and opinion. Even though we might think that everyone should avoid causing other people to have mental breakdowns, is it a moral or a legal failure if a mental breakdown occurs? Are there situations where it is not possible to avoid causing mental breakdowns, however hard one might try, without one’s own area of freedom of belief and opinion becoming to narrow? I suggest that at least some kind of intentionality should be seen as one requirement of psychological abuse. Freedom of belief and opinion could be restricted in order to prevent a mental breakdown which would otherwise be caused intentionally, and there could be legal punishment for people who have caused a mental breakdown intentionally.\textsuperscript{39}

Sometimes so-called psychological abuse is actually social coercion, which cannot be punished by the state. Feinberg describes social coercion by referring to Mill:

We can’t prevent people from disapproving of an individual for his self-regarding faults or from expressing that disapproval to others, without undue restriction on their freedom.\textsuperscript{40}

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\textsuperscript{38} For more considerations about conflicts between the right to the freedom of belief and opinion and the right to mental health and mental integrity, see chapter 4.1.3. (from the viewpoint of authenticity) and in chapter 5.1.3. (from the viewpoint of capabilities).

\textsuperscript{39} In Finland’s legal system, psychological abuse can be defined as assault, which is illegal according to the Criminal Code (39/1889, Chapter 21, §5): “A person who employs physical violence on another or, without such violence, injures the health of another, causes pain to another, or renders another unconscious or into a comparable condition, shall be sentenced for assault to a fine or to imprisonment for at most two years.” See, Alastalo 2012. However, in the Government of Finland’s proposal, it is claimed that the concept of psychological assault is too unclear to include in the Criminal code. See Hallituksen esitys eduskunnalle rikoslainsäädännön kokonaisuudistuksen toisen vaiheen käsittäviksi rikoslain ja eräiden muiden lakien muutoksiksi. 1993/94, 1,9.1.4.

\textsuperscript{40} Feinberg 1973, 32.
It is also worth noting that questioning somebody’s beliefs and criticising their religion or opinions is not considered as interference with their freedom of belief and opinion. It is in accordance with other’s human rights to claim that somebody is mistaken, wrong or holding a heretical view. Ovey and White refer to the Otto-Preminger Institute case when they define the stand of the European Court of Human Rights:

> those holding religious beliefs ‘cannot reasonably expect to be exempt from all criticism’ and must ‘tolerate and accept the denial by others of their religious beliefs and even the propagation by others of doctrines hostile to their faith’.41

When freedom of belief and opinion is understood in the negative sense, it is meaningful to ask whether it is even possible for other people to interfere with the core area of this right, namely, the forum internum. If the interference with freedom can only come in the form of juridical duties or technically and physically verified “concrete” obstacles posed by other people, it is worth asking if the human being’s internal sphere can ever be threatened by these kinds of interferences. For example, manipulation and brainwashing as psychological measures are not technically and physiologically verified concrete obstacles. It also seems that there cannot be any legal duty to think or believe or not to think or believe in a certain way. Therefore, it seems that if freedom of belief and opinion is understood in the negative sense, only some kind of biological and physical way of manipulating an individual’s brain could be counted as interference with the forum internum.42

It seems that the view of freedom of belief and opinion as negative liberty is quite deeply linked with the human rights discussions which is focused on the content of beliefs and opinions: the forum internum is understood mainly as an absolute right to hold “content” in the mind while the forum externum is understood as the right to express that content in different ways.43 However, the view of freedom of belief and opinion as negative

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41 Ovey & White 2006, 301.
42 See Nowak 1993, 314. For example, the interpretation of Tazhib (1996, 25-26) is wider than this since he lists, for example, “discrimination on the basis of having or not having a certain religion or belief” and “the use of threat of physical force or penal sanctions to compel individuals to adhere to their religious or other beliefs, and congregations to recant their religion or belief or to convert” as violations of the forum internum.
43 See, for example, ICCPR 1966 (Article 18:1), which declares that freedom of thought, conscience and religion includes “freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching”. ICCPR 1966 (Article 19:1) states that: “everyone shall have the right to hold opinions without interference”. Italics mine. The verbs “to have”, “to adopt” and “to hold” seem to refer here to actions which deal with the contents of the beliefs and opinions. Moreover, in human rights theory discussion focuses on definitions of religion, belief, and so on. See chapter 2.2.2.
liberty seems indirectly to address or touch upon the process of thinking and believing and even the abilities needed for believing and thinking. Namely, when freedom of belief and opinion is understood as negative liberty, there is a requirement that there is sufficient competence at least for the dimension of the *forum externum*. Competence as a requirement seems to be linked, first, with the process of thinking and believing since it is required that the person forms his or her beliefs and opinions through a competent process. Second, competence seems to be linked with abilities since it signifies that the person is able to make decisions. Because of the requirement of competence, children and adult individuals with psychotic disorders or mental retardation do not necessarily hold the right to freedom of belief and opinion in the same way as competent people do. However, it is unclear, whether competence is also a requirement for the *forum internum*, and how the concept of competence and the concept of the *forum internum* are linked. It is also unclear whether we should discuss interferences with the freedom of belief and opinion of incompetent people or whether it is more a question of whether the concept of the freedom of belief and opinion applies at all to such people. However, I will return to this lack of clarity in chapter 3.4.4.

The negative view of liberty has been criticized. It has been said to be too narrow, since people who are “left” without interference, do not necessarily have the possibility of choosing between different meaningful options. It can be asked whether it is meaningful to see other people primarily as potential intruders especially in situations where the person has a lack of meaningful options. It also seems that views which emphasize freedom in the negative sense often assume that people are competent, adult and mentally capable. For example, when John Rawls describes his idea of society as a fair system of cooperation, he explicitly assumes that citizens and persons are free and equal, and normal and fully cooperating members of society over a complete life. Rawls himself acknowledges that people are not always in that assumed condition but he needs this supposition in order to develop a theory of justice as fairness:

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44 Rawls 1993, 20. See Rawls 1993, 301-302: “Our focus, then, is on persons as capable of being normal and fully cooperating members of society over a complete life.” Rawls (1993, 77-78) seems to describe this process of free and equal cooperating citizens by using the concept of “full autonomy”, which “is realized by citizens when they act from principles of justice that specify the fair terms of cooperation they would give to themselves when fairly represented as free and equal persons.” According to Rawls, full autonomy is a political value which is realized in public life by affirming the political principles of justice and enjoying the protections of the basic rights and liberties. It is realized when citizens participate in society’s public affairs and share in its collective self-determination over time.
But given our aim, I put aside for the time being these temporary disabilities and also permanent disabilities or mental disorders so severe as to prevent people from being cooperating members of society in the usual sense.45

It seems that at the same time that people with psychosis are defined as human beings with human rights, such as the freedom of belief and opinion, they are ignored or excluded when humanity and human rights are defined. The negative view of freedom of belief and opinion often seems to assume that the people, whose freedom we are discussing are not psychotic. This is probably a primary reason for the challenges and inconsistencies which occur when we discuss the psychotic individual’s freedom of belief and opinion in the negative sense. I will describe, among others, these challenges and inconsistencies in the following subchapters but I will also go in to more detail in order to understand better and test more thoroughly the nature of freedom of belief and opinion in the negative sense in the context of psychosis.

3.2. Psychiatric treatment and freedom of belief and opinion in the negative sense

In this subchapter, I first clarify how the negative view of freedom of belief and opinion is implied in legislation, ethical guidelines and discussions concerning psychiatric ethics when the idea of “least restrictive treatment” is described. After that I describe how non- or involuntary placement and treatment restrict freedom of belief and opinion in the negative sense. I also discuss the problematic relationship between the psychotic patient’s right to the forum internum and the use of involuntary antipsychotic medication in more detail.

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45 Rawls 1993, 20. Nussbaum (2006, 109-110) criticizes this kind of supposition of “fully cooperating” citizens in Rawls’s theory: “Thus the unusual needs of citizens with impairments and associated disabilities – needs for special educational treatment, for the redesign of public space (wheelchair ramps, wheelchair access on buses, tactile signage, and so on) – do not seem to be included at this initial stage, when basic political principles are chosen. Rawls makes it clear that he understands the concept of the “fully cooperating” in a way that excludes people with severe physical and mental impairments.”
3.2.1. The obligation to “stay outside” and the principle of least restriction

One way of understanding freedom of belief and opinion in terms of negative liberty is clear, for example, in the legislation and ethical principles which guide psychiatric care in that they note that other people have a duty not to restrict freedom or have a duty to restrict it as little as possible. The patient’s freedom of belief and opinion obligates nursing staff to stay outside the psychotic individual’s area of freedom\(^{46}\) as far as possible. There is a responsibility to let be, as Stanley Reiser puts it.\(^{47}\)

According to international human rights conventions and ethical principles, the psychotic individual’s freedom of belief and opinion is a starting point, and there should be a specific legal reason for interfering with it. It is stated that restrictions of freedom of belief and opinion should be the exception rather than the norm.\(^{48}\) This approach seems to express the idea that there is “a presumption in favor of freedom, even though it can in some cases be overidden by more powerful reasons on the other side”, as Feinberg puts it. Even though coercion is sometimes necessary in order to prevent something which is considered evil it always “has its price”.\(^{49}\)

It seems to be in accordance with this “starting point principle”, which can also be defined as the fundamental “least restriction principle”,\(^{50}\) that the legislation and ethical principles which guide psychiatry note that the treatment of mental patients should be the least restrictive possible. For example, the PUN notices:

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\(^{46}\) See Berlin’s definition of negative liberty in chapter 3.1.1.

\(^{47}\) Reiser 1980, 329.

\(^{48}\) See, for example, the Explanatory Memorandum to RCE (2004, Article 4:47) that notes: “Restrictions on these [civil and political] rights should be an exception rather than the norm. Given the importance of these rights, any restrictions on them must be prescribed by law.” According to the PUN (1991, Principle 1:5), every person with a mental illness has a right to exercise all the civil and political rights defined in international human right covenants. According to the General limitation clause of the PUN, the exercising of the rights set forth in the Principles may be subject only to limitations that are prescribed by law and are considered necessary.

\(^{49}\) Feinberg 1973, 21. Referring to the idea that freedom is necessary for each individual’s highest good which is a dynamic process of growth and self-realization, Feinberg (1973, 22) continues: “Such are the grounds for holding that there is always a presumption in favor of freedom, that whenever we are faced with an option between forcing a person to do something and letting him decide on his own whether or not to do it, other things being equal, we should always opt for the latter. If a strong general presumption for freedom has been established, the burden of proof rests on the shoulders of the advocate of coercion, and the philosopher’s task will be to state the conditions under which the presumption can be overidden.”

\(^{50}\) The Explanatory Memorandum to the RCE (2004, Article 8:58) notes that the principle of least restriction should be seen as a fundamental principle.
Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment.\footnote{PUN 1991, Principle 9:1. See also the Mental Health Act (Mielenterveyslaki 2001/1423, 22a§) that notices: “A patient’s right of self-determination and other fundamental rights may be limited in virtue of the provisions of this Chapter only to the extent necessary for the treatment of the illness or for the person’s safety or the safety of others or for safeguarding some other interest laid down in this Chapter.” See also Laitinen 1996, 10; Peele & Chodoff 2009, 213.}

In addition, the Madrid Declaration declares that psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient,\footnote{Madrid Declaration 1996, 1.} while the RCE notes that:

Persons with mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others.\footnote{RCE 2004, Article 8.}

The Explanatory Memorandum to the RCE mentions, moreover, that a person with mental disorder should not automatically be deprived of the right to vote, or make a will.\footnote{In this article, the Explanatory Memorandum refers to Principle 3 of the Council of Europe Recommendation R (99)4 on principles concerning the legal protection of incapable adults. RCE 2004, Explanatory Memorandum, Article 4:49.} This is one of the rare examples of how the principle of least restriction appears in legislation and ethical guidelines when it comes to the question of the freedom of belief and opinion.

Legislation and ethical principles which guide psychiatric care also note that the patient should be respected. They rule that nursing staff should respect the psychotic individual’s conviction and take his or her opinion into account in administering treatment. The PUN mentions that:

every patient in a mental health facility shall, in particular, have the right to full respect for his or her...freedom of religion or belief.\footnote{PUN, Principle 13:1. The Act on the Status and Rights of Patients (785/1992, 3§) states: “The care of the patient has to be arranged so and he/she shall also otherwise be treated so that his/her human dignity is not violated and that his/her conviction and privacy is respected.”}

The duty to respect a patient’s conviction means, in terms of negative liberty, that the psychotic individual’s believing and thinking, as well as acting and making decisions according to his or her beliefs and opinions, is restricted by other people’s concrete measures or by juridical duties as little as possible. Respecting understood in the negative sense of liberty signifies that there is an obligation not to interfere. The focus is not, for example, on taking the patient’s view actively into account in deciding on treatment options or in influencing what else the nursing staff could arrange for the patient.\footnote{In my opinion, the latter view refers to viewing freedom of belief and opinion in terms of capability.}
In the Oviedo Convention the obligation to “stay outside” is implicitly present in articles which consider human dignity and threats to that dignity. The Oviedo Convention emphasizes the need of “ensuring the dignity of the human being” and mentions that “the misuse of biology and medicine may lead to acts endangering human dignity”.\textsuperscript{57} The purpose of the Convention is to ensure that:

Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.\textsuperscript{58}

It seems that the Oviedo Convention sees other people and the application of biology and medicine carried out by other people as the main possible threat to human dignity and fundamental freedoms.\textsuperscript{59}

The principle of least restriction imposes an obligation to ensure that the individual’s treatment is modified to his or her health needs. Therefore, the less serious the individual’s health is, the less restrictive the treatment should be.\textsuperscript{60} However, it is not always clear what treatment options are less restrictive than others. One argument seems to be that treatments to which the patient has given his or her informed consent are less restrictive than treatments which are given without such consent. It is notable that the voluntary treatment and treatment of outpatients are considered, in accordance with the principle of least restrictive treatment, the primary choice for psychotic individuals. For example, the Mental Health Act of Finland states:

Mental health services must be organized primarily on an out-patient basis and in a way that supports the patient’s own initiative in seeking treatment and their independent coping.\textsuperscript{61}

\textsuperscript{57} Oviedo Convention 1997, Preamble.
\textsuperscript{58} Oviedo Convention 1997, Article 1.
\textsuperscript{59} This is also an example of how the concept of human dignity is tied up with the concept of human rights. For more discussion about the relationship between these concepts, see chapter 2.2.2.
\textsuperscript{60} The Explanatory Memorandum to the RCE (2004, Article 8:58) notes that: “As the person’s illness improves, the principle of least restriction implies that they should be moved to a less restrictive environment when this would be appropriate to the person’s health needs.” See also the Mental Health Act (Mielenterveyslaki 2009/1066, 12§), which states that the decision to prescribe nonvoluntary treatment is not unlimited since it is valid for only three months. After that, the need for such treatment has to be re-evaluated.
\textsuperscript{61} Mielenterveyslaki 1116/1990, 4§. According to the Explanatory Memorandum to the RCE (2004, Article 8:58), alternatives to involuntary measures should be made as widely available as possible. In Article 10:73, the Explanatory Memorandum notes that: “If a person has been subject to involuntary measures in the past, the availability of after-care and early intervention services can help to minimise the need for placement in the future.” Article 10:75 continues: “Involuntary placement and involuntary treatment are measures that involve a significant restriction of the rights of the individual concerned. They should be a last resort. Indeed it of Article 10 emphasizes the need to develop alternatives to involuntary placement and involuntary treatment, in accordance with the principle of least restriction.” See also Kuosmanen et al 2007, 598.
Also psychiatric patients note the aspect of giving their consent when they define the concept of self-determination in Välimäki’s study. Self-determination means for the patients, for example, that they can refuse treatment and that they can decide themselves whether they go to the hospital or not or whether to go for therapy.62

The other tendency which is brought up when “the least restrictive treatment” is discussed concerns the definition of physical force and the use of medication that is more restrictive than psychological or psycho-social interventions. This tendency seems to be in accordance with the negative view of freedom of belief and opinion since it focuses on technically and physically verified concrete obstacles. According to Bruce Winick’s analysis of juridical decisions in the United States, psychotherapy and other verbal interventions have been considered less intrusive than, for example, psychosurgery, electroconvulsive therapy and psychotropic medication (including antipsychotic medication). According to Winick, psychotherapy and other verbal measures are such slow techniques that it is possible for the patient to accept or reject a change in their beliefs and opinions. In these discussions the focus is on the process of believing and thinking with which the state should not interfere by using restrictive treatments.63

However, it is not so clear that psychotherapy is necessarily always less intrusive than the use of psychopharmacon. The case of Raphael Osheroff from the United States in the 1980s reveals that sometimes it can be quite the opposite. Raphael Osheroff was a middle-aged physician who after serious difficulties in his relationships was admitted to treatment in a private psychiatric hospital. Psychiatrists diagnosed him with narcissistic personality disorder. They decided not to use medication (Osheroff had refused medication in previous treatments contacts) and chose to treat Osheroff with psychodynamic therapy. Their evaluation was that Osheroff should stay at the hospital for about three years. Since Osheroff was suicidal and in a bad condition, he was placed under 24-hour surveillance. There were also restrictions on his phone calls. Osheroff felt that the treatment was demeaning. After seven months Osheroff was transferred to an other psychiatric hospital. A psychiatrist there diagnosed Osheroff with psychotic depression and treated him with medication and supportive therapy. In about two or three weeks, Osheroff seemed less depressed and eventually he could live as an outpatient and was able to work. After getting better Osheroff took legal action, and there was a malpractice suit against the private hospital where Osheroff was first treated. According to the court, the psychiatrists in the first hospital had failed

to diagnose and treat his depression with appropriate biological measures and had failed to inform Osheroff of treatment options.  

Many themes are interesting in Osheroff’s case but in terms of the use of the least restrictive treatment there are at least two points to make if the freedom of belief and opinion is understood in the negative sense. First, it can be asked whether the use of medication is really more restrictive than the use of psychological treatment if it involves such a restrictive environment, as was the case with Osheroff. Second, in some cases a decision not to use medication could be considered as malpractice, which means that psychiatrists should seek not only the least restrictive treatment but also the most suitable. Treatment has to meet the health needs of the patient.  

The Explanatory Memorandum to the RCE points out that different people might have different kinds of opinions about what they would regard as more or less restrictive or intrusive:

some people may consider a type of psychotherapy in which it is necessary to explore intimate beliefs and feelings as more intrusive than the use of medication. Other people may take the opposite view.

Because of this, the Explanatory Memorandum emphasizes that the intrusiveness of any particular treatment is a matter of subjective evaluation. The Explanatory Memorandum suggests that the person’s opinion is taken into account when his or her treatment is being decided upon. Even though this notion has its uses, the problem is that the psychotic patient is not necessarily competent of expressing a view about what he or she considers to be the least restrictive option. In these situations, other people should also have the right to express an opinion about what might be the least restrictive treatment. Thus, the question about what constitutes the least restrictive treatment cannot be fully left as a matter of subjective evaluation.

From the viewpoint of psychotic patients who are being treated in a psychiatric hospital, the aspect of “least restrictive treatment” is connected to the question of permissions and rules. If the patient has to stay in the hospital, the rules can be seen as “legal duties” which restrict his or her freedom of belief and opinion. The absence of some rules signifies permission in those matters, which means that there is more freedom. This issue of freedom is

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64 Kader & Pantelis 2009, 357; Malcolm 1986, 9, 16-25, 34; Robertson 2005, 348. Robertson (2005, 349) sees the Osheroff case as an example of the battle between two forms of knowledge in psychiatry, namely, evidence-based-medicine and clinical experience.

65 See, for example, the RCE (2004, article 8) which states that psychotic persons have a right to be cared for using the least restrictive or intrusive treatment available, taking into account their health needs.

66 Moreover, the Explanatory Memorandum notes that in some situations a person may wish to waive their right to receiving the least intrusive treatment available. RCE 2004, Explanatory Memorandum, Article 8: 59-60.
noticed by psychiatric patients in Välimäki’s study. Patients define the meaning of self-determination, for example, in various ways: “But I mean I am more or less free to live here as I please”, “It’s like we have permission here to stay up at night or to get up almost whenever we want”, “You don’t have to go down for coffee in the morning” and “You can say what you think”.

3.2.2. Non- and involuntary treatment as an interference with negative liberty

Non- and involuntary psychiatric treatment is seen as a interference with freedom of belief and opinion in the negative sense. For example, the way in which concepts such as “deprivation of liberty” or “loss of freedom” are used when non- or involuntary treatment is being discussed implies that freedom is understood as negative liberty. For example, Matti Pellonpää notes that prescribing a patient involuntary treatment in a psychiatric hospital signifies a loss of freedom even though the patient is able to move freely within the hospital’s grounds. Lauri Kuosmanen argues that:

In certain situations nursing can include interventions depriving patients’ of their liberty as part of managing disturbed or distressed behaviour or in maintaining the safety of patients and staff in psychiatric settings.

In the “White Paper” on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment, involuntary treatment is

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67 Välimäki 1998, 63. According to Välimäki (1998, 64), the absence of any limitations imposed by others helps to support self-determination.

68 See Pellonpää 2011, 291-292. See also Bolton & Banner (2012, 81, 89), who note that “mental health legislation permits deprivation of liberty for reasons of mental illness” when they define autonomy as “freedom of the individual citizen to carry on with his or her own affairs, in particular freedom of the individual from state control, provided this does not interfere with the freedom of others”. It seems that Bolton & Banner define autonomy here in the way in which negative liberty is defined in my study. However, it is not only the freedom of others which imposes limitations on liberty, as Bolton & Banner put it, but all kinds of human rights. See also Widdershoven & Abma 2012, 217; Peele & Chodoff 2009, 212.

69 Kuosmanen 2009, 13. Kuosmanen (2009, 13, 49) also mentions involuntary admission and detention, seclusion and restraint, restrictions on communication or leaving the ward and confiscation of patient’s personal property as restrictions of patient’s liberty and notes that patients experienced these interventions negative.

70 The White Paper was drawn up by a Working Party of the Steering Committee on Bioethics of the Council of Europe and it was published for public consultation in 2000 in order to develop guidelines, which were later set out in the RCE. See the Explanatory Memorandum to the RCE 2004, 8. It is interesting that in the RCE expressions like “deprivation of liberty” are not used in the context of involuntary treatment. One possible explanation for this is that a consensus was not
considered as a restriction of freedom or as a deprivation of liberty. First, it refers to the European Convention on Human Rights which concerns legal procedures in situations when somebody is deprived of their liberty. Second, when the White Paper considers the criteria for prescribing involuntary treatment it discusses the deprivation of liberty that occurs as a result of involuntary placement or the administration of an involuntary treatment.

Involuntary treatment was defined as a restriction of self-determination by the patients interviewed in Välimäki’s study. For example, one patient said that: “There’s no right to self-determination here. If you’re told to go to hospital, that’s where you have to go”. According to Kuosmanen et al’s study “patients experienced restrictions on leaving the ward and on communication, confiscation of property and coercive measures as deprivation of liberty”.

I want to add two notions to the concepts of non- or involuntary treatment. First, the term “involuntary” have been interpreted in different ways. One interpretation is that the term involuntary means that the individual has not given his or her consent to something. For this interpretation I use the term nonvoluntary treatment in this study. According to this interpretation, nonvoluntary treatment is not necessarily treatment against the patient’s expressed wishes. It is nonvoluntary treatment if some treatment is given to the patient without asking his or her consent for this treatment to be given. However, in this study the concept of nonvoluntary treatment refers mainly to cases where the patient is not able to consent. In these cases it does not matter whether the patient objects or accepts the treatment. His or her wishes or

found on questions such as whether freedom should be understood as negative liberty or in some other sense and whether competence should be seen as a requirement when applying the concept of liberty. See the considerations presented in chapter 3.4. and in chapters 4 and 5. However, the Explanatory Memorandum to the RCE (2004, Article 10:75) states that “involuntary placement and involuntary treatment are measures that involve a significant restriction of the rights of the individual concerned. They should be a last resort.”

The White Paper (2000, Introduction) states: “Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.”

See the White Paper 2000, Article 3. The White Paper (2000, Introduction) also notes that the opinion of the Working Party on Psychiatry and Human Rights was that: “no matter what independent bodies supervise this restriction of freedom, they do not relieve the therapists and professionals in direct contact with people suffering from mental disorder of their ethical and legal considerations which must constantly accompany them in their work.” Italics mine.

The other patient defines self-determination: “In practice it doesn’t mean anything, if they want to restrict you. If they want to restrict your self-determination, there’s no way mental patients can have their share of it. No way.” Välimäki 1998, 64.

Kuosmanen 2009, 4.

The Explanatory Memorandum to the RCE 2004, Article 26, 187.

It is nonvoluntary treatment in this meaning, for example, if during surgery some additional surgical measures are conducted for the patient without the patient being asked in advance whether he or she gives consent to these measures.
attitudes have no relevance in deciding about the need for treatment – and this is why such treatment is called nonvoluntary. This is the way the term is used in the Finnish Mental Health Act. However, the Explanatory Memorandum to the RCE defines “involuntary” in the sense that it is against the individual’s current expressed will or attitude, which means that the individual objects to or refuses it and the treatment is carried out anyway. The Explanatory Memorandum to the RCE defines an “involuntary” measure as a measure that is against the person’s will “when the person has the capacity to consent and refuses the measure, or does not have the capacity to consent and objects to it”. Thus, it is stated, that if the person has no capacity to consent, he or she has no capacity to refuse. However, he or she is still able to express an objection. One Finnish textbook of psychiatry also discusses involuntary treatment in this sense, since the supposition seems to be that the person subject to this treatment objects to it. The textbook, for example, uses the concept of “treatment against the will” when it discusses the background of the Finnish Mental Health Act, which is misleading since the Act talks about nonvoluntary treatment, which is not necessarily against the patient’s will.

In order to make this difficult issue conceptually clearer I will use the concepts of involuntary treatment and nonvoluntary treatment to mean different things. When I discuss involuntary treatment, the focus is on the fact that the patient “expresses” an opinion against a particular treatment (does not accept, objects, refuses or fights against treatment). Voluntary treatment (or compliance with treatment) is the opposite of involuntary treatment. When I discuss nonvoluntary treatment, the focus is on the lack of consent (which in this study is usually a result of the incompetent state of the patient, which in turn means that he or she is not able to give consent). The opposite of nonvoluntary treatment is treatment in which the patient gives consent (which requires competence). The difference between involuntary and nonvoluntary

77 Mielenterveyslaki 1990/1116, §8. See Laitinen 1996, 1, note 1. It is worth noting that the unofficial English translation of the Mental Health Act (see http://www.finlex.ﬁ/en/laki/kaannokset/1990/en19901116.pdf) defines nonvoluntary treatment as something to which a person is ordered “against his or her will”. This translation is conceptually misleading here, because the term “tahdosta rippumaton hoito” used in the original Finnish version does not require that the treatment is against the patient’s will.

78 The Explanatory Memorandum to the RCE 2004, Article 16:123, Article 26:187. The Explanatory Memorandum notes that involuntary measures are seldom forced measures, since only a few patients subject to involuntary treatment actively resist treatment. Moreover, the Explanatory Memorandum points out that involuntary measures can be used in situations when the individual’s opinion changes recurrently. The Explanatory Memorandum to the RCE 2004, Articles 16:121, 125-126; 26:187. Moreover, the Explanatory Memorandum (2004, Article 16:123) points out that if the person has the capacity to consent to an intervention then the person also has the capacity to refuse it.

79 Heikkinen et al 2007, 689. See also Lönnqvist & Lehtonen (2007, 18) who, when they discuss informed consent seem to assume that involuntary treatment is treatment against the psychotic individual’s will.
treatment is that in the former the expressed opinion towards treatment is always negative while in the latter it is not necessarily (or would not necessarily be) negative. However, involuntary and nonvoluntary treatment are not opposites; they have common areas (the same treatment can be both involuntary and nonvoluntary). Nonvoluntary and voluntary treatment are not opposites either, but also have common areas (the same treatment can be both nonvoluntary and voluntary). The following table clarifies these conceptual differences:

<table>
<thead>
<tr>
<th>State of the patient</th>
<th>Involuntary treatment (Forced treatment)</th>
<th>Nonvoluntary treatment (no consent to treatment)</th>
<th>Voluntary treatment (compliance with treatment)</th>
<th>Consent to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incompetent (justified paternalism) or competent (usually unjustified paternalism)</td>
<td>Incompetent (not able to consent) or competent (not asked for consent)</td>
<td>Incompetent or competent</td>
<td>Competent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expressed opinion towards treatment</th>
<th>Does not accept / objects / refuses / fights against</th>
<th>Incompetent patient: The expressed opinion, whatever it may be, is not relevant; Competent patient: a lack of an expressed opinion</th>
<th>Accepts to / agrees / asks for treatment</th>
<th>Accepts / agrees to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
<td>Does not give consent / is not able to give consent</td>
<td>Is not competent of giving consent (or consent not asked)</td>
<td>Gives consent or is not able to give consent</td>
<td>Is competent of giving consent and gives consent</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Options of the patient</th>
<th>Involuntary or voluntary</th>
<th>Nonvoluntary treatment (no consent to treatment)</th>
<th>Voluntary treatment (compliance with treatment)</th>
<th>Consent to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Involuntary treatment (Forced treatment)</strong></td>
<td>No options (options of involuntary and voluntary treatment can be presented as a test if the purpose is to find out whether the patient is competent)</td>
<td>Incompetent patient: involuntary or voluntary; Competent patient: voluntary or no consent to have treatment</td>
<td>Consent to treatment or withholding consent to have treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Opposite</strong></td>
<td>Voluntary treatment</td>
<td>Consent to treatment</td>
<td>Involuntary treatment</td>
<td>Nonvoluntary treatment</td>
</tr>
<tr>
<td><strong>Conceptual clarification</strong></td>
<td>If the patient is incompetent, involuntary treatment is also nonvoluntary treatment</td>
<td>If the patient’s expressed attitude towards treatment is negative it is also involuntary treatment, if positive, it is also voluntary treatment</td>
<td>If the patient is incompetent, voluntary treatment is also nonvoluntary treatment</td>
<td>Consent to treatment is voluntary treatment (quite passive accepting and agreeing) of competent patients</td>
</tr>
</tbody>
</table>

It seems that both non- or involuntary treatment can be seen as interferences with the freedom of belief and opinion in the negative sense. Even if a person who is sent for nonvoluntary treatment “accepts” the decision, his or her freedom has been restricted because he or she could not make any other choice. Moreover, a person’s freedom can be said to be limited if his or her options are to be treated either voluntarily or involuntarily, even though he or she chooses voluntary treatment, since, in this case, the person cannot choose the option “not to be treated at all”.

The second issue regarding non- or involuntary treatment is that many ethical guidelines such as the PUN and the RCE make a distinction.

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80 Compared to Feinberg (1973, 5-7), if somebody forces you to vote for the person whom you would have voted for anyway, you cannot be said to be free because you don’t have the possibility of changing your mind, if you wished to do so.
between involuntary placement and involuntary treatment and define the criteria for placement and treatment separately. The Mental Health Act of Finland also seems to differentiate between nonvoluntary placement and nonvoluntary treatment since it notes, in section 8, that a person can be ordered to have treatment in a psychiatric hospital without consent when certain criteria are fulfilled, but considers limitations on patients’ fundamental rights during nonvoluntary treatment and examination separately from section 8 in chapter of 4a, which was added to the Act in 2001 and which considers, among other things, the treatment of mental illness. It states: “In

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81 The PUN (1991, Principle 16:1) considers, firstly, involuntary placement: “A person may (a) be admitted involuntary to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers: (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.” The PUN (1991, Principle 11:6) notes separately that involuntary treatment may be given if the following conditions are satisfied: “(a) The patient is, at the relevant time, held as an involuntary patient; (b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient’s own safety or the safety of others, the patient unreasonably withholds such consent; and (c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient’s health needs.” The RCE (2004, Article 17:1) defines involuntary placement, as follows: “A person may be subject to involuntary placement only if all the following conditions are met: i. the person has a mental disorder; ii. the person’s condition represents a significant risk of serious harm to his or her health or to other persons; iii. the placement includes a therapeutic purpose; iv. no less restrictive means of providing appropriate care are available; v. the opinion of the person concerned has been taken into consideration.” The RCE (2004, Article 18) considers involuntary treatment in the following way: “A person may be subject to involuntary treatment only if all the following conditions are met: i. the person has a mental disorder; ii. the person’s condition represents a significant risk of serious harm to his or her health or to other persons; iii. no less intrusive means of providing appropriate care are available; iv. the opinion of the person concerned has been taken into consideration.” As one can see, neither of these measures requires that the patient has a psychotic disorder, since the RCE uses the more general definition of “mental disorder”. However, the Explanatory Memorandum (2004, Articles 17:1, 18:140) clarifies this by stating that: “Involuntary placement/treatment is in general only considered appropriate with regard to certain types of mental disorder, for example psychoses or other severe mental disorders.” The criteria are more general in the Madrid Declaration (1996, 4) as it notes: “No treatment should be provided against the patient’s will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her.”

82 Section 8 of the Mental Health Act of Finland considers the criteria of nonvoluntary treatment: “A person can be ordered to nonvoluntary treatment in a psychiatric hospital only (1) if the person is diagnosed as mentally ill; (2) if the person needs treatment for a mental illness which, if not treated, would become considerably worse or severely endanger the person’s health or safety or the health or safety of others; and (3) if all other mental health services are inapplicable or
treating a patient’s mental illness nonvoluntarily only such medically acceptable methods of examination and treatment may be used the failure to use of which would seriously jeopardise the health and safety of the patients or others.”83 After adding chapter 4a, the meaning of section 8 referred to above seems to change, so that it considers, actually, nonvoluntary placement, even though the concept of nonvoluntary treatment has been used.84 Both non- and involuntary placement and non- and involuntary treatment can be seen as restrictions of freedom of belief and opinion in the negative sense. However, they seem to restrict different dimensions of the freedom of belief and opinion. I will return to this question in the following two chapters.

3.2.3. The forum externum in non- and involuntary placement and treatment

Some restrictions of liberty which occur in non- or involuntary placement and treatment are limitations of the external dimension of freedom of belief and opinion (the forum externum). These restrictions, it is argued, are justified in terms of protecting the patient’s health and safety and the health and safety of other people.85 It is worth noting that restrictions are also regarded as justified in cases where the beliefs and opinions manifested are not considered delusional. For example, manifesting traditional religious beliefs or shared political convictions can also be restricted in certain situations.

Firstly, the person’s right to move can be restricted. For example, The Mental Health Act of Finland states:

The patient may be prohibited from leaving the premises of the hospital or the premises of a certain care unit. If the patient leaves the hospital without permission or fails to

83 Mielenterveyslaki 1990/1116, 8§. Kaltiala-Heino (1997) has analysed the criteria used in deciding upon nonvoluntary treatment by distinguishing a fundamental criterion and additional criteria, which can be divided in to three groups. The diagnosis of psychotic disorder can be called the fundamental criterion of nonvoluntary treatment, since, according to general practice and legislation, only psychiatric patients who are suspected to be psychotic can be referred to nonvoluntary placement and treatment. The additional criteria of nonvoluntary placement and treatment are (1) the need for treatment, (2) presenting a danger to oneself, and (3) presenting a danger to others. The need for treatment and presenting a danger to oneself are criteria that refer to the patient’s best interest, and when coercion is used on the basis of this criteria it is called paternalistic coercion. Nonvoluntary placement and treatment always require paternalistic coercion, because an individual cannot be referred to such placement or treatment if he or she is not in need of treatment. The criterion that the patient is dangerous to others is based on the duty or concern to protect others.

84 See Mielenterveyslaki 2001/1423, Chapter 4a; Mielenterveyslaki 1990/1116, 8§.

85 See the criteria for restricting psychiatric patients, for example, in Mielenterveyslaki 2001/1423, 22b§. For more about the reasons for such restrictions, see chapter 3.3.
return to the hospital after having got permission, the patient can be brought back to the hospital.86

Kuosmanen et al describe how the patients interviewed in his study considered that they had been deprived of their liberty because they were not allowed to leave the ward freely.

In order to go out they had to ask a nurse to open the door. Patients described situations where they were not allowed to leave the ward under any circumstances or their leaving was restricted, for instance, being allowed to go for walks only twice a day or only with a staff member, or going for group walks with staff and other patients.87

Restricting the right to move may also constitute or result in the individual being prevented from exercising and expressing his or her beliefs and opinions outside the hospital and from sharing them with other people. A person who is in hospital non- or involuntarily can be kept apart from his or her religious, political or ideological community during his or her stay in hospital. The person can also be put under physical restraint or secluded within the hospital in order to “prevent immediate or imminent harm to the patient or others”, as the PUN puts it.88 This means that the area in which a patient can manifest his or her beliefs and opinions is even narrower. If, for example, a Muslim patient is tied to bed, it is impossible for him or her to kneel towards Mecca during prayer.

Also communication with people who are connected with the patient’s religion, beliefs or opinions can be prevented. The Mental Health Act of Finland states:

A patient’s contacts with persons outside the hospital may be limited if they seriously hamper the treatment, rehabilitation or safety of the patient or if the limitation is necessary to protect the privacy of some other person.89

86 Mielenterveyslaki 2001/1423, 22d§. See also PUN 1991, Principle 15:3.
87 Kuosmanen et al 2007, 600. See also the opinion of one psychiatric patient interviewed in Välimäki’s study: “We don’t have have the same rights as other people. I mean like in walking freely”. Välimäki 1998, 64.
88 PUN 1991, Principle 11:11. See also Mielenterveyslaki 2001/1423, 22e§; RCE 2004, Article 27. One Finnish textbook of psychiatry pays special attention to questions concerning isolation and tying patients up. These are defined as “strong interfering with the patient’s personal integrity”. Heikkinen et al 2007, 694. According to Kuosmanen et al (2007, 601), patients reported “having experienced deprivation of their liberty in situations where they had been subjected to various coercive measures. Some had been in seclusion rooms and some reported the use of mechanical restraints.”
89 Mielenterveyslaki 2001/1423, 22j§. See also RCE 2004, Article 23. On the other hand, the psychotic patient’s right to communication is also highlighted. See, for example, the Explanatory Memorandum to the RCE (2004, Article 23:169) that notices: “The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has highlighted the importance of those subject to involuntary placement being able to communicate with the outside world, both from a therapeutic standpoint and as a safeguard against abuse.” See also the opinion of one patient in Iso-Koivisto’s study (2004, 66), who said that not being allowed to use
In Kuosmanen et al’s research, some patients reported that they had too few opportunities to communicate with the outside world:

This was because of limited time being allowed to meet relatives and friends. They considered that short or limited visiting hours kept them isolated from the outside world. In addition, some patients were not allowed to use their cellphones or were allowed to use them only at certain times.  

Nursing staff may, for example, decide that the friends or other carers should not pray together with a patient with manic disorder because it would threaten the patient’s rehabilitation. Exorcism, executed by the patient’s religious carers, may also be evaluated as a threat to the success of the treatment. Restrictions of communication in order to protect other people’s privacy may come into question, for example, if an individual believes he or she is a prophet and wants constantly to communicate messages to somebody who finds this irritating. One interesting question is whether a patient’s freedom of belief and opinion should be restricted in order to protect his or her reputation. For example, if a patient wants to preach about his or her delusion to other people and tell his or her boss about these, should the nursing staff prevent this in order to keep it private?

Moreover, since in non- or involuntary treatment an individual’s personal property can be seized by the mental health unit, this might also include items of personal property that are used in exercising, manifesting and developing a person’s beliefs and opinions. For example, if the nursing staff thinks that reading some ideological book influences a patient’s thoughts and emotions negatively, they have to consider whether the book should be seized in order to protect the patient’s well-being. Sometimes a patient with

the phone was the most tiresome issue in his psychiatric treatment: “there was no phone, and I couldn’t contact to my friends”. It is unclear whether in this case calling was really prevented (in the negative sense of liberty) or whether it was more a lack of resources, namely the lack of a phone (freedom in the terms of capability) that was the problem.


See Wilson (1998, 170), who notes that it is better for a manic patient to avoid praying together with him or her. An individual with manic disorder may need religious support after a manic episode if he or she feels shame and guilt. According to Wilson, a person with psychotic depression may need spiritual support like encouragement and prayers for getting better. It seems that Wilson recommends a prayer which promotes well-being. He does not consider the question from the viewpoint of freedom of religion.

See the considerations presented by Radden 2012, 124-134.

See Mielenterveyslaki 2001/1423, 22g. Kuosmanen et al (2007, 601) note that patients had said that it was a deprivation of their liberty when they had to wear hospital pyjamas and dressing gowns at the beginning of the treatment period. Moreover, they had to give their cash to nursing staff on admission and could obtain some of it only on certain occasions.

See Wilson (1998, 170), who notes that it might be good to restrict, for example, a manic patient from reading the Bible constantly. However, Wilson notes that it would be best not to seize the Bible and prevent reading totally because in that case the patient may feel that he or she is treated badly, and this may influence the treatment’s effectiveness adversely. It is worth noting that
psychotic disorder may use some material in order to convert other patients to his or her religion or convictions. In this case, the nursing staff has to consider whether seizing such material is necessary in order to protect other patients’ well-being and public order in the hospital.

In addition, if an individual is in non- or involuntary treatment, his or her right to decide about treatment for a physical illness is more restricted than it would be if he or she were not undergoing non- or involuntary treatment. The Mental Health Act of Finland states that a physical illness can be treated if the patient in nonvoluntary treatment is considered unable to decide about the treatment and if it is considered necessary to avert a danger to the patient’s life or health. This means that the individual with psychosis cannot necessarily refuse treatment, for example, on religious or ideological grounds. For example, it is unclear whether a psychotic patient who is a Jehovah’s Witness and in nonvoluntary treatment can refuse to have a blood transfusion even if doctors think it is medically necessary. However, a Jehovah’s Witness who is not in nonvoluntary psychiatric treatment can refuse to have a blood transfusion, and it would be illegal, according to the Act on the Status and Rights of Patients, to give him or her a blood transfusion against their will.

When it comes to freedom of belief and opinion it is also interesting to note that some patients may conduct themselves in a way that they think nursing staff think is the “right way of conduct” in order to make their involuntary treatment come to an end. They learn to say the “right things” and avoid saying the “wrong things” to the nursing staff. Kaltiala-Heino notes:

The patients realize that to reach discharge they need to hide their opinions and to restrict their behaviour.

It is worth asking whether treatment can be successful if the patient does not regard it as meaningful. However, from the viewpoint of negative liberty the question is whether such “game playing” by patients should be seen as a restriction of their freedom of belief and opinion. In “game-playing” situation, patients could, if they wanted, express their true opinions. However, since patients choose not to do so in order to make the duration of involuntary treatment shorter, it could also be claimed that outside pressure, namely, the

Wilson does not consider a patient’s reading of the Bible from the viewpoint of the freedom of religion. His focus is, instead, on the well-being of the patient and the success of the treatment.

Mielenterveyslaki 2001/1423, 22c.

See Laki potilaan asemasta ja oikeuksista 489/1999, 6§, 9§. See also Louhiala 1995, 60.


When game-playing occurs, goals are defined inside the game, and nursing staff may also end up game-playing and adopting their own goals of the game. This might happen little by little without anybody recognizing what is going on.
fact that they are in involuntary treatment, is like a juridical duty which the patient is not free of. If people outside psychiatric hospitals restrict their behaviour or expressions in order to prevent juridical sanction, their liberty can be said to have been limited since there is a juridical duty not to behave in certain way or not to express certain opinions. It seems to be almost the same situation if people restrict their behaviour or expressions in order to avoid a longer stay in a psychiatric hospital. Moreover, if patients are capable of “game-playing”, the question arises whether they are incompetent (or if they once were, are they still and in what respects). An ability to play social games in a hospital environment shows, after all, the ability to define goals and to choose ways of reaching them.

3.2.4. The forum internum in non- and involuntary treatment

If freedom of belief and opinion is understood in the negative sense, it is relevant to ask whether in involuntary treatment the psychotic individual's right to the forum internum might sometimes be interfered with. For example, Roger Peele and Paul Chodoff discuss involuntary psychiatric treatment as something which may change patients’ thoughts, emotions and attitudes.99 The question arises, in particular, when antipsychotic medication is used as an involuntary form of treatment for involuntarily hospitalized patients. This is a crucial question since the forum internum is defined in human rights theory and human rights conventions as an absolute right which should not be interfered with in any situation for any reason.

The use of involuntary antipsychotic medication is justified in ethical guidelines and, for example, in the Mental Health Act of Finland.100 Since the purpose of antipsychotic medication is to relieve psychotic symptoms, delusions included, it can be asked, from the viewpoint of negative liberty whether nursing staff violate the absolute rights of a psychotic patient by manipulating his or her brain without consent.101 This might be defined as interference with a person’s right to hold thoughts and opinions.

This potential tension between the forum internum and the use of involuntary antipsychotic medication does not seem to be acknowledged, or commented upon, in international human rights covenants or the ethical guidelines of psychiatry. It is not usually acknowledged in discussions

99 See Peele & Chodoff 2009, 211.
101 See, for example, Partonen et al 2007, 727. Kader & Pantelis (2009, 356) report that in most cases refusing medication is caused by grandiosity, psychotic perceptions, anger, ambivalence, negativism and conflict with the family or with the nursing staff.
concerning the ethics of psychiatry, either. For example, Lauri Kuosmanen mentions the use of forced medication as a restriction of liberty and reports that a number of the patients interviewed in his study had been forced to take medication orally or by injection. However, Kuosmanen does not seem to make a distinction between so-called external measures and so-called internal ones, and he lists the use of medication together with, for example, restrictions of movement and communication. It is also common for ethical problems about physical restraint such as tying somebody up to be emphasized as significant restriction of liberty in psychiatry, even though, from the viewpoint of the forum internum, it is not as questionable as the use of involuntary antipsychotic medication.

However, the problematic relationship between the use of involuntary antipsychotic medication and the psychotic patient’s right to the forum internum is also acknowledged by some writers. Some of these notions can be defined as antipsychiatric. For example, Thomas Szasz and Richard Gosden have stated that the use of involuntary antipsychotic medication is against the patient’s freedom of thought. The potential tension between the forum internum and the use of involuntary antipsychotic medication is acknowledged also elsewhere. For example, Kaltiala-Heino et al refer to the idea that psychotropic medication could be seen as preventing a patient’s right to free thinking. Eeva Iso-Koivisto discusses the possibility that psychiatric medication breaks the border between the individual’s internal and external dimension – a border protected by legislation and conventions. According to Iso-Koivisto, some patients have stated that medication creates the feeling that their self has been moulded. Partly this feeling arises from the undesirable effects of the medication, which is a different issue, but partly the background for the feeling is the way the medication influences a person’s psychological functions. Maurice Ford also refers to the problem of involuntary antipsychotic medication by noting that some people consider psychotropic drugs to be problematic because they affect a person’s mental processes and are mind-altering. There has even been juridical debate concerning this

103 See, for example, Heikkinen et al 2007, 694. The Finnish Association of Mental Health describes in its declared principles concerning the rights of the mental patient that isolation and tying up are measures which strongly restrict the patient’s personal liberty and right to self-determination. The use of involuntary medication is not described in such terms. See Mielenterveysopillan oikeudet 2001, 33.
104 See Gosden 1997; Szasz 1990, 563.
105 They point out that the use of medication can also be seen as a form of punishment for patient’s mental state and thus, if this is what is thought, could be a violation of the prohibition of cruel punishments. Kaltiala-Heino et al 2000, 213; Kaltiala-Heino 1995, 17.
106 Iso-Koivisto 2004, 43.
107 Ford 1980, 333. Ford (1980, 338) describes the opinion presented in the Boston State Hospital case: “The capacity to produce ideas, even ones which many people may believe to be crazy, is
issue in the United States. However, it seems that these debates haven’t been able to take into account the challenge of the forum internum, which I presented in chapter 2.2.3.

Before going further, there are some points worth noting when it comes to the question of whether the use of involuntary antipsychotic medication violates the psychotic patient’s right to the forum internum. First, when freedom of belief and opinion is understood in the negative sense only the giving of antipsychotic medication by physical force like by injection or by putting tablets straight into a patient’s mouth and ensuring that he or she really swallows them is counted as a possible interference with the forum internum. On the other hand, if the doctor instead gives the tablet to a patient who then puts it into the mouth, this is not seen as possible interference with the forum internum. However, if the patient can only choose between putting the medication into the mouth himself or herself and being given medication by physical force, then clearly he or she does not have the option of choice “not taking the medication at all”. If this option is totally absent, we can speak about an interference with liberty even though the patient does put the medication into his or her mouth himself or herself.

Second, the problem between the patient’s right to the forum internum and the use of involuntary antipsychotic medication is connected to the question concerning the use of the least restrictive form of treatment. I noted in chapter 3.2.1. that there has been tendency to see treatments to which the person has consented as being less restrictive than treatments to which they have not consented. Second, I mentioned that there has been a tendency to conclude that treatments given with the help of physical force and the use of medication generally are more restrictive than psychological or psychosocial interventions. When we consider the question of the use of the least restrictive form of treatment from the viewpoint of the forum externum and the forum internum, we could state that treatments which interfere with the former are less restrictive than treatments which might interfere with the latter. Thus, it seems that involuntary treatments that are (1) physical or biological and (2) influence the mind, are the most restrictive. From this point of view, even the treatment which Osheroff received in the first hospital and which the court judged to be a case of malpractice, was actually less restrictive than the use of involuntary antipsychotic medication. Even though the psychiatrist thought that Osheroff should have been in the hospital for about three years and even though there were, for example, restrictions on phone calls, the

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108 For example, English law requires that psychical contact between the doctor and the patient takes place for the treatment to be defined as given without consent. See Fulford, Thorton & Graham 2006, 550-551.
treatment could be seen as less intrusive because the restrictions were external and violated only the *forum externum*.

Thus, the border between the external and internal dimension of a human being or the relationship between body and mind seems to be central here. It seems that so-called bodily integrity has not been considered in ethical guidelines to be as important as so-called mental integrity. While the PUN absolutely prohibits sterilization and psychosurgery as treatments of mental illness, it notes that “a major medical or surgical procedure may be carried out on a person with mental illness” if it is permitted by domestic law and if the patient is unable to give informed consent. 109 This seems to imply that the integrity of the human brain and the ability to be fertile are (perhaps as “internal” dimensions which refer to the mind) more strictly protected by legislation and ethical guidelines than the integrity of other parts of the body (which are perhaps seen more as “external” dimensions).

Third, it seems that some people who believe, for example, in God continue to believe in God even though they are taking antipsychotic medication. And patients usually continue to hold their political views during and after involuntary antipsychotic medication, even though sometimes the experience of psychosis and treatment is such a huge life challenge that it may cause a change in the person’s world view. However, it seems that most of the beliefs and opinions which a person held before receiving antipsychotic medication also stay throughout his or her medication. This seems to mean that medication does not change everything. This argument is strong and seems to be valid if we are discussing the beliefs and opinions of a patient with psychosis which are not defined as delusions (such as traditional religious views and shared political convictions). However, if antipsychotic medication did not influence significantly a patient’s delusions that are considered to be the symptoms of psychosis it could reasonable be argued that it wasn’t an effective medication for that illness. Thus, even though medication does not change everything, it still seems to influence in some respect and in some way or another, some thoughts and opinions, namely, delusions, which is the main issue here.

Fourthly, it can be claimed that it is an external and, thus, a non-absolute dimension of freedom of belief and opinion, which is significant when antipsychotic medication is being used. Nobody is treated only because they have delusional thoughts. As a matter of fact, it would be impossible to recognize delusions if they are not expressed or manifested in some way in the public sphere. It is true that delusions are recognized on the basis of behaviour

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109 See PUN, Principle 11:12-14. It seems that psychosurgery is not included in the PUN in the concept of “major medical or surgical procedure” since it is absolutely prohibited in other contexts. Thus, it seems that the expression “major medical or surgical procedure” refers to measures which interfere with the “external” but not the “internal” dimension (or mind).
and expressions. However, the use of antipsychotic medication does not just concern this external dimension as, for example, physical isolation does. The purpose of the medication is to influence the delusions which the person has in the mind.

Fifth, it might be claimed that even if antipsychotic medication “changed” beliefs and opinions, this interference with the *forum internum*, if it is seen as such, is an undesirable effect of the medication rather than the intended goal of the treatment. When put this way, the use of involuntary antipsychotic medication could be justified with the same kind of logic as that used by people who hold that abortion should be absolutely prohibited but still think that it is alright to treat a pregnant woman suffering from cancer even though the treatment results in a “indirect abortion”. Many people who consider euthanasia to be absolutely wrong still hold the view that it is allowed to relieve the pain of a dying person even though the method used to relieve the pain might indirectly shorten or even end the life.\(^{110}\) However, since delusions are defined as symptoms of illness and it is precisely those symptoms which are being treated, it seems that the approach which accepts “undesirable effects” cannot be applied here. It is not that the goal of medication is to influence something else and that it, unfortunately, also influences delusions. The goal of antipsychotic medication is conceptually linked with delusions. However, when it comes to the undesirable effects of antipsychotic medication, this kind of argumentation can be applied. This is the case in the Explanatory Memorandum to the RCE when it states that the use of involuntary antipsychotic medication is justified even though it may produce potentially irreversible side effects such as tardive dyskinesia, since “doctors prescribing such drugs do not intend to produce such an effect”.\(^{111}\)

A stronger argument against the view that there is something problematic about the use of involuntary antipsychotic medication from the viewpoint of a patient’s right to the *forum internum* is that even though this medication influences the brain and thereby thoughts and opinions, it does not do so permanently. Compared, for example, to psychosurgical operation, antipsychotic medication can be seen as being less irreversible. The RCE makes a distinction between “treatment for mental disorder that is not aimed

\(^{110}\) See Boyle 2001, 78.

\(^{111}\) See the Explanatory Memorandum to the RCE 2004, Article 28. See also Ford 1980, 334. However, it is also worth noting that the purpose for which the medication is used determines which effects are defined as effects and which are defined as side effects. This is the reason why I have chosen to discuss desirable and undesirable effects instead of effects and side effects. For example, antipsychotic medication may in some cases affect not only delusions but also make the person more tired. In this case, the first is a desirable effect while the latter is an undesirable effect, from the viewpoint of treating this kind of illness. However, for example in the case of a person with sleeping problems it would be a desirable effect of the medication if it made him or her more tired and even able to sleep.
at producing irreversible physical effects but may be particularly intrusive” and “treatment for mental disorder with the aim of producing irreversible physical effects”. While it is permitted to use the first kind of treatment involuntarily “if no less intrusive means of providing appropriate care is available”, the use of the latter kind of treatment “should be exceptional, and should not be used in the context of involuntary placement”. The Explanatory Memorandum to the RCE gives electroconvulsive therapy as an example of the first kind of treatment and psychosurgical operation of the latter kind of treatment. It also mentions that antipsychotic medication is not included in the latter kind of treatment even though it may produce potentially irreversible and undesirable effects.

However, Manfred Nowak mentions mind-altering drugs as one means of intruding into a person’s internal sphere. Thus, it seems that these kinds of drugs are considered effective enough when one is discussing a non-delusional person’s forum internum. Moreover, some psychotic patients are forced to take antipsychotic medication for quite a long time. They have a “legal duty” to take antipsychotic medication for years or even for the rest of their life. Even though they might no longer be in involuntary treatment they don’t have the choice of “not taking it” since they are told that they either take their medication “voluntarily” or they will end up undergoing involuntary treatment where the medication will be given to them using physical force.

Moreover, when it comes to the Finnish Mental Health Act, there is no absolute prohibition of the use of treatments with irreversible effects such as psychosurgical operation in nonvoluntary treatment since it is stated that:

Psychosurgical or other treatments that seriously or irreversibly affect the patient’s integrity may only be given with the written consent of an adult patient, unless it is question of a measure that is necessary to avert a danger to the patient’s life.

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113 See the Explanatory Memorandum to the RCE 2004, 205-217. See also Ford 1980, 334. The Explanatory Memorandum to the RCE considers the question of involuntary medication by establishing two different categories of medication which are both thought to be problematic, though for different reasons. First, there is antipsychotic medication which seeks to “change” the thoughts and experiences of the psychotic patient. This type of medication is considered treatment of a psychotic disorder and therefore its use is allowed. Secondly, there is so-called restraining medication, often referred to by the term “chemical restraint”. On this second group of problematic medication the Explanatory Memorandum to the RCE notes that: “In the context of involuntary measures concern has been expressed about what is sometimes called “chemical restraint”. Medication is used as a restraint if it is used to control the person’s behaviour, is not medically necessary, and is not a clinically appropriate treatment for the person’s condition. Medication should never be used for the convenience of staff or as a means of coercion, discipline, or punishment.” The Explanatory Memorandum to the RCE 2004, Article 2:34, Article 19:145.
114 See Nowak 1993, 314.
115 Mielenterveyslaki 2001/1423, 22b.
Thus, it seems that in order to protect a patient’s life, even treatments that seriously or irreversibly affect the patient’s integrity could be given in Finland nonvoluntarily. This statement is interesting from the viewpoint of the *forum internum* since the right to life has not been considered an absolute right as the right to the *forum internum* has. The question arises then, whether producing an irreversible influence on delusions has been seen as a problem at all. Is it more the undesirable effects and risks which is the problem, and why is a distinction between irreversible and reversible treatments made in the first place?

We can try to capture what is really seen as problematic with irreversible treatments by the following imaginary example. If we imagine that there is a psychosurgical measure which is very effective in the sense that it removes psychotic symptoms permanently without any risks and without any undesirable effects, would it really be questionable to use such an amazingly effective measure in non- or involuntary treatment? If we imagine that we are dealing with a patient who is incompetent to give consent because of psychosis, should we use antipsychotic medication, which might have undesirable effects and involve a certain amount of risk in order to promote his or her competence so that he or she could give consent to this amazingly effective psychosurgery? If we imagine a situation in which antipsychotic medication would not help and that there was no “less effective” treatment which would make the person competent, would it still be prohibited to use this good and effective psychosurgery? I emphasize that this is purely a theoretical and conceptual exercise. However, I doubt that effectiveness is the main problem with psychosurgery and other treatments that are defined as irreversible. It seems that it is not necessarily the *forum internum* understood in the negative sense which is being protected by the prohibition of irreversible treatments. Perhaps it is the mental health and well-being of the patient which is protected by this prohibition, instead.

The other strong argument which questions the problems linked to the use of involuntary antipsychotic medication is that antipsychotic medication does not “change” beliefs and opinions directly. Since the medication’s influence is only indirect the person is quite free to either accept or reject this change. This kind of argumentation could be rooted, for

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116 The ending of life is, of course, also the end of the *forum internum*. Thus, it seems, that interference in the form of distorting or interrupting beliefs and opinions is understood to be more serious an issue in human rights theory and conventions than ending the holding of beliefs and opinions by killing the person holding the beliefs and opinions. The reason why the *forum internum* is defined as an absolute right and the right to life is not might also be that it is thought that the former cannot be in conflict with the rights of others while the latter can (in situations where it is necessary to kill the person in self defence).

117 See Winick (1997, 145-136, 171-176, 210-212) who refers to possibility to accept or reject a change in the context of psychotherapy and notes that this is a reason why these treatments have
example, in the Sihtij Kapur’s ideas, who states that the primary feature of psychosis is a feeling of aberrant salience, namely, a feeling experienced by an individual that “something important is going on”. According to Kapur, delusions play only a secondary role in psychosis since they are in effect a mechanism that allows an individual to explain why something important is going on. Antipsychotic medication influences primarily (through processes in the brain) the feeling of aberrant salience from which it follows that the person no longer needs delusions as explanations and, in the long run, may stop having them. Kapur notes:

According to the idea of salience attenuation, antipsychotics do not primarily change thoughts or ideas; instead, they provide a neurochemical milieu wherein new aberrant saliences are less likely to form and previously aberrant saliences are more likely to extinguish.118

This theory is in accordance with the idea held by many who have treated psychotic patients that delusional people who are medicated with antipsychotics do not suddenly change their thoughts. Instead, their ideas become less troublesome. For example, a person who believed that somebody was after him or her all the time believes, when medicated, that “they have not been after me lately”.119 On the grounds of theory presented by Kapur, it could be claimed that antipsychotic medication influences delusions only indirectly and, thus, does not violate the forum internum.

However, it is worth asking whether it is, in fact, possible to influence somebody’s beliefs and opinions “directly” at all. Perhaps it is, with psychosurgery. However, when discussing the protection of the forum internum measures such as manipulation and brainwashing120 are also mentioned as interferences with this absolute right even though their effect cannot be defined as “direct”.121 Even though manipulation and brainwashing as psychological measures are not counted as interferences with the freedom of belief and opinion in the negative sense, these examples, since they are mentioned in human rights theory, still lead one to think that interferences with the forum internum can also be in a certain sense indirect. It seems to be unclear how far a person who is being medicated with antipsychotics is able to decide how this medication influences his or her mind and how far the medication leads his or her thoughts.

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118 Kapur 2003, 17.
119 See Kapur 2003, 16-17.
120 For more about manipulation and brainwashing, see chapters 4.1.2. and 4.1.3.
121 Involuntary antipsychotic medication is used to guide the patient in the right direction while the purpose of manipulation is to mislead. In spite of this conceptual difference, the comparison can be made in order to understand whether interference with the forum internum has to be direct.
We also end up to wondering what the *forum internum* protects. If the purpose of the *forum internum* is to protect the core of humanity it does not sound right that holding something secondary (namely delusions) is protected while something primary (the feeling from which the delusions follow) is not protected. In the philosophy of psychiatry, Lynn Stephens and George Graham have stated, quite similarly to Kapur, that delusional beliefs (with contents) are not central in psychosis. According to them, the focus should be, instead, on delusional stances and on the question of how the person believes (believing as a process) and how they deal with the contents.\textsuperscript{122} In this context it could be asked whether the core of humanity is in beliefs which are secondary or whether the core is in stances.

If freedom of belief and opinion is understood in the negative sense one can say that influencing the aberrant salience or stance is interfering with liberty. The question is then whether all kinds of stances or aberrant saliences are protected. The question seems to be whether there are requirements for the protected thinking and believing processes. When freedom of belief and opinion is understood in the negative sense this question seems to be quite open. I will return to this question in chapter 3.4.2., which considers competence and rationality even though I cannot promise any final truth.

### 3.3. Freedom of belief and opinion vs. other rights

Interfering with a psychotic person’s freedom of belief and opinion is, it is argued, justified because it is seen as necessary for the protection of other rights. In this chapter I present my analysis of how other rights are invoked in order to justify interfering with the freedom of belief and opinion. In the first two chapters I consider the psychotic individual’s freedom of belief and opinion in relation to other people’s rights. Chapter 3.3.1. considers the health and safety of others while chapter 3.3.2. deals with “public order” issues by discussing patient’s irritating behaviour and the rules of the hospital. The last two chapters consider the conflict between the psychotic person’s different

\textsuperscript{122} For more about the delusional stance, see chapter 2.2.1. Stephens and Grahams 2004, 236-237. Stephens & Graham (2007, 208) give an example: “Suppose that Laura believes that unseen speakers are commanding that she pace up and down the ward. Whether she is deluded in so believing does not depend on whether outside observers regard her convictions as bizarre or radically unsupported by the available evidence. Rather, it depends on how she relates to the belief – to the picture of reality that it presents to her. Does she test it: seeking evidence for or against its truth? Would she abandon it if she were presented with powerful counter-evidence or a more plausible alternative hypothesis? Does she consider it in the context of her other beliefs and is she prepared to accept its logical consequences? Or, does she compartmentalize it, avoiding situations where she might be forced to reconsider it? Does she appreciate the effects that this belief might have on the rest of her life? Does she persist in the belief in the face of strong reasons for abandoning it, or does she refuse to face such reasons?”
rights. In chapter 3.3.3. I consider the relationships between the psychotic person’s freedom of belief and opinion and their right to treatment, health and safety. Chapter 3.3.4. clarifies how the right to competence conflicts with the freedom of belief and opinion.

3.3.1. The health and safety of others

One of the criteria which legislation and ethical principles present for non- or involuntary placement and treatment is that other people’s health and safety might be in danger if the liberty of a person with psychotic disorder is not restricted. This criterion is neither necessary nor sufficient but in some situations it is crucially important. For example, Lauri Kuosmanen argues that restrictions of liberty are necessary since “when a patient is disturbed, distressed or aggressive, the health care organization has to protect the safety of other patients and staff”.\(^{123}\) The patients interviewed in Riittakerttu Kaltiala-Heino’s study also saw that being a danger to others was the most acceptable reason for involuntary treatment.\(^{124}\)

The PUN expresses this criterion by stating that the person may be prescribed involuntary placement in view of the fact “because of that mental illness, there is a serious likelihood of immediate or imminent harm” to other persons. When it comes to involuntary treatment, one of the possible criteria used in deciding whether to apply it is that the safety of others needs to be protected.\(^{125}\) According to the RCE, one criterion of involuntary placement and treatment is, that “the person’s condition represents a significant risk of serious harm...to other persons”.\(^{126}\)

It is worth noting that, according to ethical principles and the Finnish Mental Health Act, the serious likelihood of harm or significant risk or severe danger to others should be caused by some psychotic disorder. Thus, in theory, the criteria of non- or involuntary placement and treatment are not fulfilled if the person is psychotic and also happens to be dangerous. The person has to be dangerous because of their psychosis not because of some other reason. The other question is whether there are, in practice, situations where a person who is dangerous and who happens to have psychosis is not sent for non- or involuntary placement and treatment because it is judged that the dangerousness has nothing to do with the psychosis.

\(^{123}\) Kuosmanen 2009, 21. Kuosmanen (2009, 50) also notes: “It is a challenge to treat aggressive or violent psychiatric patients in a safe environment without restricting all other patients on the ward.” On the other hand, Kuosmanen et al (2007, 597) argue that it is unclear what the ultimate value of seclusion and restraint is.


\(^{125}\) PUN 1991, Principle 11.6; Principle 16.1a.

\(^{126}\) RCE 2004, Articles 17.1:ii, 18:1:ii. See also Mielenterveyslaki 1116/1990, 8§; 2001/1423, 22a§.
When it comes to the formulations presented in ethical principles and the Mental Health Act, it should also be noted that they speak not about any risk but about *significant* risk, not about any kind of likelihood, but *serious* likelihood and not about any danger but *severe* danger. One Finnish textbook of psychiatry mentions the danger of violence as one example of severe endanger but also notes that non- or involuntary placement and treatment may be considered in order to protect the mental health of other people. For example, if a child’s development is threatened because of somebody’s psychotic behaviour, the criterion of being dangerous to others may be fulfilled.127

One aspect of protecting other people’s health and safety is that it may require intruding upon the privacy of the patient. Jennifer Radden notes that in order to protect others psychiatric nursing staff are often required to expose, report and notify others about a patient’s private matters. According to Radden, the possibility to distribute a patient’s private information creates a system which “extends an extraordinary power to the mental health practitioner”. They may:

- seclude and treat innocent individuals against their wishes when there is reason to suppose they pose a wide range of threats to the safety or well-being of other people, and even to themselves.128

However, there is nothing special in the fact that the protection of other people’s health and safety may restrict the individual’s freedom of belief and opinion. Since human rights conventions state that there are limitations to everyone’s freedom of belief and opinion for this reason, the freedom of belief and opinion of the individual with psychosis is restricted, at the level of general principle, in the same way as that of other people. For example, there is a juridical case against an American church where charismatic healing was practised by handling serpents.129 When the State became involved the practice was not banned in order to protect the serpent-handlers themselves but in order to protect other people. It was stated that people belonging to the church could not have continued this practice without endangering nonconsenting parties. It was claimed that there was a danger to public safety and in particular to children. Since snakes were being handled by people in a state of hysteria, there weren’t sufficient safeguards, and were children roaming about unattended.130

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127 Heikkinen 2007, 690. Kaltiala-Heino (1994, 14) points out that it is difficult to evaluate the future behaviour and, thus, the dangerousness of the patient.
128 Radden 2012, 134.
129 The practice of serpent-handling was based on Mark 16:17-18 which states: “They take up serpents, and if they drink any deadly thing it shall not hurt them”.
However, it seems that this general limitation, which is common to everyone, is applied in the case of psychotic patients with the use of anticipatory measures. Kaltiala-Heino also points out that while criminals are jailed only because they have done or are suspected of having done something, mental patients are sent for involuntary treatment because of “what they might do”. Moreover, the criterion of being dangerous to others influences the role of health care since “involuntary treatment is said to push the psychiatric profession more towards being social controllers and away from the role of treatment providers”, as Kaltiala-Heino puts it. In addition, dangerous patients are not always treatable, which questions the meaningfulness of depriving people of their liberty in the name of psychiatric care. Kaltiala-Heino notes:

The personal liberty must not go as far as harming others. (Threat of) violence towards others is serious enough to justify deprivation of liberty and involuntary treatment, but it can be questioned whether it provides the mentally ill with the best protection of their rights. It is protection of society.

The other difference compared to other people is that patients with psychotic disorder can also be treated with antipsychotic medication in order to protect others even though the use of medication is not necessarily the only way of doing this. A person with psychosis who resists antipsychotic medication could, in principle, be isolated physically so that there would be no threat to others. This point is significant when we discuss the problematic relationship between the patient’s right to the forum internum and the use of involuntary antipsychotic medication.

\[131\] In the context of criminal law there has been discussion about whether planning a serious crime is punishable. In this context punishable planning is linked with possession of a gun or other instrument for realizing a crime, having a detailed plan, or an agreement with others about how to carry out a crime. See Oikeusministeriön tiedote 25.10.2012. However, it seems that it is impossible to punish mere planning an idea in someone’s mind since there has to be some kind of external sign of the plan, at the very minimum, an expression of the existence of a plan.


\[134\] On the other hand, it might even be asked whether other people’s mental health (even though it would perhaps be better to speak about peace of mind here) is protected by using involuntary antipsychotic medication as a treatment measure. For example, in most cases it may be easier for the carers (nursing staff, close relatives and friends) of the patient to deal with the use of involuntary antipsychotic medication than to deal with physically isolating a person. It may protect the mental health or peace of mind of people close to the patient if they feel that the patient is not alone and will suffer as little as possible. Therefore, antipsychotic medication, if it relieves symptoms and makes it possible for a patient to move and communicate with others, may be a better choice when it comes to protecting the mental health of others.
3.3.2. Public order and morals

There is also a general restriction of the freedom of belief and opinion, which is not mentioned as a criterion of non- or involuntary placement and treatment, namely, “public harm”. The ICCPR states that freedom to manifest one’s religion or beliefs as well as freedom of expression can be restricted by limitations prescribed by law if they are considered necessary in order to protect public safety, order, health or morals. When it comes to public safety and public health, it can be stated that these restrictions of a psychotic individual’s freedom of belief and opinion are also included in the criteria of non- or involuntary placement since it also mentions the protection of other people’s health and safety. Thus, if a psychotic individual manifests his or her beliefs and opinions (because of the psychotic disorder) in a way that constitutes a threat to public health or safety, he or she might be prescribed non- or involuntary placement. So, when compared with other people, the reason for restriction is the same but the method of restriction is different.

However, when it comes to the protection of public order and morals, the restriction of a psychotic individual’s freedom of belief and opinion is more questionable. The protection of public order and public morals are not mentioned as criteria of nonvoluntary placement in the Mental Health Act of Finland or as criteria of involuntary placement in the PUN or the RCE. From this it seems to follow that if the psychotic person manifests his or her beliefs and opinions (because of psychosis) in such a way that endangers public order and morals, he or she is restricted, not only for the same reason but also in the same way as other people. Since preventing harm to public order and public morals are not mentioned as criteria of non- or involuntary placement, the psychotic person cannot, in theory, be prescribed non- or involuntary placement for these reasons. However, it is worth asking whether a psychotic person who manifests his or her beliefs and opinions in an irritating way might quite easily be suspected of being a serious threat to the health or safety of others (or his or her own health and safety) and in this

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135 According to Feinberg (1973, 25), harm to others can be private or public. Feinberg describes the “private harm principle” as an approach which justifies the “restriction of one person’s liberty to prevent injury to other specific individuals”. The other approach, called the “public harm principle”, permits society to restrict freedom in order “to prevent impairment of institutional practices and regulatory systems that are in the public interest”.

136 Article 19:3 speaks about national security as one possible reason for restriction of the freedom of expression, while in article 18:3 (which considers freedom of religion and belief) the expression “public safety” is used. ICCPR 1966, Article 18:3, Article 19:3. See also the ECHR 1950, Article 9-10.

137 See Mielenterveyslaki 1116/1990, 8§; PUN 1991, Principle 16; RCE 2004, Article 17. However, the PUN mentions, as a general limitation clause, that all the rights listed in the document can be limited by restrictions prescribed by law in order to protect public safety, order, health or morals.
way be prescribed non- or involuntary placement. The question here is whether the psychotic individual is more easily seen as a serious threat. It might be that more allowances are made for people who have not been diagnosed as having a psychotic disorder than for people with such a diagnosis.

When an individual with psychosis is admitted to hospital non- or involuntarily, the protection of public order comes up as a criterion for restrictions. The Mental Health Act states that “substances and objects that seriously hamper care and constitute a serious risk to public order in the unit can be seized.”

I suppose that in hospital the property of a psychotic individual can be seized more easily than if he or she is outside the hospital and, in this way, there might be more tolerance of irritating behaviour outside hospital. It might be thought that in a psychiatric hospital there is a greater need for order since mentally ill people are considered to be in need of a peaceful atmosphere which would assist their recovery. Thus, it seems that the protection of public order (and also public morals) might be connected to the protection of other patients’ health and recovery.

It also seems that the protection of other people’s right to health and right to health care may justify restrictions of someone’s freedom of belief and opinion more in a psychiatric hospital than outside it. We might also suspect that if the degree of “irritating behaviour” was as high outside a mental health facility as it is inside it, there might be a stronger need for restricting someone’s freedom of belief and opinion in order to protect public order and public morals even outside the psychiatric hospital. Tolerance is possible in society if its price is not too high and does not have to be paid too often.

It is also worth noting that outside hospital people can more easily avoid the irritating behaviour of others. If there is somebody waiting for a train at the station who behaves in an irritating way or smells, for example, one can move somewhere else to wait or even decide to take a later train. There are more options. In hospital there is no such possibility if you are being treated in the same unit as a person who behaves in an irritating way. Therefore, it is quite understandable that freedom of belief and opinion is restricted more strictly in hospital.

Some patients think that the strict rules of an acute psychiatric ward are acceptable and reasonable restrictions of liberty. However, it can be asked whether less rules and restrictions and, respectively, more tolerance

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138 Mielerterveyslaki 2001/1423, 22g.
139 This idea can also be expressed by saying that the private harm principle (protection of other individuals) and the public harm principle (protection of institutional practices and regulatory systems that are in the public interest) are deeply connected in the context of a mental health facility since the purpose of a mental health unit as an institution is to protect the health of the mentally disordered and help them to recover. See Feinberg 1973, 25.
140 See Kuosmanen 2009, 50.
might be needed in some mental health units. It can be asked whether irritating behaviour should sometimes be seen as harmless or if it is seen as harmful, is it sufficiently harmful to justify the restriction of somebody’s freedom of belief and opinion. For example, how justified is it to create rules such as “here we don’t speak about religion and politics” which might be imposed in some units in order to protect public order and ensure a peaceful environment for patient’s recovery?

It should also be considered how justified it is to give more freedom of belief and opinion to some patients as a prize for their “good behaviour”, which also happens in psychiatric hospitals. Riittakerttu Kaltiala-Heino mentions that nursing staff might be more tolerant towards patients who are in voluntary treatment than towards patients who are sent to hospital involuntarily. According to Kaltiala-Heino, coercive measures might be considered to be more acceptable when one is dealing with a patient who has been hospitalized involuntarily.

3.3.3. The right to treatment, health and safety

It seems in the case of a psychotic patient, there is a tendency to prioritize the person’s own health and safety as values and rights over that person’s freedom of belief and opinion in the negative sense, and this can be seen in the criteria of non- and involuntary placement and treatment. For example, the Finnish Mental Health Act states as one criterion of nonvoluntary treatment that the person needs treatment for a mental illness which, if not treated, would become considerably worse or severely endanger the person’s health or safety. It is noted in one Finnish textbook of psychiatry that a patient’s

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141 See Feinberg 1973, 28-29.
142 The other question here is if the patients’ existential needs are ignored by these kinds of rules. I will return to this when I discuss freedom of belief and opinion in terms of capability in chapter 5.3.2.
143 See Välimäki (1998, 64), who notes that “some wards have very strict norms of behaviour and monitor and evaluate patients so that those who cope well and perform the jobs assigned to them are given greater freedoms” and gives an example of a patient who said: “If they don’t put a tick against my name that means I’m free to go out for a walk”.
144 This notion is grounded in what Kaltiala-Heino (1995, 76-77) had found, namely, that patients in involuntary treatment experience more restrictive measures than patients who had been admitted voluntarily. A noteworthy distinction can be made between coercive measures and coercive treatments. While coercive measures (like seclusion and the use of restraints) are primarily used in order to control agitated behaviour, coercive treatments are used in order to treat, help and cure. However, the border between measures and treatments is not clear in everyday practice. For more details, see Kaltiala-Heino et al 2000, 214-217.
145 Mielenterveyslaki 1116/1990, 8§. Need of treatment is a necessary criterion while “would become considerably worse” and “severely endanger the person’s health or safety” are alternative criteria together with “severely endanger the health or safety of others”. See also the PUN 1991, Principle
condition has to be evaluated to see if it can be relieved or if proper medical treatment can prevent it from getting worse. The criterion “if not treated, would become considerably worse” comes to the fore, for example, in a situation where the patient refuses to use medicine which would reduce his or her symptoms. The patient’s health or safety is endangered, for example, if a patient is not able to take care of him- or herself and his or her everyday needs because of psychotic symptoms. A patient may, for example, put him- or herself in danger in traffic or by going out in winter without warm clothes. They may also be in danger of suicide. There are also differences in the ethical principles when it comes to the criteria of non- or involuntary placement and treatment. However, the shared and common criterion seems to be protection of the patient’s health. For example, the RCE does not mention the safety of the person as a criterion of involuntary placement and treatment but, instead, states as a criterion that “the person’s condition represents a significant risk or serious harm to his or her health”. The Oviedo Convention, instead, does not mention the protection of other people as criterion of involuntary placement or treatment, but does consider the protection of the person’s own health as a criterion.

16. According to the Finnish Mental Health Act, the right to treatment obligates health centres to be aware of and act and “find” psychotic people. If there is reason to suspect that within the area served by a health centre somebody fulfills the requirements for nonvoluntary treatment it is the obligation of the doctor responsible at the health centre to send them for such treatment. Mielenterveyslaki 1116/1990, 298; Heikkinen et al 2007, 693.

146 Heikkinen et al 2007, 690. Borrad et al (2007, 1242) noticed that 31% of nonadherent patients with schizophrenia and 27% of partially adherent patients with schizophrenia thought that taking medication was incompatible with or contradicted their religious views. Only 8% of adherent patients with schizophrenia considered that there was such a conflict. The reason for this low percentage was not, however, because of any lack of religious belief as most adherent patients considered religion more important in their lives and attended religious group activities more. According to Borrad et al, individual religious belief is more often associated with nonadherence while communal religious beliefs and activities are linked more often to adherence.

147 Heikkinen et al 2007, 690. The need to protect the psychotic person from him- or herself also leads one to consider the conflict between the way in which non- or involuntary placement and treatment is justified and the view which is presented when it is claimed that delusions are not beliefs. On the one hand, non- and involuntary placement and treatment can be justified (partly) by arguing that the psychotic person’s delusions may be guiding them to act in a way that threatens their safety and health. On the other hand, if we look at the discussion concerning the status of delusions as beliefs (see chapter 2.2.1.), it is presented as a feature of a belief that a person seems to act according to them. If we adopted this view, it seems to follow that the more the person acts according to what he or she holds in his or her mind the more questionable it should be, actually, whether the person should be restricted (because he or she might hold beliefs instead of delusions).


149 The Oviedo Convention 1997 (Article 7) states that “a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health”. On the other hand, the Oviedo Convention (1997, Article 26:1) also mentions the rights of others when it considers the restrictions of rights: “No restrictions shall be placed on
It seems to be clear and quite commonly accepted that the psychotic individual has a right to health, health care and safety.\textsuperscript{150} However, what seems to be more problematic is the way in which a patient’s right to health, safety and health care is prioritized over his or her freedom of belief and opinion in the negative sense since this would not come into question when considering the relationship between the different rights of competent adults. People usually have a right to manifest their beliefs and opinion in ways which might in fact endanger their own health and safety. For example, they may refuse medical treatment on the grounds of their beliefs. They may do missionary work in unsafe countries, and so on. It seems that they even have a right to handle serpents as part of a process of charismatic healing if no threat is caused to outsiders.\textsuperscript{151}

It is argued in this study that the potential difficult conflict between the right to freedom of belief and opinion and the right to health and safety in the case of a person with psychosis challenges us to find a balance between these rights. Maurice Ford notes how psychiatrists may find themselves in a moral dilemma when a patient refuses medication.

Certain medication, he knows, may greatly help his patient to feel less troubled and to be more open to the benefits of psychotherapy. Yet forcing medication on a patient undermines his or her sense of autonomy.\textsuperscript{152}

The Explanatory Memorandum to the RCE points out that the patient’s opinion should be taken into account when seeking a balance between different rights. However, the Explanatory Memorandum also states that the patient’s opinion should not always be followed, which implies that the right

\textsuperscript{150} For example, the PUN (1991, Principle 1:1) notes: “All persons have the right to the best available mental health care, which shall be part of the health and social care system.” See also the RCE (2004, Article 10:i) which declares that member states should take measures to provide a range of services of appropriate quality to meet the mental health needs of persons with mental disorder. The Act on the Status and Rights of Patients notes: “Every person who stays permanently in Finland is without discrimination entitled to health and medical care required by his state of health within the limits of those resources which are available to health care at the time in question.” Laki potilaan asemasta ja oikeuksista 1992/785, 3§. Moreover, the PUN notes that every person with a mental illness shall have the right to exercise rights which are recognized in the International Covenant on Economic, Social and Cultural Rights (ICESCR). The ICESCR (1966, Article 12:1) states, for example, “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. The Covenant also recognizes the right of everyone to social security. ICESCR 1966, Article 9.

\textsuperscript{151} For more about the case, see chapter 3.3.1. See also, Nussbaum 2008, 146-147.

\textsuperscript{152} Ford 1980, 332-333.
to health and safety is prioritized higher than their freedom of belief and opinion.\textsuperscript{153}

The conflict between rights can also be described as a conflict between the various principles of medical ethics. According to the school of ethics at Georgetown University,\textsuperscript{154} medical ethics is built on four fundamental principles, namely, autonomy, justice, beneficence and nonmaleficence.\textsuperscript{155}

These principles are also used in order to solve conflicts, which occur in psychiatric treatment, between the different rights of the patient. According to Heather Sones, the principle of beneficence has been used as an argument against the patient’s right to refuse antipsychotic medication:

Proponents of this argument claim that the greatest ethical obligation of health care personnel is to do what is good for the client, even if it must be done against the client’s will. They say that people who have been prescribed psychotropic drugs are not always in a position to know what is good for them, due to cognitive or affective dysfunction.\textsuperscript{156}

Sones also recognizes that the principle of nonmalefience is used in order to defend the use of involuntary antipsychotic medication, “because of staff fears, clients who are allowed to refuse psychotropics may experience inhumane treatment, such as extended seclusion, physical restraints and punishment”\textsuperscript{157}.

Juhani Pietarinen presents six different ethical principles for bioethics, namely, respecting life, respecting human dignity, care, autonomy, justice and maximizing utility. Even though classifications of ethical principles may differ and even though it is questionable whether it is possible to base ethics on these kinds of theoretical principles, it is, however, clear that in the case of the individual with psychosis, autonomy is not the only ethical

\textsuperscript{153} The Explanatory Memorandum to the RCE (2004, Article 17: 136) states: “The balance between respecting self-determination and the need to protect a person with mental disorder can be difficult, and hence it is emphasised that the person’s own opinion should be explicitly considered on the issues relevant to the possible placement.” Article 18:142 continues that, when it comes to the article which states that the opinion of the person concerned has to be taken into consideration when the decision of involuntary treatment is made, it should be noted that “the right to self-determination is particularly important in the context of long-term use of medication. Some patients may prefer not to take medication at all, but to live with some symptoms of their illness. Others may be willing to take a certain amount of medication, but live with some symptoms (such as hearing voices), if complete symptom control required a higher level of medication associated with a level of sedation the person found unacceptable. A difficult balance has to be struck, and the person’s opinion on the different therapeutic alternatives must play a full part in finding that balance. This does not imply that the patient’s opinion must always be followed.”

\textsuperscript{154} “School of ethics in Georgetown University” refers to Tom Beauchamp and James Childress, who wrote the book called \textit{Principles of Biomedical Ethics}. It was first published in 1979. It has been said that the book gave the patient’s autonomy a central role whereas previously in older works on medical ethics the doctor’s beneficent paternalism was the main focus.

\textsuperscript{155} Fulford, Thorton & Graham 2006, 500; Louhiala 1995, 56.

\textsuperscript{156} Sones 1997, 219.

\textsuperscript{157} Sones 1997, 219.
principle that matters. According to Pietarinen, “an ethical problem usually arises when there are several ethical principles which offer different kinds of advice in dealing with the same situation”.  

It is clear that this is exactly what happens in the case of a psychotic individual. When we ask how we should respect the individual’s freedom of belief and opinion in the negative sense, the principles of beneficence and nonmaleficence, or the principles of care and respecting life, give advice that may differ from the advice inherent in the principle of autonomy. There is a conflict between these principles, at least if we understand freedom of belief and opinion (as well as the concept of autonomy) in the negative sense.

It has been questioned whether the principle of autonomy should have a leading role in medical ethics. For example, Fulford et al note that even though autonomy is a widely recognized value in the western world, “there will come a point beyond which any one person will not be prepared to go, a point at which, as we say, we ‘draw the line’ in respecting someone else’s wishes”. Moreover, Fulford et al point out that in other than western societies the value of autonomy may be questioned at an even earlier point, because more value is given to family ties and to the integrity of communities.

In is also important to recognize that most people with psychotic disorder who are given involuntary treatment are afterwards grateful that this intervention had been carried out. Dangerousness to oneself is quite widely accepted by patients as a reason for involuntary treatment and psychosis is also considered by many patients to be an illness which needs to be treated sometimes even involuntarily. It has been claimed that the experience of psychosis is more traumatic to an individual than being forced to have involuntary treatment. According to Kaltiala-Heino, for most patients it seems not to be crucial whether they are in a psychiatric hospital voluntarily or involuntarily since patients from these different groups hold quite similar attitudes towards treatment. On the grounds of this notion it can be asked

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158 Pietarinen 1995, 33. Translation by Mari Stenlund. However, sometimes people consider their choices to be ethically simple even though they might be emotionally hard. For example, a staff member wrote in his or her ethical diary in Pelt-Piri et al’s study (2012): “Today I tube-fed a patient with anorexia. She exhibited acute anguish, wept and cried when given the gruel. However, I did not experience an ethical dilemma when forcing her. If she doesn’t eat she will die, so the choice was simple.”

159 The psychotic individual’s right to freedom of belief and opinion can also be discussed as problem internal to the principle of autonomy, if the idea is that only a sufficiently competent or authentic person’s views are autonomous and worth respecting. However, in these cases the view of freedom is wider than it is when freedom is understood in the negative sense. See chapters 3.3.4., 4.1.3 and 5.1.1.

160 Fulford, Thorton & Graham 2006, 474. When it comes to valuing autonomy, there are of course differences between western societies and between people living in western societies, as well.


162 Even though voluntary patients had more positive experiences about admission process the more
whether prioritizing freedom of belief and opinion in the negative sense over other rights meets the values of most patients sufficiently well. Most patients seem to value their own health and safety more than they value negative liberty.

However, some patients experience deprivation of their liberty as harmful and traumatic. Restrictions of liberty may also impair patients’ satisfaction with their psychiatric care, which may negatively influence a treatment’s outcome. Lauri Kuosmanen notes that psychotic patients are actually the group which is most dissatisfied with their treatment. Thus, involuntary treatment may not only solve health problems but may also cause them both directly (traumas) and indirectly (negative attitudes towards treatment). Moreover, as Kuosmanen points out, personal liberties are important curative factors during hospital care. Kuosmanen suggests that patients should have an opportunity to consider afterwards what happened during their restriction and why it happened. This could be in some situations one way to avoid negative experiences and trauma, since if a patient understands the reasons for such restrictions it may be easier for them to cope with the situation.

Kaltiala-Heino discusses so-called “true involuntary” patients who do not share the opinion of professionals about themselves and remain negative in their attitudes about treatment. When it comes to this group of patients, Kaltiala-Heino asks whether treatment can benefit them. Compared to other patients, “true involuntary” patients reported more negative feelings were aroused by admission. They felt that they had got worse during it, they had less favourable expectations of its outcome, they had a more negative attitude to involuntary treatment as a social issue and they felt bad about hospitalization. Their opinion did not change after being discharged when the period of involuntary treatment was over. Thus, a negative experience when being admitted to hospital seems to affect the entire treatment, and possibly affects the outcome of the care, too. However, if the criteria of non- or involuntary treatment are fulfilled, nursing staff also have a legal duty to treat a patient even in cases where it might appear that involuntary treatment has worse consequences than leaving the person without treatment. This raises the question of whether there should be a greater variety of options from which the patient (and nursing staff) could choose in these kinds of situations.

Prioritizing a psychotic individual’s health and safety over his or her freedom of belief and opinion in the negative sense, has been criticized in

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162 See Kuosmanen 2009, 18, 22-23. See also Kuosmanen et al 2007, 597.
164 Kuosmanen 2009, 50. See also Kuosmanen et al 2007, 604.
antipsychiatric discussions. For example, Thomas Szasz claims that a person should not be sent to any institution against his or her will if he or she has not done something illegal. Richard Gosden takes a similar view, stating that the right to treatment “can have a hollow ring to it when psychiatry is practiced on people against their will”. According to Gosden, involuntary psychiatric patients often find themselves in a situation in which:

they are incarcerated for an indefinite period without being charged with a criminal offence, interrogated, coerced into changing their thoughts and beliefs, subjected to painful and uncomfortable treatments if they cannot or will not make the required mental change, and denied freedom until their identity has been sufficiently modified.

In the United States some lawyers have also strongly defended the psychotic patient’s right to refuse treatment. This has displeased some psychiatrists who have tried to describe the helpless reality of many mental patients. For example, Maurice Ford criticizes lawyers who have questioned psychiatrists:

Many such lawyers exhibit a lack of awareness of the seriousness of their clients’ precarious clinical situations. Their very idealism may allow their client-patients “to die with their civil rights on”.

Even though the conclusions made by some lawyers and the views presented in antipsychiatric discussion might seem unacceptable, they seem to be actually quite valid if freedom of belief and opinion is understood in the negative sense and if the forum internum is considered as an absolute right. Namely, it seems that, even though the patient’s right to health and safety are good reasons for interfering with a psychotic patient’s freedom of belief and opinion as negative liberty, they are not, necessarily, justified reasons in cases where no reason (however good) is not in theory sufficient. While the rights to health, safety and health care are not absolute human rights, and neither is the right to life, they cannot be prioritized over the forum internum which is defined as an absolute human right. If this notion seems to be unacceptable, the challenge to develop human rights theory should be acknowledged.

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166 According to Szasz, it is misleading and dangerous to define somebody as being mentally ill, because when this is done, the person loses their status as a moral agent who is responsible for their actions. Szasz 1979, XIX, 106; Szasz 1972, 276; Szasz 1970, 118. See also Szasz 1990, 558-560. In Finland, Puhakainen (1999) presents the same kinds of ideas.
169 Ford 1980, 332. See also Pele & Chodoff (2009, 212), who present the differences between legal and medical concerns. While the first states that “it is better that ten guilty people go free than that one innocent person be punished”, the second adheres to the position “that saving a patient from death is worth an unnecessary hospitalization”.

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3.3.4. The right to competence

It seems that the conflict between the psychotic individual’s freedom of belief and opinion in the negative sense and his or her right to health, health care and safety, leads one to recognize the crucial role played here by the concept of competence. In this chapter, I consider the conflict between the right to freedom of belief and opinion in the negative sense and the right to competence. However, I will also continue with competence issues in chapter 3.4.

Competence, which is seen as a requirement for the right to negative liberty, signifies the abilities a person needs to make decisions; for example, abilities which the person needs in order to give consent to treatment. According to Tom L. Beauchamp and James F. Childress, the concept of competence is “a precondition of being able to authorize autonomously”.\(^{170}\) Autonomous action requires that the person acts intentionally, with understanding and without controlling influences that determine the action.\(^{171}\) They state that:

A person is competent if and only if that person can make reasonable decisions based on rational reasons. In biomedical contexts this standard suggests that a competent person is able to understand a therapy or research procedure, to deliberate regarding major risks and benefits, and to make a decision in light of this deliberation.\(^{172}\)

According to Juhani Pietarinen, competence includes three dimensions: competence in thought, will and action, and as I see it, the first two dimensions could be seen as requirements of freedom of belief and opinion in the negative sense. Competence in thought means that an individual has the ability to carry out consistent thinking and deduction, and that he or she has a justifiable and quite stable system of beliefs and values. An individual with competence in thought has the ability to receive information and place it into his or her belief system. Competence in will indicates the ability to make considered decisions and commit oneself to decisions. Individuals with competence in will are able to domain their desires when striving for something of interest.\(^{173}\) Riittakerttu Kaltiala-Heino defines

\(^{170}\) Beauchamp & Childress 1989, 79.

\(^{171}\) Beauchamp & Childress 1989, 69.

\(^{172}\) They also note that the criteria for judging whether a person is autonomous or competent are very similar and, thus, autonomous persons are competent persons and vice versa. Beauchamp & Childress 1989, 83. However, this is the case if autonomy is defined in the way that Beauchamp & Childress define it.

\(^{173}\) Competence in action means ability in terms of normal physical skills and having all the skills required to act. Moreover, competence in action requires that no mental factors can prevent the individual from acting. Pietarinen 1998, 17-22. It seems that competence in action cannot be defined as a requirement of freedom of belief and opinion in the negative sense. However, that dimension of competence is relevant when we discuss freedom of belief and opinion in the terms
competence in the light of four categories of mental functioning, which are (1) capacity of communicating a choice, (2) capacity of understanding relevant information, (3) capacity of appreciating the current situation and its consequences and (4) capacity of processing information rationally which involves “the ability to reach conclusions that are logically consistent with starting premises”. The ability to evaluate the consequences of one’s actions and decisions, which is seen as one of the central features of competence, can be seen in forensic psychiatry, which states that a person may not be fully or even partly responsible for the crime if he or she is unable to understand the consequences of his or her actions. From the viewpoint of forensic psychiatry, competence also seems to require the ability at some level to control one’s behaviour and actions.

In discussions concerning the rights of psychiatric patients the concept of capacity is also used side by side with the concept of competence. According to the World Health Organization (WHO), the concept of capacity means having the psychological ability which is needed when making decisions. Thus, the concept of capacity is related to health. The concept of competence, instead, means the juridical consequences of capacity and thus, it is a juridical concept. Therefore, competence always requires capacity.

The right to competence signifies the individual’s right to the abilities needed in decision making. The right to competence requires that the person has a right to support from others which in turn enables the development of such abilities. It is unclear whether and in what sense there is a right to competence in traditional human rights theory. If freedom of belief and opinion is understood in the negative sense, it seems, that competence is considered more a requirement of the right to negative liberty than a right or freedom itself. However, the right to negative liberty protects the right to competence in the negative sense since the person is protected from interferences, such as certain kinds of brain surgery, which might weaken his or her competence.

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174 Kaltiala-Heino 1995, 21. See also Kaltiala-Heino 1997. The criteria for competence seem to be quite high. The question arises whether people, in general, are actually not competent in this defined sense, even though they are supposed to be competent. For example, it is often assumed that the patients who agree with a physician about treatment are competent. However, if there is a lack of competence, it does not necessarily come out in the a situation where the patient agrees. The other question is whether nursing staff actually want the patient to be competent in this defined sense. If patients were fully aware of and interested in their situation and treatment options, it might be even more challenging to treat and come to agreement with many of them.

175 See Rikoslaki 2003/515, 4; Tiithonen 2007, 655-656. See also Laitinen 1996, 33.

176 WHO 2005, 39-40. According to Fulford et al (2006, 544), competence is a composite term that includes capacity among information and voluntariness. Capacity means in the medical context, according to them, the patient’s capacity to make a true treatment choice.
When competence is seen as a requirement of negative liberty, Pietarinen discusses a narrow view of the right to self-determination. However, competence can also be seen as a part of freedom when we discuss, according to Pietarinen, the wide view of the right to self-determination. When the wide view is represented, competence (or some dimensions of it) is included in the concept of freedom or autonomy, as is the case with Tom Beauchamp, who claims that the concept of autonomy signifies, among other things, “the presence of critical mental capacities such as understanding, intending and voluntary decision-making capacity”. Veikko Launis describes one aspect of autonomy, as follows:

Autonomy in thinking means the person’s ability to consider issues rationally, compare their relations and understand the consequences of his or her own action. The individual who thinks autonomously is able to seek and receive information and utilize it when he or she builds up his or her beliefs and opinions.

However, if competence is included in the concept of freedom, as it is in the wide view of the right to self-determination, we don’t speak about freedom in the negative sense. When freedom is understood in the negative sense, competence (or more precisely, mental competence) is considered as a requirement of the freedom of belief and opinion. This is the way of thinking which I will follow here.

Conflict between the psychotic patient’s freedom of belief and opinion in the negative sense and his or her right to competence may arise because while the first right obligates other people only in a negative sense, that is they have a duty not to intrude into an individual’s business, the latter right creates not only negative but also positive obligations for others. The others may have a duty to support the individual’s competence, at least in situations where the individual whose rights are in question is a patient and the people who have an obligation belong to the nursing staff. According to the PUN, “the treatment of every patient shall be directed towards preserving

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178 Beauchamp 2009, 34. See also Widdershoven & Abma 2012, 217.
179 “Ajattelu autonomialla tarkoittaa henkilön kykyä asioiden järjestyiseen harkintaan ja vertailuun (siis suhteiden taju) ja oman toiminnan seurausten ymmärtämiseen. Autonomisesti ajatteleva yksilö kykenee myös hankkimaan (ja vastaanottamaan) uutta informaatiota ja hyödyntämään sitä muodostaessaan omia uskomuksiaan ja mielipiteitä.,” Launis 1998, 51. When Launis (2007, 47) considers autonomy he refers to the same dimensions and abilities which Pietarinen mentions in his discussion of competence. See also Edwards (1997, 52-53, 56), who describes autonomy as the actualization of the capacity to make one’s own choices, managing one’s own practical affairs and assuming responsibility for one’s own life including its station and duties.
180 For more about competence as freedom, see the considerations in chapter 5.1.1.
181 In addition, the state has a positive obligation to ensure that nobody intrudes into other people’s business.
and enhancing personal autonomy, which can be understood as a duty of nursing staff to support the patient with psychosis to develop abilities which he or she needs in decision making, which are discussed here as competence.

Preserving and enhancing personal autonomy (or competence) may mean that psychotic individuals should not be treated like children even though they at the time lack competence. As Joel Feinberg expresses it:

If adults are treated as children they will come in time to be like children. Deprived of the right to choose for themselves, they will soon lose the power of rational judgement and decision. Even children, after a certain point, had better not be “treated as children,” or they will never acquire the outlook and capability of responsible adults.

A duty to enhance autonomy might then mean that nursing staff have to be very careful and aware about where that “certain point” in a psychotic individual’s life is. They should be careful not to make decisions for that person but actively encourage the person to decide for him- or herself.

However, it is also possible to argue that the patient’s right to competence obligates nursing staff to resist the patient’s right to refuse antipsychotic medication and defend the practice of involuntary antipsychotic medication. This can be done by invoking the principle of autonomy if it is claimed that this treatment “is likely to increase clients’ overall autonomy through an increased ability to become an active participant in treatment and by allowing for earlier release from psychiatric facilities”, as Heather Sones describes Turnquist’s argument. Rem Edwards also notes the possibility that renewal of rational autonomy may be correlated with the return to more normal brain chemistry brought about by antipsychotic medication.

The right to receive information is part of the right to competence and giving information is one of the ways in which nursing staff can enhance a patient’s competence. According to the PUN, the informed consent to treatment of the patient presupposes that the patient has adequate and understandable information on, for example, the diagnostic assessment, the purpose and method of the proposed treatment and on alternative modes of treatment. Such information ensures that the patient is aware of all the

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182 PUN 1991, Principle 9:4. It seems that the concept of autonomy is not used here in the negative sense or in the narrow sense of the right to self-determination. Instead, the view of the right to self-determination and autonomy seems to be wider since there is a positive obligation for nursing staff to preserve and enhance a patient’s personal autonomy.

183 Feinberg 1973, 46.

184 In this case the principle of autonomy is used in order to resist the patient’s right to refuse medication. Sones 1997, 219.

185 Edwards 1997, 56.

186 PUN 1991, Principle 11:2. See also Feinberg (1986, 152), who discusses how ignorance or mistakes diminish voluntariness: “We fail to know because “no one ever told us,” or we have not read or remembered the appropriate books, or had the appropriate experiences. We have mistaken beliefs because someone or some book that we trusted misinformed us, or we have a distorted
relevant issues which might be important when he or she makes the decision and expresses an opinion. The Madrid Declaration states:

   It is the duty of psychiatrists to provide the patient with relevant information so as to empower the patient to come to a rational decision according to personal values and preferences.\textsuperscript{187}

The role of religion and culture are mentioned in the Madrid Declaration in the article that considers organ transplantation where it states that a psychiatrist should also “advice on religious, cultural, social and family factors to ensure that informed and proper decisions be made by all concerned”.\textsuperscript{188} The PUN and the RCE also note that a patient has a right to be informed of all his or her rights and to receive an explanation of what the rights mean and how they can be exercised.\textsuperscript{189}

  It seems that in many cases there is no conflict between freedom of belief and opinion in the negative sense and the right to get information. When it comes to the treatment of patients with psychosis, in most cases the question is whether they are sufficiently well informed by others and, thus, whether, partly because of this, they are incompetent (and do not fulfill the requirements of the freedom of belief and opinion as negative liberty). It has been noticed in surveys that patients complain especially about not being given enough information about their illness and treatments. Lauri Kuosmanen notes that from the patient’s point of view the right to information does not seem to be realized fully. In Eeva Iso-Koivisto’s study, patients criticized the fact that they got too little information about psychosis, treatment and prognosis.\textsuperscript{190}

\textsuperscript{187} The Madrid Declaration 1996, 3. The PUN (1991, Principle 19:1) note: “A patient shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient’s health and avoid putting at risk the safety of others.” See Peele & Chodoff (2009, 223), who note how difficult it is to determine when the patient is adequately informed: “Does one cover all two dozen or so anti-psychotics or only those one prefers to use? Does the psychiatrist mention all side-effects or only the most relevant to the particular patient? Is it really possible to inform adequately about benefits versus harms?”

\textsuperscript{188} It is also stated that “psychiatrists should seek to protect their patients and help them exercise self-determination to the fullest extent possible in situations of organ transplantation”. The Madrid Declaration 1996, Guidelines concerning specific situations, Organ Transplantation.

\textsuperscript{189} PUN 1991, Principle 12:1. See also the RCE (2004, Explanatory Memorandum, Article 22: 165) that notes: “Patients subject to involuntary measures are entitled to the same information about their rights as patients as specified in Article 6. Because of the infringement of the person’s rights and freedoms entailed by involuntary measures, this Article specifies that they should be given the information both verbally and in written form.”

\textsuperscript{190} Kuosmanen lists patient education as a method which could increase the realization of this right. Kuosmanen 2009, 22, 49; Iso-Koivisto 2004, 72. Even though there might not be any conflict between the right to competence and the right to freedom of belief and opinion in the negative sense, there might be a conflict between the right to competence and the patient’s right to health.
However, sometimes conflicts between these rights occur. For example, it is possible that a psychotic person does not want to know helpful information since he or she holds his or her own views and does not want to take any other views into account, not even hear them. According to the Oviedo Convention, the wishes of individuals not to be informed should be observed.\textsuperscript{191} However, a conflict arises if the person does not know something which he or she would need to know in order to give consent. According to Kati-Pupita Mattila, a person may autonomously refuse to hear any information provided or offered, but in this case the person gives up the opportunity to influence the treatment.\textsuperscript{192}

Sometimes patients have insufficient information because their right to information has not been taken properly into account when the treatment options used are considered to be less restrictive from the viewpoint of freedom in the negative sense. For example, many outpatients interviewed by Iso-Koivisto stated that they did not receive enough information.\textsuperscript{193} From this point of view, the treatment which restricts freedom of belief and opinion in the negative sense more (as does involuntary treatment in the hospital), may enhance competence since the patient may be better informed (than he or she might be if treated as an outpatient).

It is also common that people who are in nonvoluntary treatment believe that they have consented to treatment.\textsuperscript{194} One Finnish textbook of psychiatry guides staff, on the one hand, to inform patients about facts and safety. There are situations where receiving information may violate the person’s health and safety. The person may be, for example, so weak that he or she seems to be unable to use the information in a way that would benefit him or her. It might be the case that receiving information, for example, hearing bad news, may hinder a person’s recovery or disturb the mind of a terminally ill old person in vain. It is worth asking whether the person should be informed about everything that is “relevant” for a person to be competent in situations like these. However, as Mattila notes, the consequence of not telling such a person everything might make that person feel excluded from their own life. Mattila 2002, 121. There are also situations where a person might use information unwisely. For example, it might well be questionable to tell to a suicidal psychotic patient that a certain amount of medication is fatal.

\textsuperscript{191} Oviedo Convention 1997, Article 10:2.
\textsuperscript{192} Mattila 2002, 106-115. There is also some discussion about whether in some cases Jehovah’s Witnesses’ religious beliefs actually prevent them from understanding the relevant information concerning the risks of blood transfusion and information concerning treatment options. According to Martin (2007, 36), refusing a blood transfusion could still be considered as an autonomous choice, while Holroyd (2012, 163-166) states that a refusal should not be accepted in these kinds of situations. However, in cases where the decision of the individual is to refuse a blood transfusion despite the consequences “in this life”, is it really relevant for judging competence that the individual be aware of information concerning the risks and options of treatments which he or she does not accept for spiritual reasons? At least, if it is ensured that this information was not relevant when the person had made his or her decision in the first place.

\textsuperscript{193} Iso-Koivisto 2004, 103, 112.

\textsuperscript{194} This means that a patient may think that they have been judged to be competent to consent to treatment, though in reality they are being treated non-voluntarily because of their incompetence. Heikkinen et al 2008, 695-696; Kuosmanen et al 2007, 604.
decisions in a straightforward way. On the other hand, this textbook notes that nursing staff should avoid any situation in which the patient feels that he or she is being forced to do something by the staff, because this might negatively influence the success of the treatment.195 Thus, a conflict seems to arise between the patient’s right to know what is happening and his or her right to mental health. On the one hand, the patient has a right to know that their negative liberty is restricted. On the other hand, understanding this may influence the patient’s attitude towards treatment negatively and, in this way, may hinder his or her recovery.

3.4. Incompetence and the freedom of belief and opinion

In this chapter I will continue with issues concerning competence by clarifying the problematic relationship between incompetence and freedom of belief and opinion in the negative sense. I start by discussing justified paternalism in chapter 3.4.1. In chapter 3.4.2. I clarify the relationship between competence and rationality while chapter 3.4.3. presents some viewpoints on the question of “best interest” and so-called “unwise choices”. In chapter 3.4.4. I once again return to the question concerning the use of involuntary antipsychotic medication as a possible violation of the forum internum by considering whether competence is a requirement for absolute rights and whether the forum internum could, actually, signify competence.

3.4.1. Incompetence and justified paternalism

According to legislation and ethical principles, it is generally the case that treatment can be given only if the person has given free and informed consent to it.196 This statement is in accordance with the general view of freedom of belief and opinion in the negative sense: the person’s right to freedom of belief and opinion is regarded as more important than his or her right to health and safety. When a person is considered sufficiently competent, the others have to trust that the person understands sufficiently what he or she is doing and what choices he or she is making even though the decisions seem unwise to outsiders.

However, more paternalistic attitudes and decisions may come into the equation when we face a person with a psychotic disorder.197 As Fulford et

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196 See, for example, the Oviedo Convention 1997, Article 5.
197 See, for example, the Oviedo Convention 1997, Article 7. When Kader & Pantelis (2009, 351-352) discuss informed consent in the context of psychiatric drug treatment, they state: “To ensure
al put it, involuntary treatment is used in mental health care, which is not the case in other areas of medicine.

In the case of bodily disorders it is now a cardinal principle of health-care law in many legislations around the world, that an adult patient who has a capacity to make the requisite choice may refuse even life-saving treatment if they so wish, provided that (as with some infectious diseases, for example) their condition carries no immediate risk or danger to others...With a mental disorder, by contrast, and only with a mental disorder, treatment without consent may sometimes considered appropriate for a fully conscious, adult patient of normal intelligence, not for the protection of others...but in that person’s own interests.\(^{198}\)

Here the assumed lack of competence of the patient is crucially important. Restrictions of a person’s freedom of belief and opinion might be justified by saying that the psychotic individual does not fulfill the requirement, namely being sufficiently competent, of this freedom. As a psychotic disorder is thought to have adverse consequences in terms of the mental abilities needed for decision making and coming to evaluations, a psychotic individual is usually considered incompetent in some sense and at some level.\(^{199}\) According

freely given consent, the therapist discusses treatment options thoroughly, objectively weighing up the patient’s preferences. In non-urgent cases, the psychiatrist must be prepared to accede to drug refusal.” It is unclear what writers mean by non-urgent cases, but it is possible that they apply to situations where non- or involuntary treatment is not an issue, since they continue: “Patient freedom can be difficult in the case of involuntary treatment but is justified when the patient lacks capacity and the treatment proposed is in the patient’s best interests.”

\(^{198}\) Fulford, Thornton & Graham 2006, 480-481.

\(^{199}\) See Pietarinen 1998, 16; Kaltiala-Heino 1997. In the Välimäki’s study (1998, 64) some patients even considered that self-determination was a right which has to be earned. The following opinions were expressed: “They [staff members] don’t order us about if we get our jobs done properly and if we’re healthy” and “If you get better there’s no compulsory treatment”. Sometimes insufficient competence is based on a lack of proper information. Sometimes people would make different choices if they knew all the relevant facts. In this sense their incompetent choices are not their “real choices”. According to Feinberg (1973, 48), these kinds of choices can be defined as completely involuntary: “when, through ignorance, one chooses something other than what one means to choose, as when one thinks the arsenic powder is table salt and sprinkles it on one’s scrambled eggs.” Mill (1948, 119) describes the same sort of incompetence with the example: “If either a public officer or anyone else saw a person attempting to cross a bridge which had been ascertained to be unsafe, and there were no time to warn him of his danger, they might seize him and turn him back, without any real infringement of his liberty; for liberty consists in doing what one desires, and he does not desire to fall into the river.” Sometimes the psychotic individual’s lack of competence is of this nature. Sometimes it is meaningful to say, “if he or she knew what the consequences are he or she would act differently”. If the main problem in psychosis is considered to be “a wrong interpretation of reality” one might even claim that if only a psychotic person knew what the reality was, he or she would make other choices. However, a psychotic person may not necessarily change his or her mind after getting all the necessary information. So, it seems, that a psychotic person’s lack of mental competence is fundamentally something other that just a lack of information. It seems that Mill (1948, 119) supposes the existence of a type of incompetence which is not based on the lack of information when he refers to people who for some reason are in a state of mind that is “incompatible with the full use of the reflecting faculty”: “Nevertheless, when there is not a certainty, but only a danger of mischief, no one but the person
to Linda Kader and Christos Pantelis, “the clinical diagnosis and associated deficits often determine the level of competence a patient demonstrates”.  

Riittakerttu Kaltiala-Heino describes the problem of ascertaining if a patient is competent to consent to treatment:

In psychiatry, the consent to treatment is an especially difficult question, because it is never sure to what extent the patient understands the information his doctor is giving to him, and to what extent he can appreciate the information as related to himself, even if he may cognitively understand. The patient’s capacity for informed consent can thus be strongly questioned.\textsuperscript{201}

However, there is no direct conceptual connection between psychotic disorder and incompetence. Psychotic disorder does not signify incompetence as such, though incompetence may often be seen as a consequence of this disorder.\textsuperscript{202} It has been claimed that the concepts used in the medical context and in the medical standards which determine psychiatric diagnoses are not considered wholly relevant in the legal context and it is said that they cannot be applied directly to the legal context. For example, the fact that an individual has been diagnosed as psychotic according to the diagnostic manuals, does not directly entail that the individual so diagnosed would have a lack of competence in the legal sense.\textsuperscript{203} However, the way in which the rights of psychotic individuals are interpreted in legal contexts reveals that there is quite a strong connection (if not, in practice, even a direct link) between the official medical approach towards psychosis and human rights theory and practice. It even seems that if a psychotic disorder is diagnosed and if there is a threat to the person or somebody else, a lack of competence is just assumed without further evaluation. For example, in European context (in Winterwerp case), it seems that the evaluation of the person’s ability to make decisions for decision-making is passed over by arguing that the use of paternalism requires that “the presence of ‘unsound mind’ must be determined by objective medical evidence” and that “mental illness must result in a condition making detention necessary for the protection of the patient or others”.\textsuperscript{204} It seems that within psychiatry there is a tendency to state that

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\textsuperscript{200} Kader & Pantelis 2009, 352.
\textsuperscript{201} Kaltiala-Heino 1995, 21. In psychotic disorders the problem is not too low intelligence as it is when the competence of mentally retarded people is discussed. See Fulford, Thorton & Graham 2006, 480-481.
\textsuperscript{202} This is the reason why I did not consider incompetence as one of the aspects of psychosis in chapter 2.1
\textsuperscript{203} DSM-IV-TR 2000, xxxii-xxxiii, xxxvii. See also Kaltiala-Heino 1997.
\textsuperscript{204} There are also more criteria for the use of paternalistic interventions: 3) the detention must be
medical diagnosis cannot have direct legal consequences, while in legal contexts psychiatric diagnoses can be used in support of an argument for paternalistic interventions. There seems to be a risk both in psychiatry and in jurisprudence that decision makers may fail to take sufficient responsibility in determining the state of a patient’s competence.205

Competence is defined to be a relative quality, since all individuals always have some lack of thinking abilities. Therefore, it is not possible to determine a clear border between competence and incompetence even in the juridical context. On the other hand, even though competence is a continuum concept, “for practical and policy reasons, we need cutoffs on this continuum, so that any person below a certain level of abilities will be treated as incompetent”, as Beauchamp and Childress express it. When it comes to the psychotic individual’s competence, the WHO has clarified that an individual with a mental disorder has the competence to make decisions if it has not been proved otherwise. Competence is not a question of the “all or nothing” -type, either. Therefore, the individual with psychosis may be competent to decide about some things concerning his or her life and treatment, even though he or she might not be competent to make every decision in these areas. According to the WHO, competence should be determined with consideration for the particular situation. For example, a psychotic patient who has been sent for nonvoluntary placement is incompetent when it comes to a decision whether he or she goes to hospital or not. However, he or she might have the competence to make at least some decisions concerning his or her treatment.206

The Explanatory Memorandum to the RCE also pays attention to the point that competence may develop during the course of treatment and states: “If the

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205 Justified on a continuing basis and 4) there must be some relationship between the ground of detention...and the place and conditions of detention. These criteria were set out as part of the Winterwerp case and they are now collectively called the “Winterwerp test”. Ovey & White 2006, 145. See also the Finnish Mental Health Act (Mielenterveyslaki 1990/1116, 8§) which does not mention lack of competence as a criterion of nonvoluntary placement and treatment. The question arises whether the Mental Health Act implies that all people with psychotic disorder who need treatment and are, because of their psychosis, a threat to others or themselves, are actually incompetent. The criterion that “the patient is not able to decide on his or her care” is mentioned only in the context of the nonvoluntary treatment of physical illness. See Mielenterveyslaki 2001/1423, 22c§. It might be that the Mental Health Act should be interpreted together with the Act on the Status and Rights of Patients which concerns treatment procedures in situations where a “patient because of mental disturbance...cannot decide on the treatment given to him/her”. See Laki potilaan asemasta ja oikeuksista 1992/785, 6§.

206 There are exceptions like the Mental Capacity Act (2005) in the UK which concentrates on the evaluation of capacity (or competence, the term we have used here).

WHO 2005, 40, 48; The Explanatory Memorandum to the RCE 2004, Article 16:125; Beauchamp & Childress 1989, 81-82; Pietarinen 1998, 21-22, 39; Pietarinen 1995, 4. The WHO uses the term capacity whereas here we have used the term competence.
person’s legal position changes in this way, appropriate action should be taken.\textsuperscript{207}

When freedom of belief and opinion is understood in the negative sense, the idea usually is that incompetence of the psychotic patient justifies paternalistic interventions. According to Irma Pahlman, justified paternalism means ignoring the patient’s autonomy and making decisions in the patient’s best interest.\textsuperscript{208} Pahlman notes that justified paternalism\textsuperscript{209} requires that the patient is in a condition which justifies paternalism and that the person exercising paternalism over the patient has a legal right to ignore his or her autonomy. Pahlman lists people with psychoses as patients who are in a condition which justifies paternalism.\textsuperscript{210}

Even though paternalistic interventions might be justified, they are still understood as restrictions of freedom of belief and opinion understood in the negative sense. For example, Tom Beauchamp seems to consider justified paternalistic interventions as restriction of freedom (which he seems to understand in the negative sense) when he mentions compulsory psychiatric

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\textsuperscript{207} The Explanatory Memorandum to the RCE 2004, Article 12:97
\textsuperscript{208} Pahlman 2003, 181. See also Kaltiala-Heino 1995, 16. The concept of best interest refers to the patient’s medical or therapeutic interests. However, the meaning of the concept has become broader in the past few years so that best interest includes different kinds of factors of the patient’s welfare interests. This means that both medical and non-medical interests are part of best interest. Fulford et al 2006, 545. For more about best interest, see chapter 3.4.3. Speaking about “ignoring autonomy” implies that freedom is understood here in the negative sense. If freedom of belief and opinion was understood in the terms of authenticity or capability, it would be better to say that the patient’s autonomy is the goal which the nursing staff are trying to reach by their intervention and, thus, it would not be meaningful to speak about “ignoring autonomy”.
\textsuperscript{209} One can also discuss weak paternalism instead of justified paternalism. See Kaltiala-Heino (1995, 16-17), who refers to the distinction between weak and strong paternalism. Strong paternalism is, for example, forcing a mentally sane somatically ill patient who, after receiving all the relevant information, decides to refuse to undergo treatment. Weak paternalism, instead, is in a situation where “the patient is incapable of voluntary choice, for example suffering from a mental illness that restricts his capacity for rational thinking”. See also Häyry (1990, abstract, 92-93), who makes the distinction between soft and hard paternalism where soft paternalism as caring control is autonomy respecting and, therefore, not generally in need of justification. However, Häyry divides hard paternalism (which is autonomy-violating) into weak and strong paternalism and considers the first justifiable and the latter not justifiable. It seems that in Häyry’s model the definitions for weak and strong paternalism are similar to the definitions used by Kaltiala-Heino, since, according to Häyry, weak paternalism is used towards individuals who are not “at the time capable of reasonable voluntary decision-making” and strong paternalism is used towards individuals who are.
\textsuperscript{210} Pahlman 2003, 181. It seems that the concept of “being in a condition which justifies paternalism” is close to the concept of incompetence. However, when Pahlman discusses the conditions which justify paternalism she lists groups of people with certain diagnoses, psychotic people included. When we discuss incompetence the focus is on individuals and their abilities. It is emphasized in the DSM-IV and the ICD-10 that having some kind of diagnosis does not automatically mean that the person is incompetent. Thus, it seems that Pahlman also follows a different tendency (which is also clear in the Winterwerp case) which supposes that having a diagnosis of psychotic disorder almost automatically means that the person is incompetent.
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care as one example of paternalism and, in addition, defines paternalism, as follows:

the word is more narrowly used to apply to treatment that restricts individual autonomy: paternalism is the intentional limitation of the autonomy of one person by another, where the person who limits autonomy appeals exclusively to grounds of benefit for the person whose autonomy is limited.211

It is worth noting that making a paternalistic intervention in the case of a psychotic patient is not the right of every human being. It is a privilege 212 and legal duty of medical doctors to, at first, to diagnose and then, to send the person for non- or involuntary treatment.213

3.4.2. Competence, rationality and the crucial role of sharedness

When mental competence is defined, issues linked with rationality are often highlighted. For example, Beauchamp and Childress define a competent person as one who “can make reasonable decisions based on rational reasons”.214 And vice versa, a lack of competence is linked with irrationality. For example, Daniel Robinson reveals that across many cultures and at different times in history people suffering from mental illness have been intuitively regarded in some sense as irrational. This is the reason why they are not considered responsible for their decisions and actions.215 On the other hand, it is stated that a competent person also has the right to make irrational choices and that the state of competence should not be evaluated according to how “good” the person’s decisions seem to be. This means that competence should be evaluated formally, not contentually. In the formal evaluation the focus is on the process of making a decision. The process has to represent a sufficient ability to engage in rational thinking, though the decision itself might be considered disadvantageous by others. If competence was evaluated contentually, the decision should, instead, be something particular in order to be considered as a competent choice.216

211 Beauchamp 2009, 41.
212 According to Feinberg (1973, 57), one way of defining a privilege is to say that it is “a license to invade another’s right”. For example, “police officers, in virtue of their office, can often lock up persons without committing false imprisonment”.
213 See Pahlman 2003, 181.
214 Beauchamp & Childress 1989, 83.
215 Robinson 1996. See also Fulford (2009, 63), who refers to Robinson’s ideas. See also Kaltiala-Heino 1997.
216 The distinction between a formal and a contentual interpretation of autonomy or right to self-determination is made by Launis (2009, 138; 2007, 67-68), and it is applied here to the concept of competence.
However, the distinction between a formal and a contentual evaluation of competence, or formal and contentual rationality, is challenging. For example, sometimes a contentually odd decision may be a sign of incompetence. Pietarinen writes:

It is part of the nature of self-determination that each may live and act in accordance with his or her own conceptions, beliefs and values. The decisions of individuals depend significantly on their views of life and convictions and they may be very exceptional. To conclude to exceptional decision is not necessarily the sign of insufficient competence, though very exceptional beliefs may also be the consequence of disordered thinking. 217

Feinberg supports this same idea by claiming:

It may be that there is no kind of action of which it can be said, “No mentally competent adult in a calm, attentive mood, fully informed, and so on, would ever choose (or consent to) that.” Nevertheless, there are some actions that create a powerful presumption than an actor in his right mind would not choose them.218

In practice it is difficult to evaluate whether a certain individual is really competent to make choices. An evaluation may be done on the basis of the nursing staff’s experience and evaluations given by some experts. However, the distinction between a formal and a contentual interpretation of competence also seems to be challenging conceptually since it seems that it is not so simple to make a conceptual distinction between a competent person’s irrational choices and an incompetent person’s choices. For example, Lubomira Radoilska discusses this difficult question without it seems finding any satisfactory answer. She wonders, on the grounds of an analysis of the Mental Capacity Act, why the choice of a Jehovah’s Witness to resist a blood transfusion is seen as competent while the choice of a deluded person not to take medication is not. For Radoilska, there is no significant difference in the rationality or irrationality of those choices and she notes two possible (but unsatisfactory) conclusions: “either the claim that both categories of treatment refusals pass the capacity test or, alternatively, that neither does, yet both should be respected for the sake of autonomy”.219

Beauchamp and Childress also seem to get stuck over the difference between competently and incompetently formed religious beliefs when they note that odd decisions may be a sign of incompetence even in a situation where decisions and actions follow “reasonably” from, for example,

218 Feinberg 1973, 49.
219 Radoilska 2012a, xx-xxii.
religious beliefs. Referring to the example of the man who was prescribed involuntary treatment because he, influenced by his exceptional religious beliefs, had tried to pull out an eye and cut off a hand, Beauchamp and Childress comment:

This troublesome case cannot be interpreted in terms of intermittent competence, but it might be argued that an analysis in terms of limited competence is justified. However, such an analysis would also suggest that persons with unorthodox (or even bizarre) religious beliefs are less than competent, even though they reason clearly in light of their beliefs. This criterion is morally perilous for policy purposes and thus is difficult to accept as a general guideline.²²⁰

It seems to me that both Radoilska and Beauchamp and Childress find these problems difficult because they don’t take into account the aspect of sharedness when someone’s competent status²²¹ is defined. Since they concentrate only aspects of irrationality and on the fact that harm is caused to the person’s health (and life), it seems that it is very difficult for them to see the difference between religiously argued competent choices and religiously argued incompetent choices. The same problem may also lie in the approach presented in the Mental Capacity Act. As I see it, when a person’s competent or incompetent status is under evaluation (and, when it is under evaluation, whether the decision-making process has been sufficiently rational), the aspect of sharedness might be central. If the choice is followed consistently from a competent status (for example, from the fact that the person is a member of some religious group with certain shared religious views), that choice might be seen as competent. It might be so, even though it is unclear whether the decision is irrational, not only contentually, but also formally.²²² If it is the case that sharedness is central when someone’s competence is evaluated, it means that the ability to share one’s views with others and the ability to connect with some epistemological community are two of a competent individual’s central abilities.

Even though there has been, in theory, a tendency not to conclude that someone has an incompetent status on the basis of a diagnosis of psychotic disorder, it seems to me that such a diagnosis is crucially important when it comes to deciding whether a person has a right to make a contentually

²²⁰ Beauchamp & Childress 1989, 82.
²²¹ By competent status, I mean that the person is considered as competent agent in respect to the issues which are being discussed and what he or she is deciding at the time.
²²² Decisions may even be formally irrational because, when we discuss human beings and their ways of thinking and deciding, there is always a bias in the processes which may influence the content of their decision. On the other hand, it is not always the case that rational processes lie behind contentually rational decisions, which might be considered, in practice, competent decisions. Moreover, it is an open question whether the background suppositions and values, and how they are chosen, should be evaluated and how this should be done.
irrational choice. On the grounds of the Winterwerp case, the Mental Health Act of Finland and the Mental Capacity Act it seems reasonable to claim that when we discuss freedom of belief and opinion in the negative sense, the fact that the person concerned is psychotic is more crucial than the evaluation of their competence. It seems to depend on whether the person is in a condition which justifies paternalism (for example, whether he or she is diagnosed as psychotic or whether the person is a child), if he or she has a right to make contentually irrational choices which are in accordance with his or her condition. If the condition of the person justifies paternalism, it is questionable whether there is much point in evaluating their competence if the choices as such are evaluated to be contentually irrational.

In cases where the person has both a (incompetent) status as a psychotic person and a (competent) status as a religious person he or she is not considered competent to make contentually irrational choices which are in accordance with his or her status as a psychotic person. However, he or she might have a right to make contentually, or even formally, irrational choices which are in accordance with his or her (competent) status as a member of some religious community which shares their religious beliefs with others. According to this view, a psychotic person’s refusal of medication should be respected if he or she has a reason which is not a product of his or her illness. For example, referring to the example given by Heather Stone, a patient may explain: “I have been a Christian Scientist all my life: I do not believe in medicines or physicians.” Even though refusal would be considered irrational by a psychiatrist, this should be considered, according to Stone, as a competent refusal. However, it might be that the person should have held

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223 If negative liberty is defined as the absence of a duty, as Feinberg does (1973, 56), one interesting and possible conclusion seems to be that the psychotic individual has more legal duties than people usually have. Namely, they have a legal duty to make rational choices. However, it can also be stated that the concept of duty should be ignored when we face an incompetent psychotic individual. We may also emphasize the link between duties and freedom by claiming that if one is not able to carry out one’s duties one is not able to carry on freedom. However, this does not mean that it is not possible to have other rights such as right to treatment. See Feinberg 1973, 61-62.

224 See the analysis of the Mental Capacity Act, Radollska 2012a.

225 See Pahlman 2003, 181. It seems that irrationality is a necessary requirement of most incompetent conditions. However, mere irrationality does not make anyone incompetent. For example, in the case of psychotic people, the criteria of being unwell and alienation have also to be fulfilled before a diagnosis of psychosis (which may lead to incompetent status) can be given. In the case of children the criteria are somewhat different. For example, the criterion of immaturity may replace the criterion of alienation. It also might be that the irrationality linked with incompetence has a particular reason, like psychosis, immaturity or mental retardation. There are also situations where a person is incompetent because he or she is not able to express his or her views (for example because he or she is not conscious at all). In these cases incompetence is not linked with irrationality but with an inability to express oneself.

226 Stone according to Ford 1980. See also Sones (1997, 221), who notes that the right to freedom of belief and opinion might support the right to refuse antipsychotic medication in the sense that, for example, religious reasons for refusing treatment could be taken seriously.
these views shared in some community before he or she is diagnosed as psychotic. It is questionable whether a person who has decided during a psychotic episode to become a Christian Scientist can refuse medication on the grounds of his or her religion. It might even be so that a psychotic person is not considered competent to adopt views, ideologies or religious beliefs which seem to have negative consequences to his or her health, even though these views might be shared beliefs in some community.

When it comes to the question of whether a psychotic person may make contentually rational or harmless choices there seem to be two possible ways of reasoning. First, it can be claimed that because of their (incompetent) status as a psychotic individual, the person is not, actually, competent to make contentually rational choices either. However, if an incompetent person happens to make contentually rational choices there is no need for paternalism. The absence of paternalism in this case is not caused by the competence of the person, but instead, is caused by the fact that the incompetent person’s choices happen to be contentually rational – the same kind of choices which others would have made for him or her – or choices without harmful consequences. Joel Feinberg seems to adopt this option when he writes (referring to John Stuart Mill’s example about preventing a mentally ill person from crossing an unsafe bridge):

On the other hand, there is no reason why a child, or an excited person, or a drunkard, or a mentally ill person should not be allowed to proceed on his way home across a perfectly save thoroughfare. Even substantially nonvoluntary choices deserve protection unless there is good reason to judge them dangerous.\textsuperscript{227}

Speaking about psychosis in the sense of a delusional stance or as an aberrant salience seems to imply that psychosis is such a complete state that it would be weird to speak about competence in some things and incompetence in some others. If we adopted this view, we might end up with “traditional juridical thinking” which, according to Beauchamp and Childress, assumes:

that a person incompetent to manage his or her estate is also incompetent to vote, make medical decisions, get married, and so on.\textsuperscript{228}

However, when it is argued that a psychotic person is not competent to make contentually rational choices either, it might also be argued that when an incompetent person is, despite his or her incompetence, allowed to make contentually rational or harmless choices, the abilities he or she needs in order to make decisions increase. For this reason it is good to give even an incompetent person the opportunity to choose in certain matters. Giving a

\textsuperscript{227} Feinberg 1973, 49.
\textsuperscript{228} Beauchamp & Childress 1989, 81.
patient the possibility of making a choice can also benefit the treatment and well-being of the patient.  

Second, it can be claimed that a person is psychotic and yet still be competent in some matters. When he or she makes contentually rational or harmless choices, this reflects his or her ability to be formally rational and, thus, enjoy a competent status, while contentually irrational choices reflect his or her (incompetent) status. It seems that Beauchamp and Children suggest something like that when they claim that it is possible for a person who is not in general autonomous to make autonomous choices.

For example, some patients in mental institutions who are generally unable to care for themselves and have been declared legally incompetent may still be able to make autonomous choices such as stating preferences for meals and making phone calls to acquaintances.

Moreover, sometimes delusions influence at some issues in life but not others. If a patient believes that nurses are trying to kill him or her, person may be incompetent when it comes to treatment decisions. However, if there are no delusions concerning the grocery shop, its personnel and services, the person may well be competent to decide what food he or she buys in the supermarket.

When we consider the link between competence and rationality it seems clear that rationality is deeply connected with well-being. For example, on the grounds of the notion of Beauchamp and Childress (above), we may assume that the choices which they call autonomous are so-called harmless and in this sense not contentually irrational choices. Namely, if a patient in mental institution prefers to eat only one deciletre of porridge per day and nothing else and decides to drink one spoon of water and nothing else per day, we probably wouldn’t say that his or her choices concerning meals are autonomous. Or if he or she makes expensive phone calls and then as a

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229 Lillehammer presents several reasons for respecting the choices made by an incompetent person (though he discusses people who are not agent autonomous) in some degree. See Lillehammer 2012, 202-203. Moreover, the possibility of choosing between involuntary and voluntary treatment may be given to an incompetent patient in order to test his or her competence. In this case, the focus is not on which of the alternatives the person chooses but on how that person makes the choice and argues for it. For example, by giving a possibility for such a choice the person’s insight can be tested.

230 This option seems to follow either a contentual evaluation of competence or shows that the distinction between a formal and a contentual evaluation is in practice difficult to make.

231 Beauchamp & Childress 1989, 68.

232 This is only what I assume. Beauchamp and Childress may actually hold another view. At least they pay attention to the danger that since determining competence is a value judgement the evaluator may conclude that a person is incompetent because that person does not make decisions which the evaluator thinks a rational person would. Thus, the view of rationality may become too narrow. Beauchamp & Childress 1989, 84.

233 If he or she has reasons to fast or go on hunger strike which do not relate to his or her mental disorder but instead his or her competent status as a member of some religious or political community, our evaluation might be different.
consequence ends up with a huge credit card debt, we probably wouldn’t consider him or her as autonomous in issues concerning phone calls. It seems that choices are often considered rational if they increase a person’s well-being and are not considered totally irrational if they are not harmful. However, it also seems to be crucial what society considers normal or what is common in mental health unit. For example, people with schizophrenia often seem to smoke, which is usually allowed in treatment culture, though there are serious health risks connected with this habit and dependency. Since prevalence of smoking among patients with schizophrenia is high it seems quite relevant to claim that smoking is connected in one way or another with this mental disorder, and thus, is connected to the person’s status as a psychotic person. However, if the person with schizophrenia started smoking during his or her stay in non- or involuntary treatment, would the nursing staff consider him or her as incompetent for making this harmful choice? If not, the reason for this cannot be that the choice of the patient to start smoking was harmless since it is not, but the reason must be something else, like “this is normal among people with schizophrenia”. However, there might still be a tendency to interfere with some other harmful choices (such as not to take one’s medicine) which would seem quite normal among people with such a diagnosis. In addition, it is worth noting that we tend to assume that people who make choices which promote their well-being are competent. If a patient agrees with the psychiatrist, his or her competence is not usually an issue at all. Riittakerttu Kaltiala-Heino notes that in psychiatry refusing treatment is usually seen as a problem. It seems to be interesting for society if others want to act and a patient wants to be left alone. However, Kaltiala-Heino asks whether there is also an ethical problem if an incompetent patient accepts treatment and is, because of this, actually ruled by others even though “on paper” he or she rules him- or herself.

When we consider the conceptually challenging link between competence, rationality and harmless choices it seems that it is conceptually impossible that a competent person could hold so-called harmless delusions.

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234 See Dervaux & Laqueille (2006), who note that the level of cigarette smoking among patients with schizophrenia is 60-90% while in the general population it is 23-30%.

235 When it comes to the harm that a person might cause to him- or herself, Feinberg makes a distinction between harm which is directly produced and the risk of harm which the person creates to him- or herself. He also points out that while it is quite normal to create risk of harm to oneself, directly harming oneself easily raises the question of whether that person knows what he or she is doing. On the other hand, Feinberg also notes that risks can be reasonable and unreasonable. Feinberg 1973, 46-47. Harming oneself directly and taking unreasonable risks both seem to raise the need to evaluate whether the person is competent.

236 Kaltiala-Heino asks whether all incompetent patients should be prescribed nonvoluntary treatment, in which case society carries the responsibility until the patient’s competence returns. Kaltiala-Heino 1997.
Namely, if a competent person has a right to make harmful choices on the grounds of his or her belief system, a person with harmless delusions – if considered competent – should have a right to make harmful choices too. However, this is not the case, since if choices based on delusion turn out to be harmful, paternalism turns out to be justified. In short, a person who holds a (harmless) delusion cannot make harmful choices without losing their status as a competent person. This argument also seems to mean that it is questionable whether being unwell is conceptually a necessary criterion of psychosis since the person who fulfils the criteria of irrationality and alienation seems to have no right to make harmful choices without being diagnosed (and people who are not psychotic should have that kind of right). Thus, if a person’s view of reality is unshared and irrational but he or she is not seriously unwell (as seemed to be the case with Simon237), should we consider that person’s view of reality as psychotic and the person, actually, incompetent? There would be no need for paternalistic interventions as long as the person’s choices are not seriously harmful. However, if the person (for example, Simon) decided to do something which seriously harmed him or her, the need for justified paternalism seems to arise, which implies that the person was not competent in the first place since he or she did not have the right to make harmful choices as competent people should have.238

If being unwell is a conceptually questionable criterion of psychosis, alienation as a criterion of psychosis seems to be even more crucial and conceptually central. It seems that if a view of reality is shared in some community a person with that view cannot be diagnosed as psychotic even though that person’s choices might be harmful. However, if a view of reality is not shared in a community but the person seems to be well and makes harmless choices, there is no need for a diagnosis of psychotic disorder. It seems that the expression “cannot be diagnosed” implies to conceptually more central features than the expression “no need for diagnosis”.

3.4.3. Best interest and harmful choices

I presented in chapter 3.4.2. that if the person has both a (incompetent) status as a psychotic person and a (competent) status as a religious person he or she might have a right to make contentually irrational choices which are in accordance with his or her (competent) status as a member of some religious community which shares their religious beliefs with others. However, it is not clear whether there is, according to the legislation and ethical principles

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237 See chapter 2.1.3.
238 This consideration reminds one of the discussions concerning non-pathological delusions. See Fulford & Radoilska 2012, 62-65.
guiding psychiatric care, such a right. For example, the question of whether a Jehovah’s Witness who becomes psychotic may still refuse a blood transfusion illuminates the problematic relationship between harmful choices and so-called best interest.

When the person is defined as incompetent it is said that decisions should be made in his or her best interest. The guideline material collected by the UK Clinical Ethics Network defines the best interest approach, as follows:

the best interest approach asks whether any proposed course of action is the best one for the patient all things considered.

The UK Clinical Ethics Network’s material also points out that there are two different kinds of approaches to best interest. It seems to depend on the approach whether harmful choices are considered to be in accordance with an incompetent person’s best interest. First, when determining best interest, it is possible to concentrate to the patient’s wishes. This approach “requires decision-makers to guess what the person would have decided if he had been competent.” According to this view, best interest can be anything that the person desires. However, it is also relevant to take into account such risks which the person him- or herself would have taken into account if he or she was able to.

The other approach emphasizes more objective elements alongside with the patient’s supposed own wishes. Then the person’s own wishes are not necessarily the decisive factor, since “objective elements may well be introduced when working out best interests”. The material points out that the British Mental Capacity Act seems to adopt the latter view, since it notes:

wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests. Any such assessment must consider past and current wishes and feelings, beliefs and values alongside all other factors, but the final decision must be based entirely on what is in the person’s best interests.

239 See the Declaration of Hawaii 1977, 5.
240 The material’s aim is to provide explanations for and discussion of sections of the British Mental Capacity Act. UK Clinical Ethics Network, Mental Capacity Act, Overview of the Act.
241 UK Clinical Ethics Network, Mental Capacity Act, Determining Best Interests. According to Feinberg (1973, 26), the concept of interest means in a legal context “something a person always possesses in some condition, something that can grow and flourish or diminish and decay, but which can rarely be totally lost”.
242 See the UK Clinical Ethics Network, Mental Capacity Act, Determining Best Interests; Fistein 2012, 181. See also Feinberg 1973, 26. Fistein (2012, 181) calls this way of understanding best interest “respect for autonomy based on substituted judgement”.
243 UK Clinical Ethics Network, Mental Capacity Act, Determining Best Interests. See also Fistein (2012, 180-181), who calls this view of best interest “paternalism based on satisfaction of corrected preferences”. Fistein (2012, 179-180) also recognizes a view which she calls “paternalism based on an ideal theory of good”. In this view priority is given to the consideration of how to best protect the person’s health and safety. In practice this view is also presented and
Feinberg defines this latter view:

A person is often said to “have an interest” in something he does not presently desire. A dose of medicine may be “in a man’s interest” even when he is struggling and kicking to avoid it. In this sense, an object of an interest is “what is truly good for a person whether he desires it or not.”

According to Feinberg this view can also be connected to desires by claiming that in the long run the something which is called interest “would effectively integrate” the person’s “total set of desires leading to a greater net balance of desire-fulfillment”.

It seems that the formulation of the Mental Capacity Act makes a distinction between the concept of best interest and the patient’s wishes and feelings, beliefs and values. Therefore, it seems that a patient who is considered competent has the right to make decisions according to his or her wishes, feelings, beliefs and values and against his or her best interest, but if the patient is considered incompetent, the decision should always be according to his or her best interest, which also includes “objective” elements.

The way in which Fulford et al describe the concept of best interest seems to follow the latter, “more objective”, interpretation. According to them, the concept of best interest has referred to the patient’s medical or therapeutic interests. However, the meaning of the concept has become broader in the past few years so that best interest now includes different kinds of factors of the patient’s welfare interests. This means that both medical and non-medical interests are parts of best interest. Fulford et al note that since best interest also includes other than medical factors, doctors are not competent to determine a patient’s best interest as a whole by themselves. It seems that the goal of the best interest approach is the patient’s welfare, not the realization of the patient’s own will, even though the patient’s will is taken into account as a part of his or her well-being – but only as a part. Of course, in practice, the patient’s own will may often be that his or her well-being is promoted. However, sometimes this is not the case and if it isn’t, it seems that welfare is prioritized over the patient’s will, even though that will followed from the patient’s competent status (for example, from his or her status as a member of some religious community which shares their religious beliefs with others). Thus, a Jehovah’s Witness who becomes psychotic would not necessarily have the right to refuse a blood transfusion. In the same way, a patient could not necessarily refuse medication on the grounds that he or she has been a Christian Scientist since childhood and do not believe in medicines or

\[\text{applied by nursing staff, as Fistein shows.}\]

244 Feinberg 1973, 26.
246 Fulford, Thorton & Graham 2006, 545.
physicians.\textsuperscript{247} It seems that Lauri Kuosmanen and Riittakerttu Kaltiala-Heino question this approach towards best interest when they ask whether others can know what is the patient’s best interest. Kuosmanen asks, when does overriding a patient’s wishes in the name of his or her best interest turn into coercion or the use of power.\textsuperscript{248}

An interpretation of best interest which may ignore the patient’s earlier competent wishes seems to be problematic from the viewpoint of freedom of belief and opinion understood in the negative sense. It seems as if the state would actually like to prevent citizens from making “unwise” decisions but it cannot usually do this because people have a right to freedom of belief and opinion and right to self-determination understood in the negative sense. However, when an individual is under the state’s control and considered incompetent, the state has an opportunity to prevent that person from making unwise decisions that the person would make if he or she was competent – and the state uses this opportunity. One can ask if this is actually unjustified paternalism and would it be, from the viewpoint of freedom of belief and opinion in the negative sense, better to follow the interpretation of best interest which “requires decision-makers to guess what the person would have decided if he had been competent.”

The problem in practice might be that people who make decisions about a patient’s best interest do not always know for sure what the patient’s (competent) will would be. Therefore, they avoid making decisions which they consider unwise and suppose that most people want what promotes their wellbeing. Perhaps it would be easier to respect unwise decisions made in a competent state if those decisions were clearly spelled out in written form and they could be sure that the person really was competent when he or she expressed his or her will. Thus, the interpretation of best interest might become clearer if it was possible for a patient to write a nursing will in case of possible psychotic episodes and if competent people used that opportunity to write a nursing will.\textsuperscript{249}

If a patient has written a nursing will but the nursing staff decide to act according to best interest (in the objective sense) instead of following the

\begin{footnotesize}
\begin{itemize}
\item[247] See Ford 1980. See chapter 3.4.2.
\item[248] Kuosmanen 2009, 18; Kaltiala-Heino 1995, 16. Here Kuosmanen seems to think that not all paternalistic decisions are coercion or use of power, since he asks when overriding a patient’s wishes becomes as such. However, in other contexts Kuosmanen seems to understand involuntary treatment as a restriction of liberty and thus a form of coercion. It seems that Kuosmanen’s view of the concept of liberty is not quite clear. It might be that in the context of best interest he means to ask when overriding a patient’s wishes becomes unjustified coercion or use of power.
\item[249] There is a suggestion of this kind of nursing will in Mielenterveys- ja päihdesuunnitelma (2009, 21). See also Kaltiala-Heino 1995, 22. See also the Oviedo Convention (1997, Article 9), which states: “The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account.”
\end{itemize}
\end{footnotesize}
nursing will of the patient, then there would be good reasons to ask if unjust paternalism has been exercised. However, the question arises whether the goal really is the realization of the patient’s (competent) will or whether it is the well-being of the patient. For example, if an incompetent patient with psychosis had written a nursing will whilst in a competent state earlier in which he or she had refused, for example, a blood transfusion, but now the patient in an incompetent state accepts a blood transfusion, would the nursing staff follow the competent but harmful will or would they follow the incompetent will which would be called wise? I suppose that the blood transfusion would be given to a patient if he or she “accepts” it, whatever his or her state of competence at the moment of “accepting” was. If it was the other way round and the will had been written in a competent state and had expressed what would be considered a wise choice, the nursing staff would of course follow it and ignore any refusal of treatment expressed in an incompetent state. This example illuminates the argument that it is not necessarily so that respecting a competent will is the highest principle of nursing staff and the state. The highest principle might deal with well-being, after all.

3.4.4. The forum internum and incompetence

At the end of this chapter concerning negative liberty, I return to the question of whether the use of involuntary antipsychotic medication violates a person’s right to the forum internum. Though it is unclear what the forum internum actually means and to what sphere in humanity it applies, I will now consider the question whether the right to the forum internum could require sufficient competence. Just to make it clear, we will not discuss whether a patient who is involuntarily hospitalized is competent to refuse antipsychotic medication. We will discuss whether such a person has the right to refuse antipsychotic medication even though he or she is incompetent.

It might be asked whether an incompetent individual has the right to freedom of belief and opinion in a minimal sense (forum internum) at all.

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250 Another kind of challenge is presented by Heal (2012, 20-21), who discusses a case where a person has voluntarily taken part in worthwhile experiment because it helps others but which turns out to be boring or mildly unpleasant. While people with “robust mental health” may be encouraged to carry on, it would feel unpleasant to encourage people with mental disorder in the same way. See also Radoińska (2012b, 266-277), who discusses the paradoxical nature of pre-commitment in relation to autonomy.

251 See the critique of Kaltiala-Heino (1995,18), who states: “If a patient is found incompetent enough to be involuntarily hospitalized, it is quite illogical to assume him competent to refuse treatment when committed.” However, Kaltiala-Heino does not take into account here that some rights are absolute and it is unclear whether holding these rights require competence.
because he or she does not fulfil the requirements of that absolute right. If he or she does not have a right to the forum internum there is no contradiction, either, between the right to the forum internum and the use of involuntary antipsychotic medication. If there is no right it does not matter whether the right is absolute or not. In other words, in cases of incompetence, the dimension of the forum internum is not restricted. It is not applied, instead.

However, this view seems to be inconsistent with views which consider non- or involuntary treatment as an interference with freedom of belief and opinion in the negative sense since these views do actually claim that freedom is restricted or limited. They do not state that the right was not applied. Legislation and ethical principles may suggest that we restrict freedom of belief and opinion in certain situations but, on the other hand, they insist that these rights should exist. For example, the PUN does not mention that some human rights are not applied in cases of patients with psychosis. The PUN discusses, instead, limitations on rights in certain situations, which seems to imply that the right to the forum internum should be applied. The Mental Health Act of Finland also uses the expression “limitations on patients’ fundamental rights during nonvoluntary treatment and examination” in the title of chapter 4a, which includes, among other things section 22b which considers the treatment of mental illness. It can also be asked how rights which should belong to each person do not, however, belong to some people. How can some human beings be totally outside the realm of absolute rights? If the incompetence of a person leads to the view that there are no certain rights, not even an absolute right, which it is possible to restrict, it seems to be tantamount to denying that such rights exist. The question arises whether the right to the forum internum is based on human dignity, which the individual has because he or she is a human being, or whether this absolute human right has to be earned by exhibiting some qualities or, as Nordenfelt calls them, merits, such as the quality of being sufficiently competent. A conflict also seems to arise in relation to the way in which the concepts of thought and opinion are defined in human rights discussion. If competence was considered a requirement for the forum internum, the crooked claim would be the

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252 See, for example, Kuosmanen 2009, 11, 13, 16-19; Kaltiala-Heino 2000, 213.
253 PUN 1991, General limitation clause.
254 See Mielenterveyslaki 2001/1423, Chapter 4a, 22b§. The expression in Finnish is: “Potilaan perusoikeuksien rajoittaminen tahdosta riippumattoman hoidon ja tutkimuksen aikana”.
255 See Nordenfelt (2003, 103-105), who makes a distinction between dignity, which is the result of a person’s merits, and human dignity which is based on humanity as such and which entails equal human rights. However, when we discuss the incompetent individual’s right to the forum internum we face a problematic background of the latter view: since the foundation of equal human dignity, which one need not earn and cannot lose, resides in different human abilities, such as thinking and the ability to create one’s own values, the question arises whether the latter kind of dignity, actually, has to be earned by these abilities. See also chapter 2.2.2, which presents the idea of human dignity as a background of human rights.

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following: thoughts and opinions can be of any kind whatsoever, but some thoughts and opinions (namely delusions) imply that the person holding them is not competent to enjoy freedom of thought and opinion.

When freedom of belief and opinion is the subject of discussion, an individual with psychosis can also be compared with children, since the relationship between competence and rights also seems to be unclear and the subject of debate in discussions concerning the rights of children. Sylvie Langlaude seems to interpret The United Nations Convention on the Rights of the Child to mean that restrictions on the forum internum are not permissible. However, it is unclear whether and to what extent the forum internum should be applied in cases involving children. One possible view is that children enjoy the right to freedom of belief and opinion in full but their parents or guardians use their right on their behalf. According to this view, rights do belong to children. In the same way, it could be claimed that the patient with psychosis has a full right to freedom of belief and opinion, the forum internum included, but the psychiatrist who treats him or her uses the right. When compared with children, it is possible for the parents of a child to decide what religious community the child belongs to. The decision about membership seems to be, according to some interpretations, a part of the forum internum, and it seems that in the case of children the parents also use this right. However, parents cannot use the rights of their children in any way they like (they cannot, for example, refuse a blood transfusion for their children) since there seems to be some rights which children hold independently even of their parents. The situation of an individual with psychosis seems to be different. Even though the use of involuntary antipsychotic medication may be seen as acceptable, it would seem to be unacceptable for nursing staff or a psychiatrist, for example, to change a patient’s membership of some religious community. Thus, the idea that somebody can use somebody else’s right does not seem to apply to a physician using a psychotic patient’s right to the forum internum, not at least in the same way as it does seem to apply in the case of children.

When it comes to the question of a psychotic individual’s right to the forum internum, one detail is interesting here. Namely, legislation and ethical principles state that when a decision about non- or involuntary

258 Viljanen 2011b, 100.
259 See, for example, Tazhib (1996, 25-26) who argues that freedom to have or adopt a religion or belief belongs to the forum internum. Tazhib lists, for example, proscription of membership of certain religions or beliefs under law, and it seems that parents may proscribe such the membership for their child if they want to.
260 However, in the same way that parents have a duty to promote their children’s competence, a doctor might have this same duty towards his or her psychotic patients.
treatment is made, the psychotic patient’s opinion should be taken into account even though nursing staff need not follow the opinion expressed. For example, the RCE points out that the patient’s opinion should be taken into account when preparing the treatment plan and when making decisions concerning involuntary placement and treatment. In practice, the patient’s opinion is taken into account by writing it down in the patient’s medical notes. If I have understood this guideline correctly, a delusional opinion or an opinion “with no sense” should also be written down. So, it seems that even in the case of a patient’s incompetence a measure of his or her freedom of belief and opinion is considered relevant. It has been thought that taking the patient’s opinion (even though it may be delusional) into account protects the patient’s freedom of belief and opinion in some sense, even though this opinion might not always be followed. The point is that the opinion is, at least, heard, or as Maritta Välimäki notes, the rule that requires that an opinion be taken into account implies that the patient’s right to express an opinion has been realized, which is considered a minimal level of self-determination. Should we think that the rule to take an incompetent patient’s opinion into account implies that there are some parts of freedom of belief and opinion worth respecting in spite of incompetence? If this is the case, we could ask whether the right to the forum internum should be seen as the core of that part that remains. However, the rule requiring staff to take the patient’s opinion into account can also be seen as a practical concession. Or, it may be considered important because of some rights other than the freedom of belief and opinion. The idea could be, for example, that the rule to take a patient’s opinion into account promotes successful treatment and, thus, the patient’s well-being.

It has been claimed that if a person is incompetent, his or her right to competence should be supported, and this is, actually, how the person’s absolute rights are taken into account and respected. The conclusion is then different – the use of antipsychotic medication is seen as a way to respect the person’s right to the forum internum. However, as I see it, the view of freedom of belief and opinion is also then different when compared with the view which understands freedom of belief and opinion in the negative sense. Freedom of belief and opinion as a negative right cannot require that others actively help a person realize this right. It also seems problematic to claim

261 Also “the opinion of the minor should be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.” RCE 2004, Article 12: 1, 17, 18, 20, 29.

262 Välimäki 2000, 92. The way in which Välimäki understands the minimal level of self-determination seems to be in conflict with the view of the forum internum as an absolute right. Expression of opinion or thought is part of the forum externum and only the right to hold the thought and opinion is considered absolute.

263 One exception is worth noting here, since protecting the individual’s freedom of belief and opinion in the negative sense means that the state has a positive obligation to ensure that people do
that there was an absolute right to get support for one’s competence because it is usually stated that absolute rights can only be negative rights, which obligate others in a negative sense.\footnote{See Feinberg (1973, 95), who states that the most plausible candidates for absoluteness are some negative rights because they do not require positive action or contributions from others and are therefore “less likely to be affected by conditions of scarcity”. For example, if the right to competence was an absolute right, there would be violations of absolute human rights in every case where somebody who is incompetent had not been helped by others properly.}

However, it is possible to think that the *forum internum* actually signifies a negative right to mental competence. This means that the *forum internum* would obligate others not to interfere with another person’s mental competence in order to reduce it but that there was no absolute right to get support for one’s competence (though, this could be a non-absolute human right). If this was the case, an involuntary measure such as brainsurgery could be absolutely prohibited if there was a significant risk that the person’s ability to be competent was destroyed for rest of that person’s life. It would be against the *forum internum*, if the person’s brain was so manipulated by surgery that the person could not process information anymore, or understand the consequences of his or her actions (though the person was calm and easy to handle). However, measures which do not interfere with mental competence but instead have a goal to increase it (as is typical with the use of involuntary antipsychotic medication), could be defined as justified even from the viewpoint of negative liberty. Also measures such as giving sedative medication in order to promote treatment options could be defined as having a goal to return someone’s mental competence through treatment, though it would not promote competence right away, but might even temporarily reduce it by making the person sleep deeply. However, if the *forum internum* was to be understood in this sense, a redefinition of this absolute right would be needed in human rights theory since the current definition of the *forum internum* does not seem to signify this kind of right.

Now that I have presented my analysis concerning the psychotic individual’s freedom of belief and thought in the negative sense, it is time to sum up some problematic issues and present some ideas about how any inconsistencies might be resolved.

First, my analysis seems to reveal that even though freedom of belief and opinion in the negative sense is, in principle, prioritized over health and even though it is emphasized that a competent person may make irrational choices which others have to respect, some exceptional and imaginative examples show that this might not always be the case. My analysis concerning irreversible treatments in chapter 3.2.4. suggests that the problem with, for example, psychosurgery is probably not the permanent effects but the risks
and undesirable effects (which are permanent). This seems to imply that well-being is prioritized higher than freedom of belief and opinion in the negative sense. I also showed that as long as people’s decisions seem to be harmless, we are not interested in whether they are competent, not even if it were quite evident that they are not. The question about whether to follow a competent and harmful decision or an incompetent but harmless decision, for example, in the case of a blood transfusion illuminates this well. Thus, it seems that the existence of freedom of belief and opinion is dependent on its usefulness in society – in the way this right creates well-being for people in general. The prize of this well-being is that some individuals destroy themselves with their irrational and harmful decisions. However, the state tries to prevent this from happening when it has the chance to do so, namely, when people are considered incompetent.

Second, if freedom of belief and opinion is understood in the negative sense, no simple and clear solution seems to be available for solving the problematic relationship between the right to the forum internum and the use of involuntary antipsychotic medication. The difficulties here seem to arise from the fact that when the idea of freedom of belief and opinion as negative liberty was developed incompetent people were ignored. Since I do not want to suggest that society should adopt the antipsychiatric view, which emphasizes that the psychotic patient has an absolute right to refuse medication, I think it is necessary to develop and clarify human rights theory concerning the freedom of belief and opinion.

The first way of solving this inconsistency would be to declare clearly that at least some absolute rights dealing with negative liberty also require competence. However, I see this solution as problematic. If some kinds of requirements are placed on absolute human rights, it would seem that the concept of absolute rights is in some danger. If some requirements are placed on absolute rights, on what grounds can we still discuss, for example, the right to treatment? If there are requirements for absolute rights, is there a danger that people who do not fulfil those requirements, actually end up in a situation where they do not have human rights – rights which are there, it is declared, to protect them? Competence as a requirement of absolute liberty rights also seems to lead to a way of arguing which is difficult to clarify to the patient. I see this as a problem because in the case of delusional people we should, in particular, find solutions for any inconsistencies which are clear and which the patients can invoke and rely on.

The second and better solution would be to claim that the forum internum is not, actually, an absolute right. In this solution we could speak about a conflict of different rights and restrictions of the freedom of belief and

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265 This conclusion seems to be in accordance with Mill’s utilitarian way of arguing for liberty.
opinion, which I see as more clear than speaking about whether this right is applied or not (as is done if competence is seen as a requirement of an absolute right). The problem with this view is that it might reduce the protective meaning of freedom of belief and opinion universally when it comes to the rights of all people.

The third possible solution is even better. Namely, it could be claimed that the practice of using involuntary antipsychotic medication and the legislation which guides its use actually implicitly deny that delusions are opinions or thoughts which a person has the right to hold. If delusions were not opinions or thoughts there is no such right as the forum internum, which would be applied to them. If this is already the implicit way of thinking in human rights theory, there is a need to redefine clearly the concepts of opinion and thought as human rights concepts in such a way that delusions are excluded from these definitions. If this was done, one possibility would be to refer to the definition of delusion presented in diagnostic classifications and the different aspects of psychotic disorder, especially the aspect of alienation, which constitute the difference between delusions and other exceptional beliefs and thoughts.

Perhaps the best option from the viewpoint of negative liberty would be to suggest that the forum internum signifies a negative right to mental competence. This means that the forum internum would obligate others not to interfere with another person’s mental competence in technically and physically concrete ways with the intention of reducing it. In this case, everyone would have the same right to the forum internum whether they were competent or not. This interpretation of the forum internum would actually solve also problems which deal with rights of children.266 If the forum internum signified a negative right to mental competence, all incompetent people would have this right and there would be no need for other people to use the right on their behalf.

However, if the forum internum actually signifies a negative right to mental competence, this absolute right should be redefined in human rights theory and different issues (like the possibility of using sedative medication) should be discussed in more detail. The question also arises whether in cases where a person is sufficiently competent it would be against the forum internum if his or her competence was increased by medication without his or her consent. For example, would it be a violation of the forum internum if the state added some kind of medication to tap water which increased people’s ability to process information without telling its citizens that it had done so?

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266 We would not need an idea about parents who use their child’s right to the forum internum when they decide about membership in some religious community, since the forum internum would not protect these kinds of choices (even though the forum externum would, and parents had a right to use the forum externum for their children).
The problem in psychiatry is, however, that since competence is a matter of degree, the evaluation of sufficient competence turns out to be a risky issue. If the people who evaluate a patient’s competence thought by mistake that the patient was not competent, they would be doing something absolutely illegal if they then medicated the patient. If a juridical violation of patients’ absolute rights is just around the corner when an evaluation of competence is being made, it is difficult to make decisions ethically and wisely with appropriate consideration being given to the context. Thus, it might be that the right of the sufficiently competent person not to be interfered with in order to become more competent cannot be included in the forum internum, though it could be a human right that is not absolute.

Thus, it seems that the view of freedom of belief and opinion in the negative sense is not, actually, as problematic as it first seemed to be when it is considered as a right of an individual with psychosis. It seems to be possible to find such an interpretation of the forum internum which would be relevant for people with psychosis without ignoring them from the human rights theory perspective. However, the view should be clarified and developed further.

However, when it comes to a right to the forum externum, it seems that the view of freedom of belief and opinion as negative liberty is too narrow if we are to understand what is relevant for many people with psychosis. Unlike the forum internum, it seems that the forum externum should also be understood in a positive sense. A person with psychosis may need help in order to develop and manifest his or her beliefs and opinions and in order to live a life which is sufficiently in accordance with his or her values. The view of freedom of belief and opinion in the negative sense does not take these needs into account.

Moreover, the question arises whether the background supposition which states that other people and the state are “a threat” to the individual’s freedom, is too strict. Namely, forming beliefs and opinions are communal processes and not just something that an individual does best when he or she is isolated from others. Also the crucial meaning of sharedness, which I noted in chapter 3.4.2., seems to question a background supposition which emphasizes the individual’s role especially as an individual, disconnected with others. It seems, that even if freedom of belief and opinion is understood in the negative sense, we need to admit that a certain level of sharedness is crucially linked with the fact that the person may live, act, think and believe under the protection of the freedom of belief and opinion.

Thus, even though we have already found one relevant interpretation of the forum internum, we still need to seek views that are more relevant in order to understand freedom of belief and opinion.
4. The psychotic individual’s freedom of belief and opinion in terms of authenticity

In order to have a better understanding about how freedom of belief and opinion could be understood and how issues relevant for psychotic individuals could be taken better into account, we now turn to discuss freedom of belief and opinion in terms of authenticity. Chapter 4 defines how freedom of belief and opinion and any interference with it are understood from the viewpoint of authenticity, especially when considering a person with psychosis. I also clarify the kinds of discourses, concepts and presuppositions on which the view is based and what kinds of challenges we face when we discuss authenticity in the context of human rights theory.

4.1. The concept of authenticity

In this subchapter I define the concept of authenticity as a human right and consider the requirements for it and interferences with it. Ultimately I describe how freedom of belief and opinion is understood in terms of authenticity. The purpose here is to consider the concept of authenticity and freedom of belief and opinion in terms of authenticity in general. I will proceed to apply the view of authenticity to individuals with psychosis in later subchapters.

4.1.1. Definitions of authenticity

In this study the concept of authenticity refers to the idea of being who one really is, in other words, being one’s own person. The authentic individual thinks his or her own thoughts and believes his or her own beliefs. Etymologically the term “authentic” is directly rooted in the Medieval Latin word authenticus and in the Greek word authentikos both of which mean original and genuine. The background of these terms are to be found in the Greek authentes, which means the person who is acting on his or her own authority.¹

The concept of authenticity refers to the internal or psychological dimension of a person. The distinction between the internal and external human being is central to understand authenticity. When I considered the concept of freedom in the negative sense, I referred to the distinction between external and internal interferences with and aspects of the person. I pointed out that a free person in the negative sense is free from technically and

physically verified restrictions which are outside the individual’s body and mind. Here, a free person in the sense of authenticity is free internally and psychologically, in his or her mind.²

Authenticity seems to be quite difficult to define further, because, firstly, the idea of being who one really is and the idea of being one’s own person have been described in several ways. Sometimes the idea is defined by using the concepts of internal, or mental, autonomy, or it involves discussing whether the person is autonomous. Second, several features are linked to the idea of authenticity. At least dimensions such as independence, self-fulfilment, reflectivity and the coherence of self-narration have been highlighted when discussing the idea of authenticity. It is worth noting that all these concepts have been used in several overlapping meanings.³ The way in which I interpret the meaning of authenticity in the context of human rights refers conceptually for the most part to the independence of the person and to the authority of his or her attitudes, beliefs and opinions. I understand self-fulfilment more as a manifestation of authenticity. When it comes to reflectivity and the coherence of self-narration, I consider them as features which can be considered when evaluating authenticity (I will discuss the evaluating of authenticity in chapter 4.4).

It seems that some definitions of autonomy refer to the individual’s freedom in terms of authenticity. Ronald Dworkin understands autonomy as a person’s right to moral independence. The individual’s right to moral independence requires that officials not violate this right even though they might think that restrictions of it would have good consequences for the community.⁴ Thomas Scanlon describes the autonomous person, as follows:

To regard himself as autonomous in the sense I have in mind, a person must see himself as sovereign in deciding what to believe and in weighing competing reasons for action...An autonomous person cannot accept without independent consideration the judgement of others as to what he should believe or what he should do.⁵

This viewpoint can be called mental autonomy, as is done by Thomas Nagel, who defines autonomy as the sovereignty of each person’s reason over his or

² See chapters 3.1.1. and 3.1.2.
³ Compare, for example, Oshana’s article on authenticity (Oshana 2007) and Brison’s article on autonomy (Brison 1996). Both consider Harry Frankfurter’s concept of autonomy/authenticity by defining the content of his concept of autonomy/authenticity in the same way, but while Oshana describes it as one of the meanings of authenticity, Brison describes it as one of the meanings of autonomy.
⁵ Scanlon 1972, 215-216. See also Bolton & Banner (2012, 80) who define one approach to autonomy by highlighting “the conditions under which a person desires, beliefs, reasons, and action can be considered as originating in or belonging to the self, as authentic in this sense – as opposed to having some other origin”.

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her own beliefs and values. According to Juhani Pietarinen, an autonomous person makes personal decisions while an unautonomous person follows the decisions and direction of others. Charles Guignon describes authenticity as the independence of inner life.

To be human, on this view, is to be a self-contained, bounded individual, a center of experience and will, with no essential or defining relations to anything or anyone outside oneself. Philosophers have labelled the self so regarded a subject. To be human, according to the modern way of thinking, is to be a subject, a sphere of subjectivity containing its own experiences, opinions, feelings and desires, where this sphere of inner life is only contingently related to anything outside itself.

The idea of authenticity is also present in Isaiah Berlin’s description of positive freedom. Berlin considers positive freedom as the individual’s ability to realize his or her goals and policies and to bear responsibility for his or her choices. According to Berlin, a free person in this positive sense is also able to explain his or her choices by reference to his or her own ideas and purposes. Berlin considers positive freedom as self-directing, as “being instrument of my own, not of other men’s acts of will”. The authentic individual is, using Berlin’s concepts, being moved by his or her own conscious purposes and not by causes which affect the individual’s decisions from outside. This seems to refer, if implicitly, to the Kantian idea that a person should not be mere instrument of others but an end as such.

The idea of self-fulfilment is also linked with the idea of authenticity. In presenting this link, the supposition seems to be that there should be no inconsistency between the person who is living a life and the life that the person is living. For example, according to Diana Meyers, autonomous agents live in harmony with their true or authentic selves. Monica Betzler describes a commonly held intuition which states that “a person cannot be self-governed if she does not act in light of considerations that express her authentic self”. On the other hand, according to this commonly held intuition “a person is autonomous only if she acts for reasons that are truly her own”. Charles Taylor seems to describe this feature of authenticity when he writes:

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6 Nagel 1995, 96.
7 Pietarinen 1990, 79.
9 Berlin 2005, 178. However, Berlin’s concept of positive freedom is wider than the concept that I call authenticity. It is also worth noting that even though the individual’s own body is part of the concept of the internal, the possibilities and restrictions that flow naturally from the individual’s body do not usually belong to the area of authenticity; it is the capability of the person that is central.
11 Betzler 2009, 51.
Everyone has a right to develop their own form of life, grounded on their own sense of what is really important or of value. People are called upon to be true to themselves and to seek their own self-fulfilment. What this consists of, each must, in the last instance, determine for him- or herself. No one else can or should try to dictate its content.12

There is the idea that authenticity fights against rules imposed from outside, against social conformity and conventionality.13 However, it seems, that independence, which is linked to authenticity, cannot be total, since no-one is “perfectly” independent. Moreover, perfect independence cannot be said to be even an ideal here. Namely, all people live and grow up in some culture and social environment, and are influenced by them. According to Taylor, people around us mould our identity and influence the language we use to describe ourselves. People develop their desires and goals in a context where the demands of history, traditions, society, nature or God influence their way of thinking.14 This means that when we speak about independence as one of the features of authenticity, we are not talking about some kind of isolation where nobody else’s beliefs or opinions influence the individual. We have to keep in mind Gerald Dworkin’s statement that we need to find a definition of authenticity which is empirically possible, so that somebody living in the real world can actually be defined as authentic according to the definition.15 In fact, it is also impossible to imagine a person growing up without the influence of his or her culture and social environment, and yet we could still describe such a person as authentic. It may be, on the contrary, that growing up to be an authentic person requires relationships with others.

Thus, authenticity does not mean freedom from social and cultural influences. Moreover, it does not mean that the individual would not take other people into account and would live without emotional ties and authorities. According to Gerald Dworkin, the autonomous individual can follow what his guru, priest or mother says without losing his or her autonomy. Dworkin points out that without this approach promising, worship, obedience to command, conformity to law, commitment and loyalty are defined as factors which reduce the individual’s autonomy, and Dworkin

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12 Taylor 1991, 14. When Feinberg (1986, 33) describes authentic self-fulfilment he seems to emphasize a form of harmony that is visible to outsiders. According to Feinberg, “the authentic person will buy his clothes in part to match his purse, his physical characteristics, and his functions; he will select his life style to match his temperament, and his political attitudes to fit his ideals and interests”.


14 Taylor 1995, 61-64, 86.

15 Dworkin (1988, 7, 12) discusses here his theory of autonomy. He claims that “a theory which requires as a condition of autonomy that an individual’s values not be influenced by his parents, peers, or culture would violate this condition”. Dworkin notes that all individuals have a history, and continues: “They develop socially and psychologically in a given environment with a set of biological endowments. They mature slowly and are, therefore, heavily influenced by parents, peers, and culture. How, then, can we talk of self-determination?”
wants to avoid this view. Moreover Dworkin notes that caring for others reduces the individual’s possibilities of doing whatever he or she wants whenever he or she wants to do whatever it is. But if we define an individual like that as being less autonomous, we are saying that selfishness increases the autonomy of the individual, a view that Dworkin also wants to avoid. Therefore, Dworkin argues:

The conception of autonomy which insists upon substantive independence violates one of the initial constraints in that it makes autonomy inconsistent with other important values.\textsuperscript{17}

It is actually worth asking whether there is something deeply unrealistic in the underlying supposition concerning independence. I will return to this question later in this chapter (4.4.5.), and also in the chapter which concerns freedom of belief and opinion in terms of capability.

It seems that the concept of mental competence (which I presented as a requirement of freedom of belief and opinion in the negative sense\textsuperscript{18}) comes really close to the concept of authenticity.\textsuperscript{19} However, these concepts seem to differ, as well. Namely, it seems that while the concept of mental competence refers to the abilities that an individual has, the concept of authenticity asks whether the individual is really true to him- or herself. In other words, in discussing mental competence, the interest is in the question what the person is able to do. When discussing authenticity, the interest is in the question who the person is. An other way of drawing a conceptual border between mental competence and authenticity is to claim that mental competence refers to internal rules. Joel Feinberg describes a situation where the person’s ideas and desires are authentic but he or she still has a lack of autonomy. It seems that this description could be seen as a description of a lack of mental competence:

A person who had no hierarchical structure of wants, aims, and ideals, and no clear conception of where it is within his internal landscape that he really resides, would be a battlefield for all of his constituent elements, tugged this way and that, and fragmented hopelessly. Such a person would fail autonomy not because he is a mere conformist

\textsuperscript{16} Dworkin 1988, 21-23.

\textsuperscript{17} Dworkin 1988, 21-23.

\textsuperscript{18} See chapters 3.1.3., 3.3.4. and the chapter 3.4. with its subchapters.

\textsuperscript{19} When it comes to discussing the dimension of authenticity, Pietarinen (1998, 16, 22-23) mentions it as a requirement of autonomy together with competence. In some discussions mental competence and authenticity are combined and no distinction is made between them. For example, Feinberg (1973, 48-50) discusses choices made by a competent person as choices which are really the person’s “own choices” and “voluntary choices”. It seems that the concepts of authenticity and mental competence are sometimes combined as Launis (1998, 51-52) does in his definition of the autonomy of will where the term “ability” seems to refer to the concept of mental competence while the term “own” seems to refer to the concept of authenticity. According to Launis, autonomy of will is understood, among other things, as the ability to build up one’s own wants and likes.
whose values are all borrowed secondhand, for his wants, ideals, and scruples could be perfectly authentic and original in him, but because these values lack internal order and structure.20

It seems that, for example, children could be considered mentally incompetent in this sense even though they would be seen as authentic. They have a lack of certain abilities even though they would be “themselves” and are “what they really are”.

When the concept of authenticity is defined in the context of human rights it is also important to draw the border between the view which emphasizes that the person thinks his or her “own beliefs and thoughts” and is “really him- or herself” and the view which emphasizes that the person thinks “right beliefs and thoughts” and is a “rational human-being”. I call the latter view “freedom in terms of rationality”. Berlin seems to describe a view of freedom in terms of rationality21 when he refers to the idea that the individual’s reason distinguishes him or her as a human being from the rest of the world.22 Berlin refers to the idea which connects freedom with understanding the difference between necessary and contingent things by using critical reason.23 Further to the philosophy of Spinoza and Hegel, Berlin describes freedom as knowing and accepting things which are necessarily as they are. Wanting necessary laws to be other than the way they are is, instead, a form of irrationality or ignorance, which are considered to signify a lack of freedom.24 When freedom is understood in terms of rationality, it is thought

20 Feinberg 1973, 14.
21 Berlin seems to collect different kinds of views under the one concept “positive freedom”. Freedom in terms of rationality is one of them.
24 However, according to Pelczynski, Hegel considers freedom in its negative sense as primary and freedom in its positive and rational sense secondary. In Hegel, the conception of negative freedom is, instead, an essential part of the conception of positive freedom. Since Hegel’s dialectical conception of freedom is complex, many interpretations exists. For example, the difference that Hegel makes between civil and political liberty is ambiguous. Pelczynski 1984, 150, 172-178. It seems, actually, that the way of understanding freedom in terms of rationality follows the ancient Stoical conception of natural law. According to the Stoical point of view, natural law was static, eternal, and even divine, and it could be realized by reason. Moreover, even though the Aristotelian view of natural rights is different from the Stoical view of natural law, the rationalistic conception of freedom seems to refer to the Aristotelian conception of human beings and their freedom. According to Aristotelian philosophy, a human being has certain goals based on his or her nature and the individual is considered free if he or she is rational and obeys reason, which is not individual, but universal. The Aristotelian view of natural rights focused on the natural purposes of human beings and the harmonic relationships between them. Douzinas 2007, 28-29, 31-32, 49-52; Rentto 2001, 39-43, 50. The conception of freedom in terms of rationality can be seen in the philosophy of Spinoza presented in Ethics. According to Spinoza, the individual following the commands of reason and being the master of his or her passion is free. For Spinoza, freedom is having adequate ideas and living in accordance with them. Even though Spinoza considers freedom as self-determination, his viewpoint is hardly the authenticity described in this
that truth makes the individual free. However, truth is not considered to be a
particular individual’s “own truth” in the spirit of postmodernity, but universal
truth. According to this approach, there is only one real and true view of
reality and that is the truth which makes the individual who accepted it free.
The individual, in a manner of speaking, assumes and internalizes the
universal truth as his or her own truth.25 According to Berlin, the threat of
totalitarianism lies hidden within this way of thinking. Those who know the
real truth can use coercion against those, as Berlin says, whose reason is
dormant, who do not understand the true “needs” of their own “real” selves:

Freedom is not freedom to do what is irrational, or stupid, or wrong. To force empirical
selves into the right pattern is no tyranny, but liberation.26

In the case of authenticity, understood in the way described in this study, the
conception of reality and the human being is, however, different. Individuals

25 Berlin 2005, 190. See also Bobbio (1996, 6-7), who describes the change that rejecting pluralism
would make to the meaning of freedom of religion and opinion: “They would no longer be the
right to follow one’s own personal religion or to express one’s own political opinion, but would
become the right not to be deviated by force from the pursuit of the one true religion or the single
political good.”

26 See Berlin 2005, 193-200. It has been suggested that Rousseau’s conception of freedom set the
foundation for later totalitarian and authoritative conceptions of freedom. According to Gardiner
(1984, 95-96), there are arguments against this claim, since Rousseau values the self-governing
community and the importance of the individual’s own judgement and opinion. Guignon (2004,
55-70) presents Rousseau as a thinker who demanded freedom from constraints and believed that
source of being can be achieved by feeling instead of through cognitive reflection. Moreover
Rousseau emphasized the importance of expressing what one has found and the need to be
recognized by others for what one is. According to Rousseau, “my truth” is prior to “objective
truth”. Fichte’s conception of freedom is, instead, a model example of the viewpoint of freedom in
terms of rationality. In Fichte’s early philosophy, the concept of freedom seems to refer even to
anarchism, but his view develops in a totalitarian direction and, finally, ends in nationalism.
Hausheer (1984, 126-142) notes how in Fichte’s later philosophy true freedom is something that
can be reached by the state’s active penetration into the life of each of its citizens. According to
Fichte, freedom is rational self-directing and being ordered according to the laws of Reason,
which means to Fichte that the individual’s mind, will and energy is in harmony with the
collective whole. Fichte pays attention to the fact that citizens might object the state’s penetration
to their lives. However, Fichte explains that such an objection is the result of an imperfection in
their rationality and, thus, these imperfectly rational citizens should be forced to live according to
Reason. Fichte considers this kind of force acceptable because it is the way to realize true
freedom. After the process of “liberation”, the state can restore personal freedom to its citizens.
However, in this phase, the individual is rational and willing to live according to Reason. He or
she cannot choose otherwise any more, since it is not rational to not live according to Reason. In
his later philosophy, Fichte considers the German nation as the nation where true freedom would
be realized. This is how Fichte’s totalitarian idea also turns out to be nationalist doctrine.
with several different kinds of views of reality are considered authentic as long as their views are their own. The focus is not on the view itself, but on how the individual has come to see reality in the way he or she does. When freedom is understood as rationality, the focus is, instead, on the view and on the beliefs and opinions themselves: for example, if the individual has the “right” beliefs and opinions after being brainwashed, he or she is considered free in terms of rationality because he or she holds the right views.27 This distinction seems to be in accordance with the general understanding concerning autonomous will. For example, Gerald Dworkin claims that decisions made by an autonomous person do not need to have specific content.28

It seems that the view of freedom in terms of authenticity and the view of freedom in terms of rationality have common philosophical roots and the views are linked to how the individual’s self has been understood throughout history. According to Guignon, there was an idea about the teleological self which concentrated on the question of what the person should be in the cosmic or divine order. According to this tradition, a person is what he or she is when he or she carries out the certain roles in community.29 In modern times, a distinction between the individual and the community was made and the role of rationality was emphasized. It was thought that the individual should be free from external constraints, social pressure and illusions in order to see things as they are.30 In Romanticism it was thought that real truth is discovered through the individual’s deep and intense feelings. A so-called subjective “my truth” was prioritized over objective truth.31 It

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27 The view of freedom in terms of rationality does not seem to be dangerous in itself as long as it is not understood as a human right. People may think that there is one real truth which makes a person free. This is the case with most religions. However, problems arise if the “only one real truth which makes you free” view is mixed with the view of freedom as human right and it is thus seen as justified to restrict the individual’s freedom as negative liberty or in terms of authenticity. It is clear that in these cases the threat of authoritarian and totalitarian tyranny is real. For example, Kant (see Taylor 1984, 108-109) seems to hold both the view of freedom as negative liberty (political autonomy) and the view of freedom in terms of rationality (moral autonomy). When it comes to politics, Kant seems to discuss freedom in the negative sense. However, Kant’s conception of freedom is wider since he connects freedom with the individual’s morality and rationality. Kant claims that being free is to follow the universal moral law, which is reachable by reason. However, he thinks that the state should not try to force people into this kind of freedom (freedom in terms of rationality) and that the state could not succeed even if it tried because no system can coerce an individual to be free in the sense of morality and rationality.

28 Dworkin 1988, 21. Compare this with the discussion concerning formal and contentual interpretations of competence in chapter 3.4.2.


31 Guignon 2004, 49-77. Rousseau’s conception of freedom seems to exemplify freedom in terms of authenticity since he stresses the significance of a person being his or her own master and describes the freedom of the individual as the following of one’s own reasons and conscience. Rousseau claims that the free individual does not follow alien or hostile forces created by the
seems that while the view of freedom in terms of rationality reflects the ideas of a teleological and modern self, the view of freedom in terms of authenticity reflects in particular the view presented in Romanticism.

There is also a postmodern view of authenticity which seems to differ from the views of authenticity presented above. Guignon notes that in postmodern thinking de-centering the subject has been one of the central ideas. Human beings have been seen as polycentric, fluid, contextual subjectivities and selves with limited powers of autonomous choice and multiple centre with diverse perspectives. The postmodern self is in dialogue with different kinds of internalized and external voices. Thus it has been asked, who is the one behind different kinds of roles and who is the one who is in a dialogue, why there should be one central role which defines the other roles and is there good reason to suspect that there is a so-called single I. According to the constructionist idea the human being’s view of him- or herself is constructed by the understanding of reality which is built into social practices and language. When the idea of authenticity is brought up in postmodern discussion the ideal is to admit with playfulness and ironic amusement that there is actually a lack of self. Guignon describes it thus: “We are really true to ourselves, in other words, when we unflinchingly face the fact that there is nothing to be true to.”

However, the postmodern idea of self has been criticized, for example, by Jane Flax. She emphasizes that the role of a centralized, cohesive self is important, for example, when dealing with people with borderline syndrome whose self is fragmented:

Those who celebrate or call for a ‘decentered’ self seem self-deceptively naïve and unaware of the basic cohesion within themselves that makes the fragmentation of experiences something other than a terrifying slide into psychosis.

According to Flax, a sense of continuity is so deeply part of one’s core self that it can easily be taken for granted and it is impossible even to image what it is like to lose that core, what kind of damage follows from its loss and what it is to need it.

pressure of the others, culture, or even his or her own desires which do not represent his or her true, or constant, will. Rousseau points out that the individual, though “externally autonomous”, might still be unfree in the sense of being dominated by internal forces. However, since Rousseau’s texts are quite ambiguous, his conception of freedom has been interpreted in many different ways. Gardiner 1984, 84, 87-92.


34 Flax 1990, 219. According to Guignon (124-125), the postmodern de-centered self is a luxury only a few can afford: “Indeed, the de-centered self begins to look more like a symptom of underlying pathologies than an insight into the truth about human existence.”
4.1.2. Interference with authenticity

Since the concept of authenticity refers to the internal or psychological dimension of a person, the restrictions of authenticity are also internal and psychological even though the source of these restrictions seems to be external to the person. It is worth noting that if the individual experiences some change in his or her life and views positively, he or she does not consider it as an interference with his or her authenticity, not at least in the negative meaning. For example, if a person converts to another religion, his or her experience may be that God’s call was so powerful that he or she could not resist it, even though he or she tried to do so for some time. In this case, the person might consider his or her own resistance in a negative light: it is myself who should be blamed. Interferences with authenticity are, vice versa, experienced negatively and the change in oneself is considered undesirable, at least afterwards: for some external reason, the person has turned out to be unauthentic, namely alien to him- or herself, and this unauthenticity is a psychological or internal state. Isaiah Berlin seems to describe the signs of unauthenticity by giving the example of an individual reflecting on some situation afterwards and thinking “I was not myself or not in control of myself, when I did it”.\(^{35}\) It seems that what has actually happened can be experienced differently by different people, and people can also change their mind. Something which the person used to experience as a positive change may turn out to be an experience lacking in authenticity because of some form of interference.

In the discussion concerning authenticity many factors like the influence of culture and the person’s wish to be like the others are described as interferences with authenticity. Authenticity is thus defined as an ideal and conformity as a threat to it.\(^{36}\) People are influenced, for example, by persuasive messages “from advertisers, from the government, from assorted authorities to take particular actions, like buy a product, vote for a candidate, give blood, avoid impending disasters, and more”, as Philip Zimbardo and Cindy Wang put it. They define the motto of persuasive communication by the expression “Do as I say”. When it comes to conformity, Zimbardo and Wang define it, as follows:

Other times the influence comes not dressed up in words in persuasive messages or visually appealing ads, but simply when the members of a group you are in, or want to belong to, act in a particular way. They don’t have to tell you what to do; they simply exhibit the behavior or the style of action that is expected of “good team members.” That

\(^{35}\) See Berlin 2005, 185.
\(^{36}\) See Guignon 2004, 76.
form of social influence is known as conformity. “Do as we do,” is the conformity motto.37

According to Charles Taylor, authenticity often requires resistance to the rules of society and to the dominant moral views.38 However, if authenticity is discussed in the context of human rights, interference should be defined more precisely. Persuasion and pressure to conform are such normal everyday phenomena that there would be no sense in defining them as violations of human rights.39 On the contrary, freedom of belief and opinion includes a right to influence others.

So-called “manipulation” is a more relevant candidate for interference with freedom in the context of human rights. Sometimes the longer expression “mental” or “psychological manipulation” is used and sometimes “mind control” or even “brainwashing”,40 but I will use the short term “manipulation” here to refer to the phenomenon which other writers have chosen to describe by these other terms. Manipulation is used to describe an act of interference with a person’s authenticity (in philosophical discussions) or human rights (in human rights discussions).41 It is often taken as granted that, firstly, it is possible to interfere with a person’s authenticity by psychological means, and, second, that this phenomenon is somehow different and can be separated from the influence that other people and interest groups may exert in everyday life (such as persuasion and the pressure to conform).42

38 Taylor 1995, 95. It is worth asking why it is supposed that people who accept the dominant moral views are not authentic. Why could some views not be common simply because many people happen to have the same kinds of authentic views? Why is it unauthentic to like the same things that many other people like and think in the same way as them? For example, many people would like to have children. However, this is not necessarily because they are unauthentic and follow a common desire. And why is it a sign of your authenticity if you have different tastes and different opinions to other people? Emphasizing the idea that not accepting dominant views is a mark of authenticity might actually be a threat to authenticity if people try to be different to others in order to be authentic. If this is the case, other people are deciding what a person has to be like, namely, the person has to be “different” to others even though he or she would really like to be just an ordinary person with the same, given dominant views as everyone else.

39 Compare with Nussbaum (2006, 411), who states, referring to psychology, that the environment and social relationships influence many aspects of people’s emotional life.
40 The term brainwashing comes from a technique of manipulation used in China (Mao Tse-Tung’s propaganda). See Ellul 1965, 301, 311-313. For more about brainwashing techniques, see, for example, Streatfeild 2007.
42 A question arises in what respects the ideas concerning manipulation are based on the views presented in anti-cult movement. For example, when Beltram (2005, 285, 303) describes the phenomenon of manipulation, she refers to Care and Investigation on Social Addiction (AIS) which is “a Barcelona-based private institution, created in 1977, being independent, not-profit-making and declared of public use, which aims at advising people affected by groups of psychological manipulation or coercive sects”. For example, Ketola (2002, 20-22) notes that there
Unfortunately, when people refer to manipulation as form of interference with someone’s authenticity, they do not always explain what they mean by that term. However, when I collect the various views concerning manipulation together and reflect upon them in relation to the view that freedom in terms of authenticity is a human right, it seems that conceptually the central features of manipulation are, first, that the manipulator has the intention to manipulate and, second, that the person who is being manipulated changes his or her beliefs, thoughts and acts involuntarily, against his or her real will. Typical, but not necessary, features of manipulation are, firstly, that it is linked to becoming a member of some group and being dependent on other people or another person and, second, that the manipulation makes the person act against his or her own good and that the manipulator is an abuser.

For example, the draft law against sects presented in France in 2000 defines mental manipulation as any activity or activities “with the goal or the effect to create or to exploit a state of psychological or physical dependence of people who are participating in the group’s activities, to exercise on one of these people repeated and serious pressure and to use patent techniques to change the person’s judgement in order to lead this person, against his or her will or not,⁴³ to an act or an abstention which is heavily prejudicial to him or her.”⁴⁴ According to Michael Langone, mind control “refers to a process in which a group or individual systematically uses unethically manipulative methods to persuade others to conform to the wishes of the manipulator(s), often to the detriment of the person being manipulated”.⁴⁵ According to Philip Zimbardo, directed behaviour change and so-called mind control are not consequences of some specific kind of influence such as psychotropic drugs or “brainwashing”. Instead it is “systematic manipulation of the most mundane aspects of human nature over

⁴³ This definition seems to suggest that manipulation is not necessarily against the other person’s will. However, I will not use the concept of manipulation in this sense.
⁴⁴ Fautre 2000. There was no proper translation available from French, which is the reason I utilized the translation given in the webpage of the Center for Studies in New Religions (http://www.cesmur.org/testi/fr2K_index.htm). See the French version, Assemblée Nationale 2000. The final version of draft law does not seem to include the concept of mental manipulation, see Assemblée Nationale 2001. See also Ketola 2002, 18.
⁴⁵ Langone: Cults: Questions and Answers. The definition is from the webpage of the anti-cult movement, but since Beltran (2005, 288) utilizes Langone’s ideas in an academic context and refers to this webpage, I openly do the same by noting that Beltran could have been more critical when it comes to the definitions to which she refers. The anti-cult movement has influenced public discussion and even legislation. However, I am aware that there is necessarily no scientific evidence for all of the criticism presented by the anti-cult movement. See, for example, Ketola 2002.
time in confining settings”. In this process the person’s wish to be accepted by others is a fundamental element. People do things in order to be admired or accepted by others and other people may imperceptibly pervert them in such a way that they become “scoundrels”. While compliance means that a person is influenced in such a way that he or she acts according to some request (even though he or she would not change his or her beliefs and opinion), there is also a kind of influence where the goal is that the person changes fundamentally and becomes a believer in some belief system or ideology:

They want individual members to internalize a set of beliefs and values, even to change their personalities, so that they totally identify with the group’s mission. One common form of this intense personal change is seen in cult recruiting and indoctrination.

It has also been claimed that the manipulator hides some significant information from the person he or she wants to manipulate. For example, Langone suggests that psychological or mental manipulation techniques involve an extensive control of information in order to limit the alternatives available and thus the choices members may make. According to Dennis Wrong, the person who is the object of manipulation does not know that he or she is the object of such an influence. In addition, the manipulator makes the person act in the way he or she wants him or her to act by hiding some

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46 Zimbardo 2007, 258. According to Cialdini, it was crucial, for example, in the mass suicide of Jonestown that people “lived in total alienation from the rest of the world in a jungle situation in a hostile country”. Cialdini notes that the charisma of the leader, the need for safety felt by the members and an unquestioned faith in the cult’s leader were perhaps significant factors but not as crucial as living in total alienation. Cialdini 2009, 128-129, 131.

47 Zimbardo 2007, 258-259. According to Cialdini, people who assisted suicide in Jonestown were probably convinced especially by social proof that suicide was the proper thing to do. The people who took the poison first were a crucial example for the others. The change in the individuals in Jonestown was a change from being a following to becoming a herd. Cialdini 2009, 129-131. Zimbardo seems to thinks that each human being has this potential to become perverted so in this sense he does not necessarily mean that people who become perverted become unauthentic. However, as perverted scoundrels they may do evil things. However, each person has the potential to become a hero, as well. See Zimbardo 2007, 488.

48 Zimbardo & Wang: Resisting Influence. Introduction. Communication theory also discusses propaganda. According to Jowett & O’Donell (1992, 4), “propaganda is the deliberate and systematic attempt to shape perceptions, manipulate cognitions, and direct behavior to achieve a response that furthers the desired intent of the propagandist”.

49 Langone lists the following techniques: deception; group pressure; intense indoctrination into a belief system that denigrates independent critical thinking and considers the world outside the group to be threatening, evil, or gravely in error; an insistence that members’ distress – much of which may consist of anxiety and guilt subtly induced by the group – can be relieved only by conforming to the group; physical and/or psychological debilitation through inadequate diet or fatigue; the induction of dissociative (trance-like) states via the misuse of medication, chanting, speaking in tongues, and other exercises in which attention is narrowed, suggestibility heightened, and independent critical thinking weakened; alternation of harshness/threats and leniency/love in order to effect compliance with the leadership’s wishes; isolation from social supports and; pressured public confessions. Langone: Cults: Questions and Answers.
decisive information. This is possible even without there being a social relationship between the manipulator and the person who is the object of manipulation. According to Wrong:

the power holder may exercise concealed control over the power subject through symbolic communications designed to make veiled suggestions, to limit or determine selectively the power subject’s information supply, or to inculcate without appearing to do so certain positive or negative attitudes.

Manipulation as an interference with authenticity concerns the authenticity of the person being manipulated in relation to other people. However, there is also the question of whether some non-human powers or the person’s psychological problems may interfere with authenticity. When we discuss authenticity as a human right, it does not seem sensible to say that common feelings of ambivalence are a restriction of freedom in the context of human rights. It is just normal to feel sometimes during some periods of one’s life that “I don’t know who I really am” and wonder after doing something shameful or stupid “what was I thinking?” If some psychological problems are defined as a form of interference with authenticity, psychotic disorder would certainly be one possible candidate. This is what has been suggested in some discussions concerning psychotic people’s freedom: it has been claimed that psychosis is a power which so distorts a person that he or she becomes unauthentic. Since the individual’s liberty rights are usually protected against other people and the state, it is questionable whether psychosis can be defined as a threat to authenticity as a right. However, since this view is important and central to my research topic, I will consider psychotic disorder as a potential violator of authenticity as a right.

It seems to be always illegal and unjustified to interfere with the core of a person’s authenticity as it would prevent one from “being who one really is”. There should be no reason to intervene in a person’s authenticity as an “inner” dimension since authenticity in this meaning cannot be in conflict with other people’s rights. Other people may have a duty to protect the individual’s authenticity but there cannot be any justified reason for making

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50 Wrong 1979, 28-29.
51 Wrong 1979, 29.
52 For example, Betzler (2009, 52) seems to describe a “normal” form of unauthenticity, which cannot be defined as a restriction of one’s human rights: “Typically, we question who we are when authenticity is lacking. This is the case when we are unable to conceptualize ourselves (i.e., determine facts about ourselves, such as our likings, dispositions, values, ideals, temperament, sexual orientation, social status, gender, etc.) against socially established norms. This also happens when we experience ourselves as fragmented in our beliefs and values, or find ourselves dissatisfied with our choices. It is then that we wonder who we really are, and thus seem to search for an accurate self-conception that would help us to lead our lives in a more rewarding way.”
53 For psychosis as a power which distorts person’s authenticity, see chapter 4.3.1.
somebody unauthentic by manipulation. However, this does not mean that everyone has an unlimited right to self-fulfilment since acting harmoniously with one’s authentic being may sometimes be in conflict with other people’s rights.

4.1.3. Freedom of belief and opinion in terms of authenticity

When freedom of belief and opinion is understood in terms of authenticity, the *forum internum* seems to signify the right to hold one’s own beliefs and opinions which are themselves the results of an authentic believing and thinking process. Thus, freedom of belief and opinion signifies the right to be the author of one’s beliefs and opinions. The *forum externum* seems to signify the right to self-fulfilment, namely, the right to a life where one’s manifestations and expressions are in harmonious relationship with one’s authentic beliefs and opinions. When freedom of belief and opinion is understood in terms of authenticity the primary potential threats to the individual seem to be, first, communities which might manipulate their members or potential members and, second, mental disorders which seriously distort a person’s thinking and believing. Since I will discuss the latter threat in more detail in chapters 4.3. and 4.4., I will concentrate here on discussing freedom of belief and opinion in terms of authenticity in relation to other people.

Susana Beltram notes how heavy psychological manipulation violates the freedom of belief and opinion. According to Beltram, the person who is the object of manipulation may experience a denial of his or her exercise of freedom of thought, conscience and religion, freedom of association and freedom of expression and opinion. According to Beltram,

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54 See Feinberg 1986, 67-68. Feinberg (1986, 67) states that even if manipulative techniques are used in order to open up a person’s options and increase his or her freedom in so doing, it is not justified because it might be done against the person’s will and without his or her consent: “Being involuntarily suffered, such treatment is necessarily a violation of a person’s right to be his own master and to make the choices himself that vitally affects his future.” Feinberg (1973, 96) discusses possible absolute rights and describes in this context “the rights not to be subjected to exploitation or degradation even when such subjection is utterly painless and therefore not cruel”. Feinberg (1973, 97) continues: “It is possible to treat human beings with drugs, hypnosis, or other brainwashing techniques so that they become compliant tools in the hands of their manipulators, useful as means to their manipulators’ ends, but with all serious purposes of their own totally obliterated...That is a right to a higher kind of respect, an inviolate dignity, which as a broad category includes the negative rights not to be brainwashed, not to made into a docile instrument for the purposes of others, and not to be converted into a domesticated animal. Rights in this category are probably the only ones that are human rights in the strongest sense: unalterable, “absolute” (exceptionless and nonconflicttable), and universally and peculiarly human.”

55 For the relationship between authenticity and self-fulfilment, see chapter 4.1.1.

56 In addition, severe manipulation may cause physical or psychological damage, and may
the realisation of freedom of belief and opinion requires that people are prevented from being manipulated and from any form of dependence generated by manipulative groups. Beltram notes that if an individual is prevented from leaving a group and from freely changing his or her religion by psychological manipulation, this would constitute coercion which violates the freedom of religion. However, it is crucial that Beltram discusses a form of coercion which is fundamentally psychological. Beltram is not discussing cases of physical or legal constraint (if people were prevented physically or by legal constraints it would be a restriction of freedom of belief and opinion in the negative sense). It seems that preventing manipulation is a justified reason for restricting the manipulators’ freedom of belief and opinion in the negative sense, since the rights of others restrict the forum externum. From the viewpoint of negative liberty it can also be asked whether parents have a right to take their children to meetings of manipulative groups if by so doing their children’s mental health would be damaged.

It is important to note that not all kinds of manipulation are considered problematic from the viewpoint of human rights. It seems to depend on the quality of the relationship between manipulator and the person who is the object for manipulation and the consequences of manipulation as to whether it is considered questionable. For example, parents, in order to make their children behave properly, may tell them that if they do not behave properly, Santa Claus will not bring them any presents. This is, conceptually, manipulation since the parents know something significant, which their children do not know, namely, that there is no Santa Claus and utilize the

contravene the prohibition against subjecting a person to torture, sentences or cruel, inhuman or degrading treatment. Beltram 2005, 289.


However, Beltram argues by referring to cases where there has been (a) physical violence or constraints or threat of it, or (b) restrictions are imposed by the state (prison, mental hospital). See Campbell and Cosans v. The United Kingdom 1982; Labita v. Italy 2000; Keenan v. United Kingdom 2001; Kudla v. Poland 2000. It is questionable whether the principles presented in the context of these cases can be directly applied to cases concerning psychological manipulation.

When freedom of belief and opinion is understood in terms of authenticity, the manipulator’s freedom of belief and opinion is in conflict with the manipulated person’s freedom of belief and opinion. However, if a manipulator only wants to abuse others the beliefs and opinions which he or she expresses are not actually his or her authentic opinions, since he or she is lying. In this case the manipulator’s freedom of belief and opinion in terms of authenticity is not, actually, restricted, even though he or she was not allowed to express lies. See considerations about the distinction between manipulation and persuasion, and authenticity as a requirement of negative liberty later in this chapter. From the viewpoint of negative liberty, it is only meaningful to speak about whether somebody’s freedom of belief and opinion should be restricted in order to prevent psychological assault (in this case there is a conflict between the right to health and freedom of belief and opinion). See chapter 3.1.3. From the viewpoint of capability, it can be asked whether protecting some people’s possibility to choose between alternatives should be regarded as a proper reason for restricting other people’s freedom of belief and opinion. See chapter 5.1.3.

See Beltram 2005, 295.
belief of their children in Santa Claus in order to make them act in a certain way. This is not seen as a violation of the children’s freedom of belief and opinion. However, it would be a problem if it was used in other kinds of relationships, for example, if a doctor gave some false information to his or her patient in order to make him or her behave in certain way or make certain choices. It would also be problematic, if, in the previous example something very harmful happened to the children. As long as the manipulation is harmless, it seems to be justified, at least in the case of Santa Claus, which is a culturally accepted and shared way of manipulating children.\footnote{My thanks to Kimmo Ketola, who mentioned the belief in Santa Claus and parents usage of this belief as an example of manipulation.}

It is also worth noting that when freedom of belief and opinion is being discussed, manipulation should be clearly distinguished conceptually from persuasion and conforming, which are normal influencing methods. For example, if a religious leader claims that people who believe a certain thing and behave in a certain way may end up in hell, it is not a case of manipulation since the leader him- or herself really believes that there is such a risk. It is persuasion since the religious leader does not hide any information but invokes the beliefs which the other people (at least if they get distressed) share. However, outsiders might easily consider this manipulation if they think that the threat of ending up in hell is not real.\footnote{Thanks to Kimmo Ketola, who explained the difference between manipulation and persuasion in this context. Warning people about hell and keeping one’s distance from people behaving and believing in a certain way can also be seen as a form of social punishment. Feinberg (1973, 32) refers to Mill’s idea that the state cannot prevent people from expressing their disapproval of an individual without restricting their freedom in an unjust way.}

The view of freedom of belief and opinion in terms of authenticity is linked with the view of freedom of belief and opinion in the negative sense. It can be said that the purpose of freedom of belief and opinion as negative liberty is to protect authentic beliefs, opinions and manifestations. In this way, freedom of belief and opinion in terms of authenticity determines when it is meaningful to apply the right to freedom of belief and opinion in the negative sense. For example, the right to negative liberty should not be applied when a person is being manipulated.\footnote{See Pietarinen (1998, 25-26), who considers authenticity as a requirement of the right to self-determination. However, when it comes to the forum externum, it might be justified, at least in some cases, to require that the person is sufficiently competent even if he or she is authentic. For example, if a three-year-old child wants to join the communist party, it would not be necessarily unjustified for the state to deny children membership of political parties, even though in a particular case the child was considered a “real communist”.} Emma Baldock suggests that competence should be seen as a requirement of the right to negative liberty to make low to medium cost decisions while authenticity should be seen as a requirement of the right to negative liberty to make high cost decisions.\footnote{Baldock (2009, 19-20) analyses the cost of a decision in terms of the severity, permanence and}
and opinion in terms of authenticity and freedom of belief and opinion in the negative sense are linked also in an other respect. Even though it has been suggested that authenticity (more specifically, the dimension of the *forum internum* of authenticity) can also be realized, for example, in prison, it has also been claimed that becoming authentic requires negative liberty. Authenticity is realized in a community where people are able to express their views and where an open and respectful exchange of views is possible.\(^{65}\)

There seems to be a link between authenticity and capability, as well. For example, it may be suggested that growing up to be an authentic person requires, for example, that a person’s talents are recognized and that equal opportunities for choice are provided.\(^{66}\) When manipulation is discussed as being a violation of freedom of belief and opinion, there is a grey area between the view of freedom in terms of authenticity and the view of freedom in terms of capability. When freedom of belief and opinion is understood in terms of authenticity, the main concern is that manipulation distorts a person’s authentic beliefs and opinions. When the emphasis is on the fact that a person living in a close knit oppressive group has a limited range of choices, we turn to freedom of belief and opinion in terms of capability.\(^{67}\)

However, it is worth noting that freedom of belief and opinion in terms of authenticity does not mean freedom of belief and opinion in terms of rationality, the view which Lubomira Radoilska seems to describe as a “value-laden approach to autonomy”. According to this point of view, freedom cannot be realized if the laws of logic are undermined, patent falsehoods are believed and evidence is ignored, as may be the case, for example, in wishful thinking. From this viewpoint, freedom of belief and opinion presupposes rules and constraints which help us to get things right.\(^{68}\) Radoilska defines this view thus:

In fact, following these rules and respecting these constraints are key expressions of our freedom of thought. Conversely, forming a belief without sufficient reason and refusing to revise an earlier opinion in the face of contrary evidence are paradigm cases of having one’s freedom of thought compromised. The core idea is that what holds a person back as a thinker boils down to an inadequate relationship between beliefs and supporting reason, from this perspective a belief is unfree to the extent that it is unwarranted.\(^{69}\)

However, authenticity does not mean getting things right. It means being the author of one’s beliefs and opinions, even though they might be false.\(^{70}\)

\(^{65}\) Guignon 2004, 160-164.

\(^{66}\) See Guignon 2004, 161-162.

\(^{67}\) For more about freedom of belief and opinion in terms of capability, see chapter 5.1.3.

\(^{68}\) See Radoilska 2012, 256.

\(^{69}\) Radoilska 2012, 256-257.

\(^{70}\) For more discussion, see chapter 4.4.5. See also the discussion about delusions’ status as beliefs in philosophy and human rights theory in chapters 2.2.1 and 2.2.2. where I note that academic
It seems that a view of freedom of belief and opinion in terms of authenticity is familiar in philosophical and psychiatric discourse. However, this view does not seem to be explicitly clear in human rights theory. For example, when Heikki Karapuu describes different ways of understanding freedom he does not seem to present the view of freedom in terms of authenticity.\footnote{See Karapuu 2011, 80-83.} He defines “juridical freedom” as an absence of juridical duty, “negative freedom”, and “factual freedom”, which signifies the individual’s factual possibility of acting according to his or her will. Negative freedom includes juridical freedom, and I discussed freedom in this sense in chapter 3. Factual freedom seems to refer to freedom in terms of capability and I will discuss freedom in this sense in chapter 5. However, Karapuu does not seem to present a view of freedom in terms of authenticity.\footnote{When it comes to factual freedom and a lack of it, Karapuu gives an example of a person who is not prevented juridically or by other people from publishing his or her opinions but because of a lack of money he or she is not able to do so, which refers to a lack of capability. By referring to Berlin, Karapuu also notes that sometimes the concept of “positive liberty” is used when factual freedom is discussed. However, Karapuu does not recommend using this concept: “It is perhaps wise to avoid using the concept of “positive liberty” because this concept is also used in other, more or less mystical meanings, such as when it refers to the idea that an individual acts in accordance with the harmonic cosmic order, God’s will or his or her “real utilities” instead of acting according to his or her desires.” Karapuu 2011, 82. It is questionable if the view which Karapuu describes as a more or less mystical signifies freedom in terms of authenticity but it seems meaningful to conclude that Karapuu is, at least, qualified when it comes to the view of freedom in terms of authenticity.}

However, the view of freedom of belief and opinion in terms of authenticity might be included in human rights theory implicitly. For example, noting that manipulation is violation of the \textit{forum internum} implies that it is possible to interfere with a person’s freedom psychologically. Furthermore, allowing the use of involuntary antipsychotic medication in mental health law may imply that unauthenticity is not seen as worth protecting. In addition, when the idea that the \textit{forum internum} is an absolute human right is adopted it is supposed that the person may hold some beliefs and opinions which are not his or her own. This is the case after the \textit{forum internum} has been violated. If all changes of beliefs and opinions were authentic, there would be no need to protect the \textit{forum internum} and there would be no way to violate this absolute right.\footnote{This means that human rights theory also seems implicitly to include the idea that there is a need to consider the process of thinking and believing, not only the content of beliefs and opinions.} However, the idea of authenticity is not explicit and perhaps not even a necessary background supposition in human rights theory since restrictions of negative liberty can also be explained by referring to the idea of competence as a requirement of freedom in the negative sense and by seeing negative discussion about rational and epistemologically justified beliefs and the human rights discussion about what kinds of beliefs people have a right to hold and act in accordance with should be distinguished.
liberty as one part but not the only part of factual freedom (or freedom in terms of capability).

I am suspicious when it comes to whether freedom of belief and opinion should also be understood in terms of authenticity. I think that the discussion of authenticity is a philosophical discussion, and it may be that freedom cannot be discussed in this sense, namely, philosophically, in juridical contexts. Even though I don’t adopt the postmodern view, which questions the existence of self, I doubt whether we are able to define or even recognize the authentic self in order for us to be able to capture it. To me it seems as if reaching the real self “like it really is” is the same kind of project as trying to achieve reality as it is. The problem is that the view of freedom of belief and opinion in terms of authenticity seems to consider what reality really is, not how it seems to be to us.

However, since freedom is discussed in terms of authenticity in the philosophy of psychiatry and also in some issues concerning human rights theory, I will now proceed to consider, in more depth, whether this view helps us to refer to freedom of belief and opinion in cases involving a person with psychosis.

4.2. The psychotic individual’s authenticity and his or her relationships with others

When freedom of belief and opinion is understood in terms of authenticity, there are two focuses when it comes to evaluating the realization of this right. First, it can be asked whether the person is authentic in relation to other people. Second, the person’s authenticity can be evaluated in relation to his or her psychological state. In this subchapter, I consider the psychotic individual’s authenticity and unauthenticity in his or her relationships with other people. At first, I present the kinds of duties the psychotic individual’s right to authenticity creates for other people, especially for nursing staff. Second, I consider the methods used to influence a patient in the attempt to secure the patient’s compliance. In the third chapter, I clarify the relationship between manipulation and shared delusions.

When the psychotic individual’s authenticity is considered in relation to other people, we seem to lean on the so-called externalist position on authenticity. According to the externalist position on authenticity, an authentic identity develops in a social and cultural environment and, therefore, relational and contextual circumstances should be evaluated when trying to test a person’s authenticity. Monica Betzler describes the externalist accounts on authenticity, as follows:
their focus lies on the social context enabling the agent to acquire authentic values, to own up to his social, ethnic, religious, cultural, and biographical identity and gender without foregoing public recognition. Agents thus have to be true to their values and identities as they are viewed and appreciated from the outside. If circumstances are such that one’s identity is thwarted, agents are forced to lead inauthentic lives. They lack the choice to be themselves, and their capacity for self-governance is diminished.\footnote{Betzler 2009, 59-60. The externalist position on authenticity cannot be fully distinguished from the internalist position, because it seems that the person cannot have authentic relationships with others without being sufficiently authentic internally.}

\subsection*{4.2.1. The duty to enhance authenticity and prohibition of manipulation}

When freedom of belief and opinion is understood in terms of authenticity, the duties which the right to authenticity creates for other people are both positive and negative. When we discuss the rights of the individual with psychosis, positive duties obligate other people to help that person find who he or she really is and what he or she really believes and thinks.\footnote{See Välimäki’s study (1998, 63) where one psychiatric patient describes self-determination, as follows: “I can be who I am, just as other normal people”. Even though it is unclear what the patient means by being who one is, it still seems that it refers to the idea of authenticity.} It seems that this kind of duty is, in general, moral and not legal since other people cannot be legally sanctioned if they don’t help a psychotic person find him- or herself. However, it might be seen as the legal duty of nursing staff and indeed the purpose of psychiatry and mental health work to help a person with psychosis in this way. For example, according to the PUN “the treatment of every patient shall be directed towards preserving and enhancing personal autonomy”.\footnote{PUN 1991, Principle 9.4.} The Declaration of Hawaii states that “the aim of psychiatry is to promote health and personal autonomy and growth”.\footnote{The Declaration of Hawaii 1978, 1.} The Madrid Declaration guides the psychiatrist to provide relevant information “so as to empower the patient to come to a rational decision according to personal values and preferences”, which may also be interpreted as a duty to promote the patient’s authenticity.\footnote{See the Madrid Declaration 1996, 3. See also the Madrid Declaration (1996, Guidelines concerning specific situations, Organ Transplantation), which notes: “Psychiatrists should seek to protect their patients and help them exercise self-determination to the fullest extent possible in situations of organ transplantation.”} In the legal context, the Finnish Mental Health Act, for example, mentions that mental health work means, among other things, promoting of personal growth of the individual.\footnote{Mielenterveyslaki 1116/1990, 1$. In one Finnish textbook of psychiatry it is claimed that social independence and a well-developed identity are central in mental health. Lehtonen & Lönnqvist 1998.}
The psychotic individual’s freedom of belief and opinion in terms of authenticity also obligates other people, including nursing staff, in the negative sense since other people have a duty not to manipulate the psychotic individual. Ethical principles prohibit manipulation and warn against using therapeutic or psychological techniques for manipulative purposes. The Madrid Declaration expresses this idea clearly in the context of a possible organ transplantation:

The psychiatrists should not act as a proxy decision maker for patients nor use psychotherapeutic skills to influence the decision of a patient in these matters.80

The idea that informed consent should be given freely also seems to refer to freedom from manipulation.81 It has also been noted in the RCE and its Explanatory Memorandum that since some psychiatric treatments involve intruding upon intimate areas of the patient’s life and require knowledge of intimate aspects of the person’s feelings and beliefs, it is important to take into account the vulnerability of the patient and ensure that a person with a mental disorder is never exploited.82 The Explanatory Memorandum to the RCE points out that since a patient who is in involuntary treatment may feel vulnerable in his or her relationship with the doctor, the presence of a personal advocate or representative of the patient may give the patient some moral support and help him or her to express his or her real views.83

The problem of giving the wrong information to a patient is linked mostly with questions concerning a patient’s competence. If the person has the wrong information, he or she cannot make an informed and, thus, competent

2007, 28. Iso-Koivisto (2004, 111) notes that being treated as a patient has been thought to be a threat to a person’s agency and ability to find his or her own solutions. Thus, it has been considered good practice to leave a person alone after his or her psychotic symptoms have been removed. However, Iso-Koivisto notes that a patient may need help in order to regain his or her self and social identity after a psychotic episode and, thus, mental health workers should actively offer their help after psychosis.
81 The PUN (1991, Principle 11:2) notes: “Informed consent is consent obtained freely, without threats or improper inducements.”
82 The RCE (2004, Preamble) declares that the Committee of Ministers stresses “the need to ensure that persons with mental disorder are never emotionally, physically, financially or sexually exploited”. According to the Explanatory Memorandum to the RCE (2004, 13), “treatments that alter such aspects of a person’s functioning may also be seen as influencing a person’s individuality. Psychiatric treatment and care requires a detailed knowledge of intimate aspects of the person’s feelings and beliefs, so that persons with mental disorder may be, or feel that they are, particularly vulnerable in their contact with mental health services. The Preamble emphasises that such vulnerability must never be exploited, in particular emotionally (or psychologically), physically, sexually or financially.” In addition, the PUN (1991, Principle 1:3) considers exploitation, as follows: “All persons with mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.”
83 The Explanatory Memorandum to the RCE 2004, Article 19:147.
choice. If this is the case, the person only becomes competent after he or she is given the right information, and may change his or her decision if he or she thinks it necessary in light of the new information. The person may say: “Oh, I didn’t know that it is like that. Okay, let’s do something else, in that case”. However, sometimes information might be given in such a manipulative way that the person does not change his or her mind even after he or she is informed properly after being informed manipulatively. The manipulated person might value information in such a way and may give such meanings to it that he or she persists with his or her view even if it is then revealed to be problematic and the product of receiving false information. The person trusts the view presented by the manipulator, anyway and may say: “Yes, I understand the information and the consequences of my decision. However, I want to do this because I believe that this is a good thing to do”. This means that the person may be competent without being authentic. For instance, the person may have the abilities needed to make decision, for example, in a medical context. He or she may understand, consider and take into account the information which the nursing staff has given him or her. However, the way in which the person values the information is not his or her own.

4.2.2. Authentic compliance?

Compliance is discussed in the context of the treatment of psychotic patients. Compliance, namely, accepting the psychiatric treatment suggested and following the advice given by nursing staff, is seen as a good thing in psychiatry. However, a lack of compliance is seen as a problem when it comes to psychiatric treatment. The question arises whether the compliance of the patient has sometimes been secured by manipulative methods. Philip Zimbardo and Cindy Wang define compliance as “a form of influence in which direct pressure is put on individuals to take some specific action”. According to Zimbardo and Wang, the purpose in seeking compliance is not to change the other person’s mind but to get the other person to act according to a certain request. 84 Seeking compliance seems to be one of the aims of persuasive communication. Jorma Laitinen claims that in the context of psychiatry methods based on persuasion are as such manipulative and their goal is to interfere with the patient’s freedom of action and expression and acquire some psychological power over the patient. According to Laitinen, the manipulative power of persuasion multiplies in a situation where the patient’s ability to consider and his or her rationality are weakened, and he or she is not necessarily competent to make decisions. 85

However, in my view, it is important to acknowledge the difference between persuasive and manipulative methods more clearly. If we say that persuasion is also a form of manipulation, we would, it would seem, define too many kinds of influence found between people in normal life as violations of human rights. What distinguishes manipulation from persuasion is the intention to make an other person change his or her beliefs and opinions involuntarily. Moreover, manipulation and persuasion use information differently: in manipulation something important is hidden from the person being manipulated and even misleading information may be used in order to make that person think and belief in the desired way.

It seems that phenomena such as dependency and pressure, which are typical features of manipulation, can also be present when non-manipulative means of seeking compliance and persuasion are used. Thus, when a person with psychosis is persuaded, for example, to take his or her medication, it is not necessarily manipulation even though it is clear that a degree of dependency and a form of pressure applied. Namely, the psychotic person is quite dependent on the psychiatrist, who has power over him or her, since the psychiatrist may, for example, determine that psychotic person be sent for involuntary treatment. The psychiatrist is also the person who prescribes the patient’s medication.

A patient with psychosis may also sometimes be pressured and controlled by being subjected to various kinds of negotiations, questions and tests. Kaltiala-Heino et al noted that some patients may feel that long negotiations concerning their medication are coercive even if they finally “choose” peroral medication. It is mentioned in one Finnish textbook of psychiatry that time should be taken during each meeting with a patient to

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86 When it comes to finding quite positive attitudes about the treatment of involuntarily hospitalized patients, Kaltiala-Heino (1995, 83, 104) mentions the possibility that patients report positive views of treatment as a defence: when patients are subjected to involuntary treatment, it may well be easier for the patient if he or she can make him- or herself believe that he or she will benefit from the treatment. Positive attitudes about treatment might also be reported by some patients after treatment since “to recover from negative and damaging coercion the patients actively forget about the whole misery and maintain and report a positive memory not to become upset any more”, as Kaltiala-Heino expresses it. However, she also notes that a mechanism of this kind probably does not explain the majority of positive attitudes, because patients with mainly positive attitudes also presented some criticism of their treatment.

87 Kaltiala-Heino 2000, 216. Compare with British legislation which requires the use of physical force for a definition of giving medication by force. See Fulford, Thorton & Graham 2006, 550-551. See also the statement of one patient interviewed in Iso-Koivisto’s (2004, 68) study who thought that it was good that discussions with nursing staff did not go too deep and that problems were not analysed. The patient said that it was good that she had a right to choose what to do and that it could be distressing if somebody else decided what was supposed to happen next. The patient may be referring to not being subjected to intrusive or even manipulative discussions or/and she may describe a situation where the nursing staff had understood which issues the patient was ready to deal with and which questions were too difficult to address that particular time.
compliance issues and that it is important for the patient to recognize that the
doctor is especially interested in this issue. For example, whether medication
has been used properly can be tested by urine tests. Moreover, some countries
use medication boxes programmed by a microprocessor which registers the
date and time that the box is opened. Also long-acting injections may be used
if the patient does not want to take his or her medication. There is also a
question about whether a patient may sometimes even be accused of not
taking his or her medication, even though psychiatrists are warned against
adopting an accusing and authoritarian attitude.

A question arises as to whether there might also be some
manipulative features in the methods used by psychiatric nursing staff to exert
influence over patients. First, since there is a tendency to value health of the
patients, the psychiatrist may well hope that the patient will accept the
treatment which has been suggested. The psychotic person’s own opinion and
view may even be seen as something of a problem if it does not lead to his or
her compliance. One Finnish textbook of psychiatry says:

A totally compliant patient takes part in the treatment in an excellent way. Bad
compliance means that treatment guidelines are not being followed; the patient does not
come to treatment meetings, finishes the treatment before it is allowed, stops taking
medication or takes it *when he or she him- or herself wants.*

Second, the psychiatrist is advised to create an atmosphere where the patient
feels that he or she herself has decided to take the medication even though he
or she had originally been suspicious towards the medication.

89 One Finnish textbook of psychiatry informs physicians about the importance of compliance by
describing the consequences if a psychotic patient is insufficiently compliant with psychiatrists.
This textbook of psychiatry argues that if patients do not comply they will get worse, suffer from
relapses and end up in hospital again and again. Moreover, complying reluctantly will make the
treatment unsuccessful, increase the suffering of the patient and of those close to the patient, and
increase the patient’s risk of committing violence. Moreover, it increases the financial expense of
90 “Täysin hoitomyöntyväänen potilas osallistuu hoitoonsa kiitettävästi. Huono hoitomyöntyvyys
tarkoittaa, että hoito-ohjeita ei noudateta; potilas jää pois sovituihpa hoitokäynniltä, lopettaa
hoidon ennen aikoja, jättää lääkityksen kokonaan pois tai säännöstee siitä *omaehoisesti
91 Zimbardo & Wang define a form of self-persuasion which is nevertheless influenced from the
outside: “One of the most powerful forms of influence is self-persuasion, where conditions are set
up that encourage individuals to engage in personal thought and decision processes. Obviously we
tend to know our strengths and weaknesses better than do others, so we can tailor self-generated
persuasive messages likely to be effective. One tactic for inducing self-persuasion comes from
role-playing positions that are contrary to one’s beliefs and values. Also when we are resolving a
commitment we have made to engage in public behavior that does not follow from our personal
beliefs, cognitive dissonance is created. To the extent that we come to believe we made that
commitment freely, without (awareness of) external situational pressures, we start to rationalize it
and come to convince ourselves that it was the right action and the right position to hold.”
The attitude towards medication may be very qualified and suspicious, and the patient may consider medication as a way of controlling his or her thoughts and will. Compliance is weakened by the inability to acknowledge one’s illness and by the patient’s opinion which considers medication unreasonable (even though it would be important) if the illness relapses, anyway. It is good for the physician to try to make the patient feel that he or she him- or herself is an active treatment agent, participant and responsible for it instead of being the passive object of treatment.92

The question arises as to what the psychiatrist is doing when he or she tries to make a patient feel that he or she is the active treatment agent. Namely, it is not emphasized here that it is important that the patient is the active treatment agent. The goal seems to be that the patient merely has the feeling that he or she is an active agent. Perhaps the expressions used by the writers of the textbook were not properly thought through, but in an analytical reading the question arises whether the patient’s compliance is so important that it does not matter if it is secured through manipulation, which means in effect that it becomes a case of unauthentic compliance. The question also arises whether the patient’s compliance is considered more important than his or her well-being. Perhaps it is poorly expressed, but it seems that, in the following passage, the argument for changing a patient’s medication is governed by the wish to secure the patient’s compliance, not, for example, the wish to improve the patient’s well-being:

If the patient cannot tolerate or feels it is impossible to continue the current antipsychotic medication, it is worth considering changing the medication because patients seldom use medication according to their instructions which they find disgusting or which they feel causes them significantly harmful effects.93

The question about compliance as a primary goal also arises when the cognitive-behavioural compliance method is analytically considered. It is stated in one Finnish textbook of psychiatry that by using this method one can try to influence a patient’s attitudes and behaviour concerning his or her medication. In a further detail the textbook mentions that in order to promote a positive attitude towards medication on the part of the patient, the psychiatrist could mention by name famous and successful people who have suffered from


93 “Mikäli potilas ei siedä tai kokee mahdottomaksi jatkaa nykyistä psykoosilääkitystä, kannattaa lääkityksen vaihtoa harkita, koska harvat potilaat käyttävät sellaista lääkitystä ohjeen mukaan, jonka he kokevat vastennäksiksi tai joka näyttää aiheuttavan merkittäviä haittavaikutuksia.” Heikkinen et al 2007, 687. Translation by Mari Stenlund.
schizophrenia. But one may ask how this information is being used here. It is a well-known fact that it is really exceptional to be successful and suffer from schizophrenia, and, vice versa, being schizophrenic means for most people a future with less opportunities. Thus, the question arises whether patients’ compliance is such an important objective that they can be given information in a questionable and somewhat twisted way in order to secure it. Is it the case that information is embroidered in order to influence the way a patient thinks about his or her illness?

One Finnish textbook of psychiatry, in discussing compliance, recognizes that threats to compliance may originate outside the hospital or treatment centre. Pressure from a patient’s friends is mentioned as a possible explanation of a lack of compliance on the part of a patient. It is also noted that a patient’s social environment may consider psychiatric treatment negatively (partly because of lack of understanding), which may weaken the patient’s willingness to comply. However, the question about whether a psychiatrist may pressure the patient to comply is not so considered in the textbook. The question arises whether the writers of the textbook or the psychiatrists who follow the ideas presented in the textbook acknowledge that they might use techniques with potentially manipulative features, and that as a consequence patients may become more unauthentic. Riittakerttu Kaltiala-Heino mentions the possibility that involuntarily hospitalized patients who have positive attitudes towards treatment adopt the nursing staff’s views about the treatment instead of having their own views:

As they [patients] cannot beat the powerful professionals they lose their natural and justified resistance and turn to become supporters of the opinions of the professionals. Thus the satisfaction the patients express cannot be taken as evidence of real uncoerced views but of the power of medicine to force people to accept the theories and opinions of the rulers, of how the social control of deviants becomes internalized in the deviants themselves.

Even the use of manipulative methods can be considered justified from some viewpoints. For example, if the background supposition is that an authentic person acts according to what is best for his or her health and agrees with the physician. Thus, the consenting view is “truly” or “objectively” authentic while other views are signs of pressure and unawareness. However, if a lack of compliance is considered as a sign of unauthenticity in this way and if it is considered justified to use manipulative methods to reach authentic views, we seem to be discussing freedom of belief and opinion in terms of rationality, not in terms of authenticity.

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97 See the distinction made between freedom in terms of authenticity and freedom in terms of
However, one might also ask whether one of the criteria of manipulation is that the manipulator knows what he or she is doing and seeks to benefit him- or herself at the expense of the person being manipulated. This is not usually the case – not at least explicitly – when a patient’s compliance is reached through the influence of the psychiatrist. However, if it was justified to use manipulative techniques in order to promote the patient’s well-being, the primary goal does not seem to be the patient’s freedom of belief and opinion in terms of authenticity but the well-being of the patient. However, it could be argued that a patient’s compliance is necessary in order to promote a psychotic patient’s freedom of belief and opinion in terms of authenticity. It might be argued that if a person with psychosis does not take his or her medication, he or she remains an unauthentic individual, which is a problem from the viewpoint of both that person’s freedom of belief and opinion, and well-being. Actually, in this case, even when there is clear evidence of manipulation of a person with psychosis, this would not be a violation of that person’s freedom of belief and opinion as only unauthentic beliefs and opinions are being manipulated. In this case, manipulation does not distort anything authentic about the patient, it just strives to “change” one set of unauthentic beliefs and opinions to another set of unauthentic beliefs and opinions. This might be justified if the goal is, ultimately, to promote a person’s authenticity, and if it is evaluated that manipulated beliefs and opinions (for example, manipulated compliance) could lead to authentic ones (to beliefs and opinions which are not distorted by psychosis). It also can be argued that unlike using physical force in order to medicate a psychotic person (which is an interference with that person’s negative liberty), manipulative techniques are somehow softer and less traumatic, the use of which increases a patient’s compliance and thus, finally, his or her authenticity. I will return to psychotic disorder as a violator of patient’s authenticity and psychiatric treatment as form of liberation for the patient in chapter 4.3.

4.2.3. Vulnerability to manipulation and shared delusions

The individual with psychosis may also be a victim of manipulation outside treatment context. When we seek a definition of freedom of belief and opinion which would also apply to an individual with psychosis one interesting question is whether the psychotic person is, because of his or her vulnerability, an easy victim of manipulation and whether he or she needs special protection because of that vulnerability. In terms of a psychotic individual’s authenticity, his or her vulnerability may be due to the fact that his or her psychotic
disorder has resulted in him or her being rendered relatively unauthentic. When the person is not really who he or she is, it may be relatively easy for outsiders to “fill” his or her inner space with something which they prefer for one reason or another but which does not seek to help the person find his or her authentic self again.

The Explanatory Memorandum to the RCE discusses what it calls deferential vulnerability, characterised by informal hierarchies based on social frameworks or on subjective deference, which it distinguishes from institutional vulnerability characterised by formal hierarchies. The Explanatory Memorandum to the RCE mentions that person who is cared for by family members may defer to the opinions of those family members. It also observes that deferential vulnerability may be found in ideologically close-knit groups:

Deferential vulnerability may also be relevant when a person belongs to a close-knit group, in which there is a more or less formalised hierarchy, which shares common beliefs and aims. If the person has few social links outside the group the person may feel pressure, whether real or imagined, to conform to the views of the hierarchy.98

However, deferring to somebody’s opinion seems to be more matter of a relationship based on an unequal balance of power. The claim here is not that the psychotic person might be manipulated but that he or she is not powerful enough to make his or her own decisions. It would sound more like manipulation if the psychotic person was being mislead. This seems to be the case when the Explanatory Memorandum to the RCE discusses the possibility of a vulnerable person becoming a victim of false promises concerning a miracle cure:

Medical vulnerability particularly affects those with disorders for which there are no totally satisfactory standard treatments. This may be relevant to some patients with schizophrenia, or patients with dementia. Such persons – or their family members – may be vulnerable to exploitation by someone promising a “miracle cure”. However, the impact of any mental illness may threaten a person’s self-image and sense of identity. If the person has insight into their situation, the person’s desire to return to his or her “normal self” may render the person vulnerable and unduly susceptible to, for example, advice from others, advertising, or claims concerning potential (in some cases expensive) treatments.99

When discussing the giving of consent, it has been required that the consent should be given voluntarily without duress or undue influence. It has also been noted that for a truly voluntary choice to be made, there need to be an equal balance of power in any relationship involved. Fulford et al present the case where the patient’s mother, who was a Jehovah’s Witness, pressured

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98 The Explanatory Memorandum to the RCE, Article 7:55.
99 The Explanatory Memorandum to the RCE, Article 7:55.
the patient over a decision concerning a blood transfusion, which the court interpreted as meaning that the patient could not have made an independent decision and, thus, was nor able to give consent. Because of that the doctors were allowed to treat the patient according to the patient’s best interest.\footnote{Fulford et al 2006, 480, 554. In this case the patient was probably not psychotic.} However, it seems to be unclear here what is meant by duress and undue influence. Is it so that because of the psychotic person’s vulnerability he or she is not able to deal with persuasive influence and is unable to resist the power of the persuader? If this is the case, we are left to discuss problems concerning freedom of belief and opinion in terms of capability. However, when we discuss freedom of belief and opinion in terms of authenticity, the problem with duress and undue influence is that it is manipulation with the goal of changing the psychotic person’s beliefs and opinions without his or her will. When it comes to close-knit ideological groups or families where, it is suspected, manipulation has occurred, we have to distinguish carefully between manipulation and persuasion.

Moreover, a distinction should be made between the manipulation used by manipulator or manipulators and the persuasion used in a group that shares a delusion. Jennifer Radden describes shared delusions as phenomena where delusions transfer from one individual to another in social isolation and intimate relationships. One partner seems to infect the other.\footnote{Radden 2011, 78-80.} Radden also wonders whether there might be group delusions, the so-called “madness of crowds”, which infects people “through a process analogous to the transmission of contagious bodily diseases and infections”. Radden does not suggest that all false, foolish and unreasonable beliefs and ideas should be described as delusional\footnote{Compare, for example, with Dawkins’s view (2007, 27-28) that believing in God is delusional. Radden’s view about shared delusions is not that wide.} but she assumes that some pathological delusions might be the result of social contagion. For example, beliefs which are commonly found in cases involving an eating disorder (such as “I am fat”)\footnote{It is contested whether beliefs which associated with eating disorders are delusions or whether they are, for example, overvalued ideas. Radden 2011, 87. For example, in Finland people with eating disorder are not considered psychotic even though they are considered as having a serious mental disorder.} might be the result of “cult of thinness”.\footnote{The cult of thinness is described by Hesse-Biber, and Radden refers to her ideas. Radden 2011, 82-83.}

Even though there are features common to manipulative groups and groups with shared delusions and between manipulative influence and delusional contagion, they seem to differ as phenomena. While in manipulation there should be a manipulator who consciously misleads others, in shared delusions and in delusional contagion there is only a delusional
person who persuades or influences others in some way. While in manipulation there is a “sufficiently authentic agent”, usually a “sufficiently authentic abuser”, who consciously misleads others, present, in shared delusions the person who is influencing others is also unauthentic and believes in the ideas which he or she spreads.105 However, it is also possible that a person with a delusion may use manipulative techniques in order to influence others. In that case he or she really believes that his or her delusions are true and worth spreading but uses manipulative techniques in order to make other people believe what he or she believes. In that case the person is both delusional and a manipulator. It might also be possible that a manipulator, who is not delusional, might spread a misleading idea which becomes a shared delusion amongst the people whom he or she has successfully manipulated into believing and spreading this idea. Even if the spreading of some idea was originally a result of manipulation (between a manipulator and the people being manipulated), the spreading of these same ideas may turn out be a genuine form of persuasion or some other kind of exerting influence which is not manipulative by delusional people, if these delusional people, who go on to influence others, really believe in the idea that they are spreading.

When freedom of belief and opinion is understood in terms of authenticity, psychiatrists are challenged to evaluate the authenticity of the values and choices of their patients carefully and also take into account the possibility that those values and choices might be the result of manipulation or shared delusions. For example L.L.E. Bolt has noted that the authenticity of the views of patients should not be taken as granted and that physicians should not just carry out the patient’s wishes.106

When freedom of belief and opinion is understood in terms of authenticity, the role of sharing beliefs and opinions within some community seems to be different to what it is when freedom of belief and opinion is understood in the negative sense. I noted in chapter 3.4.2. that alienation might have a more crucial role than irrationality or being unwell when psychosis is diagnosed and when the person is considered to be incompetent. I also concluded in chapter 3.4.4. that a certain level of sharedness is crucially linked with a person exercising the right to freedom of belief and opinion in the negative sense and living, acting, thinking and believing under its protection. However, when freedom of belief and opinion is understood in terms of authenticity, sharedness is not valued as much, because, it is argued, the person may also be manipulated by other people and, thus, the community is a potential threat to that person’s authenticity. Actually there seems to be an interesting conflict between alienation as a necessary criterion of psychosis

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105 When discussing “memes” the idea usually is that “memes” find hosts accidentally and that people are not affected by “memes” intentionally. See Radden 2011, 91.

106 Bolt 2007, 297.
and independence as a feature of authenticity. On the one hand, if a person shares his or her view of reality within some community, that person is not considered psychotic (even though the question of shared delusions needs further consideration) and, in this sense, he or she is considered sufficiently authentic. On the other hand, when a person shares a view of reality with others it might be asked whether that person really holds his or her own views. If a person has an original view of reality it could be seen as a mark of independence and a feature of authenticity. It seems that freedom of belief and opinion in terms of authenticity requires that the person’s reasons for sharing his or her views with others are authentic. It also seems that when freedom of belief and opinion is understood in terms of authenticity, being unwell as a criterion of psychotic disorder is more crucial than alienation. There seems to be some kind of background supposition that an authentic person is well and wants to be well.

4.3. Psychotic disorder as a violator of the forum internum

In the discussion concerning the justification of non- and involuntary treatment, it is sometimes suggested that psychotic disorder itself should be understood as a factor which reduces the individual’s freedom. This seems to refer, on the one hand, to the idea that being incompetent signifies a lack of freedom: the argument is that psychosis reduces the abilities needed in decision making. On the other hand, it can also be claimed that psychosis as an alien power distorts a person’s beliefs and opinions thus rendering them unauthentic. Thus, psychosis violates, at least in the metaphorical sense, a person’s right to the forum internum. I have already implied this in chapters 4.1 and 4.2. but now it is time to present my deeper analysis concerning psychosis as a violator of a person’s freedom of belief and opinion. First two chapters consider the idea of psychotic disorder as a distorting power, and chapter 4.3.3. considers the idea of psychiatric treatment as liberation. In the end I will present an alternative and challenging view which considers psychosis as an authentic process.

4.3.1. Psychotic disorder as an alien power

It has been suggested that psychotic disorder is an alien power which makes a person unauthentic and distorts his or her beliefs and opinions. This person’s distorted self develops distorted beliefs and opinions which are alien to the person’s authentic self.
This idea is often presented implicitly or in such a way that it is unclear whether it refers to a lack of competence, that is a lack of certain abilities or to unauthenticity, that is, a more all-embracing absence from one’s real self. For example, when the DSM-IV says that mental disorder may be associated with “an important loss of freedom”, it is unclear, what is meant by the concept of freedom in that context.\textsuperscript{107} It can also be claimed that an individual with psychosis does not act autonomously or does not make autonomous choices because of his or her illness.\textsuperscript{108} When Rem B. Edwards defines mental illness as a loss of practical, rational autonomy it is also unclear whether he is speaking only about a person’s competence or whether he also includes a person’s authenticity in the term practical, rational autonomy.\textsuperscript{109}

It has also been suggested that the psychotic individual’s decisions are not necessarily voluntary. For example, the Explanatory Memorandum to the RCE seems to suggest that there might be a difference between voluntary will and current will, as it notes that “involuntary measures are those that are against the current will of the person concerned”. It seems that involuntary measures are, according to the Explanatory Memorandum, against the current will but not necessarily against the voluntary will.\textsuperscript{110} According to Feinberg, a person “not being in his or her right mind” is not capable of giving a voluntary consent.\textsuperscript{111} The idea that psychotic disorder is an alien power which distorts authenticity may also be seen in the idea of protecting the patient’s real

\textsuperscript{107} See the DSM-IV-TR 2000, xxxi.

\textsuperscript{108} See, for example, Beauchamp & Childress 1989, 224; Fulford, Thorton & Graham 2006, 598.

\textsuperscript{109} Edwards mostly discusses mental illness but also uses the concept of mental disorder, which is confusing. His view of mental health seems to be negative, namely, mental health is the absence of mental illness. According to Edwards, mental illness means “only those undesirable mental/behavioural deviations which involve primarily an extreme and prolonged inability to know and deal in a rational and autonomous way with oneself and one’s social and physical environment”. By contrast, Edwards includes in his concept of mental health “those desirable mental/behavioral normalities and occasional abnormalities which enable us to know and deal in a rational and autonomous way with ourselves and our social and physical environment”. However, when Edwards defines mental health in short as “practical rationality and responsibility”, I regard this as a somewhat problematic definition. For example, young children who are mentally healthy are not necessarily practically rational and responsible. Thus, I see that Edwards’ longer definition includes significant criteria of undesirability (mental illness) or desirability (mental health). In the case of young children it might be desirable to be practically rational and responsible some day but not right now. See Edwards 1997, 52-56.

\textsuperscript{110} The Explanatory Memorandum to RCE 2004, Article 16:121. The Explanatory Memorandum to the RCE (2004, Article 28: 211-212) also suggests that the voluntary nature of somebody’s consent might be questionable in certain circumstances such as whether psychosurgical operation should be permitted: “such treatments should not be used on a person subject to involuntary placement, in particular because of the difficulty of ensuring that any consent given in those circumstances was voluntary”.

\textsuperscript{111} Feinberg 1986, 73. Feinberg says this in the context of considering the possible reasons for a person in his or her right mind to sell him- or herself into slavery.
interests and true wishes during psychosis instead of protecting so-called psychotic interests and psychotic wishes.\textsuperscript{112} For example, in Fulford et al’s analysis of the case of Mr AB, they note that Mr AB’s wishes were taken to be invalid and were not taken to be his true wishes. His wishes were considered instead as products of his delusional beliefs.\textsuperscript{113} Derek Bolton and Natalie Banner argue that the reason why mental health legislation permits in certain situations over-ruling the psychotic person’s expressed wishes is because these wishes are regarded as unauthentic:

In brief, a person’s mental states and behaviour, when mentally ill, may not be considered a true expression of themselves, but rather as expressions of illness, and therefore as lacking autonomy in this sense.\textsuperscript{114}

The Explanatory Memorandum to the RCE explains that people close to the patient have an important role because they “may be aware of other information, including the person’s background and culture, which may alter the opinions held on a person’s mental state”. The Explanatory Memorandum notes that this information supports good professional practice.\textsuperscript{115} The Explanatory Memorandum also points out that a patient’s “real will” develops during the treatment.\textsuperscript{116}

When it is claimed that psychosis influences a person’s identity, it suggests that something totally all-embracing changes in the person. However, this sort of change is described in quite a neutral way, for example, in the Explanatory Memorandum to the RCE, which notes that “mental disorders can have significant effects on a person’s emotions, perceptions, and capacities to think and to reason” and that these effects “may be seen as concerning the essence of a person’s individuality”.\textsuperscript{117} However, this psychotically induced change is given a negative connotation by discussing it in the context of the patient’s vulnerability. It is also mentioned that if a person with mental disorder has some insight into his or her situation, he or she might desire to return to his or her “normal self”.\textsuperscript{118}

The idea that psychotic disorder violates a person’s authenticity is also expressed more explicitly. For example, Thomas Gutheil describes the view of clinicians (in general), who, unlike juridical thinkers, point out that:

\begin{footnotes}
\item[112] For the different interpretations of best interest, see chapter 3.4.3.
\item[113] Fulford, Thorton & Graham 2006, 481.
\item[114] Bolton & Banner 2012, 80-81.
\item[115] The Explanatory Memorandum to the RCE 2004, Article 20:157
\item[116] See the Explanatory Memorandum to the RCE 2004, Article 12:97.
\item[117] The Explanatory Memorandum to the RCE 2004, Article 1:13. See also RCE 2004, Preamble which notes (italics mine) “that both mental disorder and certain treatments for such disorder may affect the essence of a person’s individuality” and stresses “the need for mental health professionals to be aware of such risks”.
\item[118] This is mentioned in the context of considering vulnerability to so-called “miracle cure”. See, the Explanatory Memorandum to the RCE 2004, Article 7:55.
\end{footnotes}
psychosis is itself involuntary mind control of the most extensive kind and itself represents the most severe “intrusion on the integrity of a human being.”119

Jonathan Glover notes how some major psychiatric disorders “can change the central core of a person”.120 The Madrid Declaration is perhaps the clearest of various ethical principles in this matter when it suggests that psychosis may distort the beliefs of the patient.121 Jorma Laitinen describes (without supporting for the view himself) a deterministic view of disease, when applied to schizophrenia, as something which sees illness as an independent and evil entity, which attacks the victim from outside and which disables and destroys the victim if there is no intervention.122 German Berrios’s view that delusions are empty speech acts seems to represent the radical view of psychosis as unauthenticity. He does not claim that authentic beliefs and opinions are distorted by psychosis. Instead, he seems to claim that there is no kind of link between authentic beliefs and opinions on the one hand and delusions on the other, since delusions do not tell us anything about a person’s internal reality. Instead of being distorted beliefs and opinions, a delusion is, according to Berrios, “a random fragment of information ‘trapped’ in the very moment the delusion becomes crystallised”.123

Some patients also experience psychosis as an unauthentic state. For example, comparing a psychotic experience with a religious experience, Andrew Sims has suggested that in the latter the person has the feeling that he or she has a free will.124 Luciane Wagner and Michael King noted in their research that many people with psychotic disorder experienced their disorder as something which they regarded as distinct from their being. Warner and King describe the experiences of mental health service users:

Something bad and inexplicable had occurred within their bodies that needed to be extirpated but they did not know how.

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119 Gutheil 1980, 327. See also Radden (2011, 126-127) who refers to Perceval’s idea about the power in human being which can form ideas upon the person’s imagination, control his or her voice and even wield his or her limbs.

120 Glover 2003, 537-538.

121 It is stated in the context of discussing euthanasia: “The psychiatrist should be aware that the views of a patient may be distorted by mental illness such as depression.” Madrid Declaration, Guidelines concerning specific situations 1996, Euthanasia.

122 Laitinen 1994, 16.

123 Berrios 1991, 6, 8, 12.

124 See Sims’s (1997, 80) comments on the case of woman called Sara: “Sara’s significant statement, “but God doesn’t take your free will away,” immediately distinguishes her diagnosis from schizophrenia. It was good that Sara’s priest did not need detailed knowledge of psychopathology to come to a common-sense evaluation of her experience.” However, when a person undergoes a religious conversion, he or she may also argue that he or she could not resist God’s call. In the Lutheran tradition it has been emphasized that human beings do not have free will in relation to God. Faith is God’s gift which a human being cannot, actually, choose for him- or herself.
According to Wagner and King, some people with psychotic disorder find it
difficult to understand the meaning of their thoughts.\textsuperscript{125} Eeva Iso-Koivisto
reports the experience of one patient whom she calls the narrator:

The narrator experiences psychosis as an alien and incomprehensible threat which may
present itself at any time. He seems to place this alien antisubject inside himself.
Medication is for him a way of controlling it. The meaning of medication as a lifebelt is
very important to the narrator.\textsuperscript{126}

Iso-Koivisto describes different kinds of styles of recovering from psychosis,
and one of them is called “sealing over”. In this recovery style, psychotic
experiences are excluded from other experiences and are considered totally
alien to one’s personality. In the “sealing over” style, a psychotic episode is
considered unrelated and unconnected with the rest of the person’s life.\textsuperscript{127}

The relatives and friends of a patient may also experience the loss
and they may describe the individual with psychosis as being in effect two
different kinds of person: the one they knew before psychosis and the one who
exists now and who is somehow the same person and yet is somehow totally
changed. Relatives and friends may express their experience by saying to the
individual with psychosis, “you are not yourself”.\textsuperscript{128} According to Iso-
Koivisto, the idea that “I am not really myself when I am mad” can also be a
way of coping with other people. When a person makes a distinction between
the healthy and the psychotic part of his or her personality, he or she is able to
hold on to a view of him- or herself as a member of a social community, who,
deep down, is able to be in the same reality as others.\textsuperscript{129}

\textbf{4.3.2. Unauthenticity, irresponsibility and the unsuitability of the
concept of paternalism}

The view that psychosis is an alien power and violates the \textit{forum internum} is
connected with the way in which the concepts of responsibility and
paternalism are understood when dealing with psychotic individuals. When

\begin{itemize}
\item \textsuperscript{125} Wagner & King 2005, 142.
\item \textsuperscript{126} “Kertoja kokee psykoosin vieraana ja käsitämättömänä uhkana, joka voi milloin tahansa taas
herätä henkiin. Hän tuntuu sijoittavan tämän vieraan, antisubjektin, itsensä sisään. Lääkkeet ovat
hänelle keino kontrolloida sitä; lääkkeiden merkitys “pelastusrenkaana” on hyvin tärkeä
\item \textsuperscript{127} Iso-Koivisto 2004, 11.
\item \textsuperscript{128} Iso-Koivisto 2004, 36-37. When other people say that “you are not yourself” is it also possible that
this is experienced by the psychotic individual as a demand or as some form of interference, or
even as an accusation since it implies that it would be better if that person was different, the
person he or she used to be.
\item \textsuperscript{129} Iso-Koivisto 2004, 19-20. Iso-Koivisto refers here to studies by Lally (1989).
\end{itemize}
freedom of belief and opinion is understood in the negative sense, the psychotic person is not necessarily considered responsible because he or she lacks of certain abilities (ability to understand the consequences of one’s acts and ability to control one’s behaviour and acts) needed in competent decision making. This view seems to be present in legislation. When freedom of belief and opinion is understood in terms of authenticity, responsibility is regarded differently, namely, the person with psychosis is seen as irresponsible not (only) because of a lack of abilities but because the psychotic acts are alien acts, the acts of somebody or something else, and, thus, not the person’s own acts, for which he or she would be responsible. For example, when Jennifer Radden considers the relationship between delusions and violence she points out that delusions may force the person into some actions.

Delusions sometimes compel action; then, the action must be excused, just as it is when, as occasionally happens, anyone is compelled to act.

However, it seems that the juridical system does not always accept insanity as an excuse for crimes in criminal cases even though that insanity is considered a condition which justifies paternalism. Fulford et al explain that in the criminal cases “the primary concern (or value) of legislators is that the law should not be used inappropriately as an ‘escape route’ for those who have committed serious crimes (such as murder).” But in the case of non- or involuntary treatment, the main focus is, instead, on ensuring that “the law is used appropriately to ensure that those who are in need of treatment receive it.” Thus, it seems that legislators are more worried about not placing authentic people who have committed crimes in prison than about placing authentic people in psychiatric hospitals by mistake.

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131 Radden (2011, 126, 129) emphasizes that the responsibility of psychotic patients in cases of violence is a matter of degree. The provenance, degree, severity and compelling power of delusions has to be reflected in order to evaluate their role as mitigating factors, for which some allowance should be made. When the person has had psychotic episodes over a long period of time, he or she may develop a degree of skill in of self-control and monitoring him- or herself. Together with these skills comes responsibility. For more about the responsibility of psychotic individuals, see Radden 2011, 125-129; Fulford, Thornton & Graham 2006, 149-150, 481. About the history of the “insanity defense” (pleading insanity by a defendant in a criminal court cases), see Robinson 1996.
132 Radden 2011, 125. In this context, Radden also notes that people who seem to have considerable epistemic capabilities are more likely those who act according to their delusions. Radden (2011, 125) writes: “Delusional action does not correlate with delusions showing greater conviction, preoccupation, systematization or insightness. Instead, at least as patients themselves understood what occurred, those with seemingly greater epistemic capabilities, who sought out evidence to confirm or refute their delusional belief, and seemed to be willing to countenance the hypothetical contradiction of those beliefs, were more inclined to act on them.”
133 Fulford, Thornton & Graham 2006, 487.
It can be also stated that a lack of certain abilities, namely, a lack of competence (at least in cases of psychotic people) signify that the person is not authentic. For example, Joel Feinberg seems to suggest this when he compares unwise choices with irrational ones. Feinberg defines irrationality as a “gross cognitive incapacity that renders its possessor incompetent and his actions not subject to normal evaluation and judgements”. According to Feinberg, only competent people can act foolishly; insane people are, instead, irrational.134 Feinberg also seems to suggest that irrationality signifies unauthenticity:

If they are unwise choices, then he can be blamed for being unwise, but if they are irrational choices, then he is at least partially “exculpated,” and there is no point in judging him “unwise”. A person’s true self is not represented by choices that are irrational.135

According to Alfred Mele, one way of understanding authenticity is to say that an authentic person is responsible for his or her values, preferences, principles, and even for his or her character.136 It seems that the concept of authenticity and the concept of responsibility are thus linked. However, as I see it, the link described by Mele is too strong since the person may be authentic without being responsible, as might be the case with children (if we consider them sufficiently authentic).137 Thus, the person may lack certain abilities required in a determination of mental competence without being unauthentic. If freedom of belief and opinion is understood in terms of authenticity, it is also possible to be competent without being authentic. It is possible for people “who are not themselves” to understand the consequences of their actions and it might seem (if their behaviour is evaluated in terms of their competence) that they are able to control themselves. However, even though they would be responsible in this sense (in a legal context these people would probably be considered responsible), if they hold unauthentic views and act unauthentically, they cannot be seen as being responsible. When the concepts of mental competence and authenticity are distinguished in this way, it can be said that both competence and authenticity are required for a person to be considered responsible.

If psychotic disorder is understood as an alien power, which distorts the person and thereby renders the person irresponsible, this seems to

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135 Feinberg gives the following examples of unwise decisions: not fastening one’s seat belt and smoking cigarette in spite of the risk of lung cancer. A rational philosopher may hold unreasonable beliefs. However, this is a particular instance of unreasonableness which “can hardly be strong evidence of general irrationality”. Feinberg 1986, 106. This distinction made between unwise and irrational choices is connected to the view of psychosis as irrationality (see chapter 2.1.2.).
136 Mele 2005, 541.
137 For more on children’s authenticity, see chapters 4.1.1. and 4.5.
be similar to the religious idea that a person may be possessed by a spirit, demon, ghost or, as in the Islamic religion, by a jinn. In both states, psychosis and possession, it has been said that the person’s own will has been wrested away. Something comes from outside the person and interferes with the person’s mind thereby distorting his or her self so that his or her actions are alien to the person. However, there might also be differences in the ways in which possessions and psychotic episodes operate. It can be claimed, for example, that while in possession the alien force comes from outside the person, in psychosis the alien force arises from inside the person, from the unauthentic part of that person’s being. While in possession the alien power is an “entity”, in psychosis the alien power is just an “illness”. It can also be asked whether a person’s belief concerning the origin of this alien power influences an unauthentic person’s attitude towards the different kinds methods available to help treat this alien force. If the threat is seen by the person concerned to be coming from within, then the person probably sees medication as being an appropriate form of help. Instead, if the threat is considered to be coming from outside, external measures, like exorcism, might be considered more suitable.

When a psychotic disorder is seen as the product of some alien power, there are also consequences in terms of how non- or involuntary treatment might be understood as paternalistic intervention. It has been claimed that it is meaningful to use the concept of paternalism only when the person is considered to be autonomous. Since in the case of unauthentic people no real will or real decisions are being ignored and no freedom (in terms of authenticity) is being interfered with by other people, it is meaningless to speak in these contexts about justified paternalism. According to this view of paternalism, so-called justified paternalism is not actually paternalism at all and the concept of paternalism should not be applied. Joel Feinberg criticizes the use of the concept of soft paternalism and suggests using the concept of “soft anti-paternalism” instead:

We could then adopt as our favored terminology that which identifies “paternalism” as with what we have called “hard paternalism”, and attaches the label “soft anti-  

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138 The person may also hold a delusion to the effect that he or she has been deprived of his or her own will. If a psychotic disorder is seen as the product of an alien power which has distorted the person’s authentic self, it might be asked whether this “delusion” is a delusion at all or whether it is an expression of a degree of insight. We end up with the same kind of paradoxical considerations we encountered in the case of a patient who had a hypochondrical delusion that he was “mentally ill”. See Fulford 1994, 212. See also Fulford 2009, 64. See also chapter 2.1.2. However, it seems that delusion can be distinguished from insight by considering the way in which the person with such a belief explains his or her situation: who or what in that person’s view has taken his or her own will away and how?

139 Feinberg uses the concept of soft paternalism but it seems that he means by this concept what I mean when I speak about justified paternalism. For the concept of paternalism, see chapter 3.4.1.
paternalism” to what we have called “soft paternalism”, the latter view being, after all, one which contradicts (hard) paternalism, but one which, like the harm principle, permits interference only in the absence of voluntariness or genuine consent.\footnote{Feinberg 1986, 15. In this context Feinberg discusses how Beauchamp (1977, 68) describes this view of paternalism: “It is not a question of protecting a man against himself or of interfering with his liberty of action. He is not acting at all in regard to this danger. He needs protection from something which is precisely not himself, not his intended action, not in any remote sense of his own making.” Beauchamp comments here on Mill’s argument about the person attempting to cross a bridge which had been ascertained to be unsafe, which I discussed in the context of incompetence in chapter 3.4.1.}

Feinberg notes that, according to the so-called soft anti-paternalistic view, paternalism cannot ever be justified because it would always be understood as “hard paternalism”. However, Feinberg decides to use the standard concepts of “hard and soft paternalism” because he wants to clarify instead of confuse the discussion. He does this “while muttering, from time to time, in sotto voce, that soft paternalism is really no kind of paternalism at all”.\footnote{Feinberg 1986, 15-16. The logical conflict which follows from these kinds of choices is visible in Feinberg’s former texts (1973, 50) when he discusses, on the one hand, nonvoluntary choices, and, on the other hand, paternalism: “This seems to lead us to a form of paternalism so weak and innocuous that it could be accepted even by Mill, namely, that the state has the right to prevent self-regarding harmful conduct only when it is substantially nonvoluntary, or when temporary intervention is necessary to establish whether it is voluntary or not. A strong presumption that no normal person would voluntarily choose or consent to the kind of conduct in question should be a proper ground for detaining the person until the voluntary character of his choice can be established.”}

However, it is not always acknowledged that a person may be authentic but mentally incompetent (or a distinction between authenticity and competence is not made for some reason). In these cases it might be reasonable to speak about justified paternalism and not to dismiss the idea of discussing it. For example, when we consider children or mentally disabled people it might not be meaningful to say that there is no real will for us to ignore since these people can be considered sufficiently authentic even though they would not be considered sufficiently competent mentally. Thus, in the case of children and mentally disabled people it seems meaningful to speak about justified paternalism since other people may ignore their true (but unwise) wishes.\footnote{On the other hand, if sufficient mental competence is seen as requirement of autonomy and justified paternalism is defined as ignoring the autonomy, it is still questionable if justified paternalism is meaningful concept at all.}

4.3.3. Psychiatric treatment as liberation

When psychosis is understood as an alien power which interferes with an individual’s freedom of belief and opinion, it is clear that psychiatric treatment
is seen as an intervention which liberates the psychotic person from his or her psychosis. Even the use of involuntary antipsychotic medication is understood as a liberation, not an interference with freedom. From this point of view, there is no inconsistency between viewing the forum internum as an absolute human right and the use of antipsychotic medication in involuntary treatment. The use of medication is not interfering with the person’s forum internum. Psychosis is. According to Thomas Gutheil, while legal thinkers want to liberate patients from the chains of treatment, “the physician seeks to liberate the patient from the chains of illness”. Kaltiala-Heino et al refer to the idea that the goal of involuntary psychiatric treatment is “to help a patient regain her/his rationality and true (psychological) freedom”.

It might be argued that nursing staff have a positive duty to liberate the psychotic patient by providing psychiatric treatment and in this way support the patient’s freedom of belief and opinion. According to the PUN, “the treatment of every patient shall be directed towards preserving and enhancing personal autonomy”, which implies that the patient’s autonomy is not interpreted only in the negative sense (whereas it would be the duty of the nursing staff not to interfere with the patient’s business). Juhani Pietarinen seems to defend this idea when he writes about justified paternalism and involuntary treatment. One of the requirements for justified involuntary treatment is, according to Pietarinen, that treatment increases the patient’s ability to exercise self-determination. It has been suggested that some of the patients who are prescribed involuntary treatment have actually hoped, perhaps unconsciously, that they could end being sent for treatment. However, they might be unable to express this desire and some may even try to hide it.

When the idea of involuntary treatment as liberation is considered in relation to freedom of belief and opinion understood in the negative sense, it could be said that the individual’s freedom of belief and opinion in the negative sense can be restricted when the goal is to maximize the sum of the

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143 Gutheil 1980, 327.
144 Kaltiala-Heino et al 2000, 213. According to Kaltiala-Heino (1995, 13), there are two main approaches towards the question of involuntary treatment. She calls the first the civil liberty approach and the other the medical approach. According to Kaltiala-Heino, in the medical approach, freedom is primarily psychological freedom, freedom from psychological illness, and therefore the focus is on the right to get treatment. See also chapter 3.3.3.
146 Either Pietarinen does not follow here Feinberg’s logic, who claims that justified paternalism is not actually paternalism at all, or he uses the concept of justified paternalism because this is what has usually been done (as Feinberg also does when he uses the concept of soft paternalism), but, unlike Feinberg, he does not matter about inconsistency openly.
147 Pietarinen 1995, 45-46. Pietarinen seems to take it quite and even too self evidently that the real interest of drug-addict is to get released from drugs and real interest of the patient with depression is to be free from the mental-disorder.
individual’s freedom in the negative sense, mental competence (as a requirement of freedom in the negative sense) and authenticity. Or more precisely: freedom of belief and opinion in the negative sense can be restricted in order to reach sufficient mental competence and authenticity. The idea is that if the person is not sufficiently authentic, freedom in the negative sense has no value since it does not connect to anybody’s real wishes. As Riittakerttu Kaltiala-Heino puts it: “In the absence of psychological freedom, physical freedom is useless”.149 Derek Bolton and Natalie Banner describe the same idea in the following way:

In circumstances in which mental health legislation is typically applied, it is assumed that the person is in a temporary state of not being themselves, in an ill condition from which, all being well, with the passage of time, or with treatment, the person will recover. With this background assumption, deprivation of liberty for the protection of the self is for protection of the future self, continuous with the past self; and it is difficult for this line of thought to avoid characterizing this self to be protected as something like the ‘true’ or ‘real’ self, while the current thinking, speaking self (the one ill-disposed) is not.150

Patients with psychotic disorder express different views and attitudes towards the idea that psychiatric treatment is a form of liberation. According to Eeva Iso-Koivisto, the recovery style of the patient influences his or her view and attitude towards the treatment they receive. In Iso-Koivisto’s study, the patients who had experienced psychosis as an unpredictable inner alien force which they could not control emphasized the importance of antipsychotic medication. One patient even said that he believed in his medication.151 However, some patients felt that medication was an artificial and external way of influencing the self. Iso-Koivisto emphasizes that if a patient has the possibility of controlling his or her medication this may reduce his or her perception that medication is an artificial and external form of influence and strengthen the agency of the patient.152

However, the idea that psychiatric treatment and antipsychotic medication is a form of liberation, which “restores” the person’s authentic self may sometimes be idealistic. In some cases liberation in the sense of “returning to the former authentic self” is not possible since the psychosis seems to have changed something permanently. Iso-Koivisto points out that the use of long-term or permanent antipsychotic medication may make the patient think that there is something permanently wrong which has to be repaired or damped. The patient ends up thinking in a spiral: as I am using

150 Bolton & Banner 2012, 89-90.
151 Iso-Koivisto 2004, 76.
152 Iso-Koivisto 2004, 43, 73, 76-77, 105. Compare with Kraemer’s study (2011, 1-15), which revealed that some people with Parkinson disease experience deep brain stimulation as alienation: they don’t feel as if they are themselves. However, some patients experience their state of mind under deep brain stimulation as being authentic. Experiences seem to vary from patient to patient.
medication, there must be something wrong with me, and as long as there is something wrong with me I will have to continue using the medication.  

Jonathan Glover refers to cases where psychotic patients feel that their original self has died.  

However, Glover states optimistically that:

- The moral case for seeing the schizophrenic personality as reflecting the illness rather than the person is linked to the desire not to give up on the possibility of a cure, a kind of keeping faith with the original person. There is the hope that the original version of the person may not be totally lost.

However, the question arises whether it is always right for the person with a psychotic disorder that other people keep faith with his or her original self. Would it be, at least in some cases, better for patient to accept the existence of the psychosis as part of a new way of being “really me” and living “my own life”. This would recognize that the authentic self can also change, and it should be possible to lead it in new directions. Especially when the individual has gone through something which has challenged his or her authenticity, it might be impossible to return to what he or she “used to be”.

If it is thought that sufficient unauthenticity for defining the person unfree follows directly from a diagnosis of psychotic disorder and if it is also thought that in this sense a sufficiently unauthentic person is totally not partially unauthentic, it seems to follow that “there is nothing left to violate” in a psychotic person’s freedom of belief and opinion. When Joel Feinberg considers cases which he calls odious, where patients are drugged, made to undergo lobotomies or other kinds of surgical manipulation or mutilation of the brain without their consent in order to close many of their options to choose as they please in the future, he seems to face openly difficulties. On the one hand, he compares this kind of drugging with assault and battery and claims that, despite the motives of the person who drug the patient, the forced use of psychotropic drugs diminishes the patient’s freedom of choice and violates his or her personal autonomy. On the other hand, Feinberg asks whether a patient in this kind of case has any autonomy left to violate since he or she has lost the competence (or authenticity) to govern him- or herself. According to Feinberg:

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153 Iso-Koivisto 2004, 75.
154 Glover 2003, 540-541. See also Iso-Koivisto 2004, 22.
155 Glover 2003, 541.
156 I noted in chapter 4.3.2. that Feinberg seems to think that a lack of certain abilities and a lack of competence (at least in cases of people with psychosis) signifies that the person is not authentic. Therefore, even though Feinberg mentions here that the patient has lost his or her competence, it seems that he discusses freedom (and autonomy) in terms of authenticity.
In such cases, a person can be made no worse in respect to freedom and autonomy than he already is, and behavior control may reduce his pain and anxiety and promote the convenience of those who must govern him.\textsuperscript{157} However, I think that it is too dramatic to suspect that there is no autonomy left to violate. Feinberg also seems to allow for the possibility that there might be some autonomy in need of protection, if not at the time, at least in the future:

Respect for personal autonomy, however, requires that the benefit of every doubt be given to the patient, that every effort be made to improve his lot without irrevocably destroying his capacity to govern himself.\textsuperscript{158}

\textbf{4.3.4. An alternative view: Psychosis as an authentic process}

Some question, however, the idea that psychosis is an unauthentic state. It seems that the view that psychosis distorts authenticity and in so doing affects the patient’s right to freedom of belief and opinion, is not fully accepted in legislation and ethical principles for psychiatry. Namely, they give some value to opinions expressed by a patient in a psychotic state since they note that the psychotic individual’s opinions should be taken into account when making a decision concerning non- or involuntary treatment.\textsuperscript{159} If this expressed opinion was considered totally unauthentic and just some idea alien to the person who expressed it, why should it be taken into account? So, it seems that some opinions expressed by a psychotic individual are considered authentic – or to have some kind of link to the person who expressed them.\textsuperscript{160}

According to some views and experiences, psychosis may even be regarded as a positive crisis or an awakening allowing the patient to see the “insanity” or deception and in this sense the unauthenticity of his or her life before the psychosis. In this situation, the “former self” is not something the person wants to return to.\textsuperscript{161} One person interviewed in Eeva Iso-Koivisto’s research experienced that his psychosis was a personal crisis in relation to so-called smart systems, institutions and society. The psychosis was a healthy experience in the sense that the person realized that some things which she
\textsuperscript{157} Feinberg 1986, 67.
\textsuperscript{158} Feinberg 1986, 67.
\textsuperscript{159} See Mielenterveyslaki 1990/1116, 11§; RCE 2004, Article 12:1, 17, 18, 20, 29.
\textsuperscript{160} It might also have been considered important to take an opinion into account because doing so might promote a patient’s compliance to treatment.
\textsuperscript{161} See Järvinen (1991, 240), who argues that even though in psychosis a person may distance him- or herself from external realities, he or she may come nearer to some inner realities. According to Järvinen, psychosis can also be understood as an enterprise to find one’s original self. See also Laing (1971, 121), who states that in a state of madness there is the possibility of being liberated and renewed as well as the possibility of being slaved.

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used to consider meaningful were actually without meaning. Another person thought that her psychosis was somehow connected with some incorrect spiritual decisions that she had made, and that she felt low spiritually. According to Iso-Koivisto, some patients integrate the psychosis in to their personal life and reflect upon it as part of their actions, history, communication and social relationships. In this recovery style, the person considers him- or herself as the originator of the psychosis and experiences that through psychosis he or she was able to get new information about him- or herself, life and conflicts. Thus, a psychotic crisis may even bring opportunities for personal growth and development.

It seems that the Hearing Voices -movement (and Marius Romme and Sandra Escher as movement’s leading thinkers) views psychosis as an “authentic crisis” and an “authentic suffering”. Even though Romme and Escher describe voices as intrusive, it seems that they at the same time consider them as an authentic experience which is linked to the individual’s personal history and inability to cope with some specific problem. Romme describes a patient who was not able to find help from medication, which prompted Romme to try something different:

The patient was in great distress and had become socially isolated. She was so frightened by her profoundly intrusive voices that she could no longer freely come and go. This can be very difficult to understand from the outside, even for a psychiatrist. She really needed someone who could identify with her experience. I therefore arranged for her to contact another patient hearing voices, hoping that they would be able to understand each other. The mutual recognition that resulted from this meeting convinced me of the authenticity of the experience of hearing voices.

According to Romme and Escher, their approach makes it possible for the individual affected to gain control over voices.

We now know that by openly acknowledging that they hear voices, people can make a choice about how to react to them. They need not feel themselves powerless and dependent because they believe themselves to be ill. By owning their voices, it is possible to gain control over them.

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162 See Iso-Koivisto 2004, 84.
163 Iso-Koivisto 2004, 85. The person does not have a clear view about what has caused her psychosis but it seems that she connects it somehow to her own life and decisions.
164 Iso-Koivisto 2004, 11. Iso-Koivisto refers here McGlashan et al. However, sometimes the psychosis has fundamentally changed something, and there is a need to be sad about losing the previous self. Not all people are able to integrate the experience of what they are and what they used to be into the same story. Iso-Koivisto 2004, 22. See also the experience of a patient interviewed in Iso-Koivisto’s study (2004, 94), who feels that she has two personalities: one before her illness and an other afterwards. The interviewed person was not able to find the same features in herself which she used to recognize before her illness.
165 See Romme & Escher 2000, 14-18, 23.
166 Romme & Escher 2000, 18.
On the other hand, they claim that if people are seen as victims of psychotic disorder and if hearing voices is only seen as a symptom of mental illness, this liberating progress may turn out to be impossible.\textsuperscript{168} Even though a psychotic experience may be considered authentic, as Romme and Escher seem to think, it does not mean that this experience was welcomed by the patient and that the person who went through this experience did not want to recover and did not need help (in some situations involving antipsychotic medication) in the recovery process. However, the problem is not that the experience is alien but that some people with such experiences – even though they are authentic – cannot solve their problems and live their life.\textsuperscript{169} This means that even though the psychosis did not affect the person’s authenticity it might still be a huge problem affecting his or her capability. Thus, I will return to these questions in chapter 5, when I discuss capability.

The way in which Charles Guignon describes the idea of authenticity in Romanticism seems to imply that a psychotic experience is, if anything, an authentic experience:

What rises up within you – the feelings, responses, thoughts, and desires – is more fundamental – more real! - than the objective realities and intersubjective involvements that make up either everyday life or Western traditions. Like Rousseau before him, Rilke envisages a form of subjective truth that is prior to and more genuine than objective truth.\textsuperscript{170}

It seems that there are two interlinked traditions in the discussion about authenticity. On the one hand there is the tradition of Romanticism, which suggests that psychosis is an authentic state. On the other hand, there is the tradition of the Enlightenment, which emphasizes the importance of seeing things as they are, which, it maintains, is only possible when people are free from illusions and social pressures.\textsuperscript{171}"The view which sees psychosis as an unauthentic state may lean on this tradition of the Enlightenment.

\textsuperscript{168} According to Romme & Escher (2000, 15): “Although psychiatry allows that mental disorders may be the result of vulnerability and stress, the labels put on them accord with the medical model of illness. Under this system, hearing voices is the product of some disease, cause unknown. This is a dangerous diagnosis. It subsumes the link between personal history and the emergence of the voices. It impedes the search for a solution and it increases the chances of a recurrence.” They (2000, 23) continue: “If all symptoms are seen as the consequence of disease, it rules out the possibility that illness may be a consequence of not being able to cope with a specific problem. All too easily, the person disappears behind the illness label.” Kaltiala-Heino et al (2000, 218) also pay attention to the danger of too easily assuming that if a patient refuses treatment this is a symptom of psychotic disorder: “In stereotypically interpreting treatment refusal as a symptom of illness the patient in question may be poorly understood, which may result in harm instead of relief.”

\textsuperscript{169} See Romme & Escher 2000, 16.

\textsuperscript{170} Guignon 2004, 74.

\textsuperscript{171} See Guignon 2004, 42-44.

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People who consider that psychosis is an authentic state may however value this authenticity in different ways. For example, Jung and Freud seem to differ in the value they attach to psychotic authenticity. Jung sees an inner childlike sphere in a positive light and emphasizes the need to be in touch with one’s inner self, which is linked to mysteries and a sense of purpose that is grounded in a collective unconscious. Jung seems to see civilization, rationality and science as potential threats to authenticity. Freud, however, emphasized rationality and the need to naturalize phenomena. Even though he saw the id as the real self of the person, he also saw that if people acted according to it, social life would not be possible, because not all the outcomes of one’s id are positive. According to Freud, people have a capacity for and even a deep impulse to do evil, as well. Even though Freud saw that civilization restricts freedom (acting according to a super-ego restricts the id), he also saw that life without civilization is not possible.

I value Freud’s ideas in that they challenge the view of freedom of belief and opinion in terms of authenticity presented in this chapter. Namely, it seems to me that view about freedom of belief and opinion in terms of authenticity idealizes humanity. The supposition seems to be that authentic human beings are happy and healthy and good to others. Moreover, the supposition is that they choose a healthy way of living. Evil, unhappiness and suffering are perhaps excluded from this view of authentic humanity.

If we accept that psychosis is an unauthentic state, are we not also accepting far too narrow an understanding of humanity? The same question arises when we discuss manipulation in ideological communities. Could it be that some people, for some personal reasons, become interested in ideological communities that have strict rules? Could there be something in their authentic humanity which lead them to these manipulative groups even though they would feel them unwelcomed or at least later as something to be a shamed of? However, if people accepted that features of their personality and experiences in their lives have lead them to become members of manipulative groups, would it be easier for them to grow as individuals? We all have in our lives things and experiences which we are not so proud of or which even frighten us.

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173 Guignon 2004, 97-103.
174 For example, one Finnish guidebook concerning the ethics of physicians presents the idea that the doctor has to help the patient by giving him or her information and psychotherapeutic help so that the patient’s ability to make choices increases, from which it follows that the patient can use his or her self-determination in order to improve his or her health. See Lääkärin etiikka 2005, 88. Ideally, it is supposed that a person who uses his or her self-determination makes choices which are good for his or her health.
4.4. Evaluating the authenticity of a psychotic person’s beliefs and opinions

In the discussion concerning authenticity, there are, it would seem, two approaches to understanding what determines a person’s authenticity. Firstly, there is the externalist approach which focuses on considering the individual’s authenticity in relation to social relationships. I adopted this externalist approach when I discussed psychotic individual’s authenticity in relationships with other people in chapter 4.2. However, the authenticity of the psychotic individual’s beliefs and opinions can also be considered from the internalist approach which Monica Betzler describes, as follows:

Internalist accounts attempt to identify a mental attitude or web of such attitudes that accounts for the agent’s self. Whatever state is identified, it is taken to reveal what the agent in question really values or finds important. Provided that there is such state, an agent has reasons to govern himself accordingly.

If it is stated that psychosis self-evidently signifies unauthenticity, further internalist evaluation of a person’s authenticity is not needed in order to determine the status of that person’s beliefs and opinions. Mere psychotic diagnosis is enough. However, if it is thought that the person is not “totally psychotic”, there is a need to understand which beliefs and opinions of the individual are disordered, the products of disorder, and thus unauthentic, and which are not. In some situations the conceptual discussion concerning psychosis and delusions presented in chapter 2.1. does not help here because in a psychotic state the person may also adopt beliefs and opinions which are not psychotic as such (for example, some religious views) but which are still considered as products of disorder and thus as unauthentic beliefs and opinions (when the idea is that psychosis has made the person adopt certain religious views). It might also be argued that some psychotic beliefs and opinions are authentic while some other psychotic beliefs and opinions are not. For example, it might be argued that the delusional statement “I am dead” refers in some way to the individual’s personal history and is an authentic, though psychotic, expression of something that is really going on in the person’s inner life. However, if same person stated that rabbits were running about in his or her garden, it might be argued that this was an unauthentic belief or opinion, which has no link to the person who expressed it.

Testing the authenticity of beliefs and opinions reminds one of the evaluation of mental competence. Both can be described as evaluations of autonomy. However, as I see it, there is a conceptual difference between the

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176 Betzler 2009, 55.
evaluation of mental competence and the evaluation of authenticity. When mental competence is evaluated, the focus is on certain abilities. When authenticity is evaluated, the focus is on the person as such. However, since it is impossible to reach the person as such, the evaluation of authenticity concentrates on some expressions of self, which are also connected to some abilities. Thus, the evaluation of mental competence and authenticity can include some common areas.\textsuperscript{177} What is also common to the concepts of competence and authenticity is that when both of these concepts are defined, it has been pointed out that a belief or an opinion need not be something particular in order to be competent or authentic. At least in theory, the content of competent as well as authentic beliefs and opinions can be of any kind whatsoever since what makes them competent or authentic is the process of believing and thinking and the abilities of the person who forms beliefs and opinions, not what they are about. When it comes to authentic state, Betzler describes this point:

Since any substantial interpretation of such a state is thought to be paternalistic, internalist accounts refrain from suggesting any values which an agent’s attitude or web of attitudes would have to be directed towards. Instead, they resort to more formal criteria that are thought to better account for the agent’s ongoing perspective.\textsuperscript{178}

In this chapter I consider the evaluation of the psychotic individual’s beliefs and opinions in terms of the person’s own evaluation of his or her beliefs and opinions, the stability and recalcitrance of the person, and the reflective self evaluation by the person, and self as a coherent story.

\textbf{4.4.1. The person’s own evaluation}

Jonathan Glover notes how in “humanistic psychiatry” the focus is on the person’s own feelings about what he or she is really like and what he or she wants to be.\textsuperscript{179} Following this idea it might be argued that outsiders should accept the psychotic individual’s own evaluation concerning his or her beliefs and opinions. As Eeva Iso-Koivisto has argued, individuals with psychosis have different kinds of recovery styles. While some experience their psychosis as an unauthentic state, others integrate their psychotic episode into their lives as an authentic experience. In the same way, psychotic people’s own evaluations of the influence of antipsychotic medication might be said to be

\textsuperscript{177} It could be even claimed that discussing authenticity is discussing competence on a deeper level.
\textsuperscript{178} Betzler 2009, 55.
\textsuperscript{179} Glover 2003, 543.
central. While some feel that medication helps them to be themselves, others consider medication as an artificial form of “help”.180

The person’s own evaluation seems to be relevant in the phenomenon of thought insertion, which Bortolotti describes, as follows:

There are number of disorders of the self that might affect the way in which one feels one’s thoughts are formed, held, reported, accessed or influenced by other individuals or external forces. In thought insertion subjects experience a thought as foreign...The thought is known first-personally by the subject and therefore the subject is aware of the content of that thought independently of behavioural evidence. But the subject regards it as alien and out of her own control.181

Thus, in the case of thought insertion some beliefs are recognized as unauthentic by psychotic individuals themselves. The person with delusions may report that some of the thoughts which he or she “has in his or her head182” are not really his or her own thoughts. There is a discussion about whether the person is or is not the author of some thought if he or she experiences the thought in his or her head. Bortolotti describes different viewpoints in this discussion:

the owner of a thought is taken to be a subject who can locate the thought within her personal boundaries and has direct access to the thought, but in some accounts it is also

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180 See Iso-Koivisto 2004, 11. When it comes to people suffering from ADHD, Bolt & Schermer (2009, 105-107) report both kinds of experiences. While some people suffering from ADHD felt that the use of medication made them feel less like themselves, less authentic, some people with ADHD reported that they felt more like themselves on medication. Bolt & Schermer note that the ability to control impulses seems to be the central influence of the medication. While some felt that they needed that control in order to work and be accepted by other people, and accepted the unauthenticity as the price which had to be paid for these benefits, others found the ability to concentrate as something they wanted to have for its own sake and even experienced that medication helped them to be themselves. There were also some people who did not think that the medication had influenced their self or personality. However, when compared with psychotic people, the difference with people with ADHD, presented in Bolt’s & Schermer’s study, is that the latter group may choose for themselves whether they will use medication or whether they prefer to be without it. They have the possibility of evaluating their authenticity. When it comes to people with psychosis, the situation is different. First, in cases of non- or involuntary treatment, people cannot choose whether they use medication or whether they would like to be without it. Second, a psychotic person’s ability to conduct a self evaluation concerning authenticity is seen as being more problematic because this self evaluation might be being made by an unauthentic self. These two problems are, of course, linked to each other since the person has been sent for non- or involuntary treatment in the first place because he or she has already been evaluated as being unauthentic.

181 Bortolotti 2010, 228. Bortolotti (2010, 229) gives an example of thought insertion in a patient reported by Jaspers: “One evening one thought was given to me electrically that I should murder Lissy.” For more about thought insertion, see Fulford 1994, 218-220.

182 This way of understanding believing and thinking is problematic. Bortolotti points out that there seems to be a supposition that the mind is a box into which you can put stuff. This metaphor is, according to Bortolotti (2010, 233), excessively crude. Compare also with the view of freedom of belief and opinion as negative liberty which focuses on the contents held in mind.
expected that the subject can acknowledge the thought as her own and ascribe the thought to herself.\footnote{Bortolotti 2010, 230-231. For more details, see Bortolotti 2010, 227-242.}

When the role of the person’s own evaluation is emphasized as is the case in humanistic psychology, the latter of these approaches seems to be adopted: authentic beliefs and opinions have to be acknowledged and formed by the person him- or herself. It is conceptually interesting that a belief that somebody or something has inserted thoughts in to one’s head and a belief that one has been deprived of one’s own will are defined as delusions. Thus, even though there is a psychiatric idea that psychotic beliefs are not authentic beliefs but beliefs distorted by illness, the patient who believes that he or she holds some unauthentic beliefs, as is the case with thought insertion, is defined as having a delusion. It seems that what is crucial here are the reasons for unauthenticity. While some explanations are considered delusional (as is the case with thought insertion) some explanations are considered scientific or philosophical (as is the case with the psychiatric view that psychotic disorder is an alien force).

One problem with the approach which emphasizes the individual’s own evaluation in identifying which beliefs and opinions are authentic is that there is no way of knowing if the individual conducting this self evaluation and claiming that certain beliefs and opinions are authentic is in fact authentic or unauthentic. What if it is an “alien force” in the person that is making him or her say “this is what I really believe and think”? The psychotic individual without insight does not necessarily consider his or her psychotic beliefs and opinions as being unauthentic or exceptional in any way. We can hardly just consider the psychotic beliefs and opinions of the individual to be authentic just because the person has no insight? If we do, it seems to follow that the use of involuntary antipsychotic medication seeks to influence and even change authentic beliefs and opinions, which would be a violation of that person’s absolute human rights. However, the need for involuntary antipsychotic medication seems to arise in particular when a person with psychosis lacks insight and for this reason resists his or her medication. Thus, emphasizing the psychotic person’s own evaluation does not seem to be a sufficiently reliable solution when evaluating a patient’s authenticity. It is also questionable whether the person’s own evaluation as such can be counted as an internalist account or whether it is more like the starting point of the whole problem concerning the authenticity of beliefs and opinions. It seems that the point of internalist accounts is to find out, among other things, whether the person really holds authentic beliefs and opinions when he or she claims that “this is how I believe and think”.

\footnote{Bortolotti 2010, 230-231. For more details, see Bortolotti 2010, 227-242.}
This does not mean that it would not be good to listen to a psychotic patient’s self evaluation. It is also possible that the person has had psychotic episodes before in his or her life and has said that he or she is not really him- or herself in the psychotic episodes. However, even in these cases it is not self evident that the current psychotic episode is the same kind of episode as the episodes experienced before. Moreover, if the person’s own evaluation was the only criterion of his or her authenticity it should be asked why the self evaluation given after a psychotic episode was more convincing than the self evaluation given during a psychotic state. Thus, it seems, that the person’s own evaluation is not alone sufficient to establish authenticity. Further criteria are needed in order to distinguish between “self evaluation expressed by a person” (which may be an unauthentic self evaluation) and “a person’s real own self evaluation” (which is a so-called authentic self evaluation).  

4.4.2. Stability and recalcitrance

It has been suggested that authentic beliefs and opinions are quite firmly held over a period of time. The steadfastness of beliefs and opinions is tested in social relationships as others might not trust someone or cooperate with them if their beliefs and opinions were to change too often. Harry Frankfurt uses the phrase “caring about something” to describe the steadfastness of people’s attitudes. According to Frankfurt, when a person cares about something he or she expresses who he or she is and what he or she identifies with. According to Frankfurt, it may be that the person who cares about things cannot stop caring about things. He or she may care about something even though it is clear to him or her that it is irrational for

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184 Even though a person might feel that he or she is not who he or she really is or says that he or she does not even know who he or she really is, this does not necessarily mean that he or she isn’t sufficiently authentic in terms of freedom of belief and opinion. For some, perhaps most, people it may be very difficult to say that they themselves are authentic, even though they are, apparently, mentally healthy and not being manipulated by other people. And it is not necessarily the case that they would consider themselves as having a psychiatric disorder. They may just consider that what they feel is what it is like to be a human being. It is part of human life that you don’t know who you really are. It is also worth noting that if a person does not express his or her beliefs and opinions at all, and thus does not give any kind of evaluation concerning the authenticity of his or her beliefs and opinions, he or she might still be authentic. Not saying anything may also be the person’s real choice in a situation which he or she considers oppressive.

185 In this way, authentic beliefs are developed in socialization. Guignon (2009, 152-155) presents this view, referring to Bernard Williams.

186 Frankfurt discusses persons and freedom of will, not authenticity. However, Frankfurt’s discussions have been considered in the general discussion concerning authenticity. See, for example, Betzler 2009; Oshana 2007; Guignon 2004.

187 Betzler 2009, 55.
him or her to do so in light of the fact that he or she will receive no
satisfaction. A person may even wish that he or she didn’t care so much about
the things which he or she cares about.188 Frankfurt refers here Martin Luther’s
attitude when he said “Here I stand, I can do no other”.

An encounter with necessity of this sort characteristically affects a person less by
impelling him into a certain course of action than by somehow making it apparent to him
that every apparent alternative to that course is unthinkable.189

Frankfurt notes that Luther had the capacity to make other choices. However, as Frankfurt puts it: “What he was unable to muster was not the power to
forbear, but the will.” This volitional necessity declares, according to
Frankfurt, that he was a subject.190 When Monika Betzler describes Frankfurt’s
idea of caring about something she argues that the recalcitrance of an attitude
is a criterion of authenticity:

It seems that it is the recalcitrance of an emotionally loaded attitude, or complex of
attitudes, that accounts for the stability necessary to capture what the agent’s self is.191

Lisa Bortolotti also describes this steadfastness of attitudes, though she uses
the term stability, when she discusses the authorship192 of beliefs:

Stability might not seem a very important factor for evaluative judgements that are
marginal to the core of our conception of our self (e.g. which jam we like best). But it
might become a very important factor for attitudes that are, to some extent, self-defining,
such as judgements about what makes life worthwhile, ideological or political
affiliations, and so on. These attitudes are of a more dispositional nature and represent
things about ourselves that we take to be less open to revision, less fleeting. We take it as
part of what it is to have such attitudes that they are to some extent stable.193

When the criteria of stability and recalcitrance are applied in order
to evaluate the authenticity of a psychotic individual’s beliefs and opinions, it
can be supposed, firstly, that the psychotic individual’s beliefs and opinions
are not authentic if they differ significantly from the beliefs and opinions
which the person had before his or her psychosis. Second, if the individual’s
beliefs and opinions constantly change, for example, if he or she changes his
or her mind about his or her treatment and does not commit to his or her
decisions it can be supposed that the person does not hold authentic beliefs

is characterized by the fact that we are even inclined to support our disposition in light of other,
potentially conflicting considerations.”
189 Frankfurt 1988b, 86.
190 Frankfurt 1988b, 86.
191 Betzler 2009, 55.
192 It seems that speaking about authorship is to speak about authenticity. The question is whether the
person is the author of some belief, which seems to be same as asking whether that belief is really
the person’s own belief.
and opinions regarding these issues. According to the Explanatory Memorandum to the RCE, involuntary measures can be used “in circumstances where a person recurrently changes his or her mind about whether or not to accept a measure, as a result of which a consistent therapeutic programme cannot be maintained, if the relevant criteria and procedures for the measure concerned are satisfied”.

It has also been suggested that a delusional person does not necessarily really believe and think what he or she says his or her beliefs and opinions are. It has been claimed that people with delusions live in two realities and that they are not fully committed to the delusional one, in which case their beliefs and opinions would not be seen as authentic. Bortolotti summarizes this discussion:

Bleuler (1924) notices that patients who claim to be a dog don’t bark like dogs, and they behave as if their delusion were to be taken metaphorically. In a later paper, Bleuer (1950) argues that there is double awareness in schizophrenia. Subjects with schizophrenic delusions may fail to act in accordance with their delusions and behave in a way that reflects how things really are. Sass (2001) talks about the notion of double-bookkeeping...and suggests that subjects with delusions are disconnected from the subject’s relevant behaviour and often fail to guide action. This is reason to think, according to Gallagher, that delusions are not erroneous beliefs, but alternative realities occasionally inhabited by the subjects.

If stability and recalcitrance were taken as the only criteria of authentic beliefs and opinions, it would follow that many delusions are, actually, authentic. If the definition of delusion presented in the DSM-classifications is taken seriously, it seems that all delusions are authentic, since delusions are defined as false beliefs which are firmly sustained or held “despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary”. Bortolotti presents the following example where the person seems to be so committed to his delusion that he even develops an imaginative theory in order to explain his belief:

a young man was affected by memory deficits following a severe head injury. He experienced feelings of familiarity towards TV programmes when he saw them for the first time (dévù vecu). He felt like he had seen the programmes before, not any indefinite

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194 However, there may also be problems in terms of mental competence in these kinds of situations.
195 The Explanatory Memorandum to the RCE 2004, Article 16:126.
196 Bortolotti 2010, 166. See also the discussion about agential rationality in chapter 2.1.2.
197 See the DSM-IV-TR 2000, 821; DSM-V 2013, 819. It seems that only delusions which are responsive to evidence can be described as unauthentic given the criteria presented by Frankfurt. According to Bortolotti, some psychotic individuals lose their belief in their delusion and renounce it when they repeatedly face evidence which contradicts their delusions. See Bortolotti 2010, 117. On the other hand, it is questionable whether they can be defined as delusions, if we take the definition presented in the DSM-classifications literally.
time in the past, but at the time when he had been hospitalised in the city, years earlier, for the accident that caused him the memory deficits. In a recorded interview, he was asked to explain how he could have seen before even live programmes, such as the news or sport events, and he provided a very elaborate explanation. He claimed (correctly) that in the rural location where he lived with his family there were fewer channels than in the city where he had been hospitalised. From this he developed the delusional explanation that in the countryside they broadcast programmes that were shown years earlier in the big city for the benefit of those who could not see them at time (this was incorrect). 198

However, so-called psychotic recalcitrance is usually seen as a sign of unauthenticity, which implies that Frankfurter’s view is not widely accepted by those who argue that psychotic disorder is an unauthentic state. 199

Moreover, the externalist approach to authenticity suggests that recalcitrance can also be manipulated. For example, if the person invokes his or her beliefs in order to explain why he or she makes decisions which threaten his or her health or life, it might be thought that those beliefs might have been manipulated. Frankfurter notes, however, that a person does not experience volitional necessity as an external force. Volitional necessity is not an alien force because it coincides with desires which the person has actively identified him- or herself. They are to a certain extent self-imposed. 200 It seems that Frankfurter puts quite a lot of trust in the person’s present experiences and expressions and does not take into account why the person has internalized this volitional necessity. For example, from the viewpoint of the externalist account, volitional necessity may be based on the person’s belief that a person who makes certain choices ends up in hell. However, if this belief concerning hell 201 and certain choices is the product of manipulation, the recalcitrance (for example, in some cases where the person refuses a blood transfusion) is not based on authentic beliefs and opinions.

The criteria of stability and recalcitrance have also been criticized for not taking sufficiently into account that sometimes there may be an authentic reason for changing one’s beliefs and opinions. For example, Betzler notes that an authentic person may have reasons to change: as circumstances change the person might sometimes need to change, as well. Thus, authenticity should not be understood as a static state, which “remains the

198 Bortolotti 2010, 180-181. For more discussion about cases where a psychotic person really seems to be committed to the content of his or her delusions, see Bortolotti 2010, 159-203.
199 Betzler (2009, 57) makes the same kind of notion when it comes to people suffering from anorexia nervosa: "someone suffering from anorexia nervosa may deeply care in the Frankfurterian sense about dieting. It is far from clear, however, whether her anorexic disorder represents what is true about her in a sense that could provide any normative backup for self-governance...Their acquired caring about dieting can thus hardly represent who they really are. Instead, it is an expression of inauthenticity.”
200 Frankfurter 1988b, 87.
201 Usually when people are warned about hell it is not manipulation, but persuasion. See chapter 4.1.3.

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same once an agent manages to achieve it”, as Betzler puts it.\footnote{Betzler 2009, 54-55, 62. Betzler suggests that emotions have a central role when authenticity is being determined. Bortolotti (2010, 219) claims that the stability of the reported attitudes is not a precondition for first-person authority: “There is no simple algorithm to determine what someone’s genuine state of mind is, but there is behavioural evidence to be taken into account: if participants report an attitude and give reasons for it, this is evidence that they have that attitude. The fact that they later act in a way that is not compatible with that attitude, may be evidence that they never had it, or simply that they no longer have it.”} If it is possible to change one’s opinion or even convert from one religion to another, the fact that a person has a different view in a psychotic state is not alone, self evidently, a mark of unauthenticity.

4.4.3. Reflective self evaluation

Some thinkers have emphasized that it should be possible for an authentic person to change his or her beliefs and opinions and have suggested that an authentic individual is able to engage in reflective self evaluation. According to Marina Oshana, authenticity is acknowledgement. It is “truthfulness toward oneself and about oneself in word and in deed”. An authentic person is “honest about the legacy she inherits from her past thoughts and feelings and doings”\footnote{Oshana refers in her definitions to Karl Jaspers and Larry May. According to Oshana, authenticity should be seen as part of the concept of autonomy. Oshana 2007, 424-425.}.

When Isaiah Berlin describes positive freedom he discusses individuals who are conscious of themselves as thinking, willing and active beings, which seems to refer to an ability to reflect.\footnote{See Berlin 2005, 178.} The way in which Gerald Dworkin describes autonomy seems to emphasize the role of reflectivity, as well:

autonomy is conceived of as a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values. By exercising such a capacity, persons define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are.\footnote{Dworkin 1988, 20.}

Harry Frankfurt also argues that authenticity is an individual’s ability to reflect upon his or her desires. Frankfurt defines persons as entities who have second order desires: they do not just want or desire, they want to want and want to desire something. They also have the ability to seek change when it comes to their desires or wants: they want not to want and not to desire. This is what Frankfurt calls the capacity to engage in reflective self
evaluation. Agnieszka Jaworska seems to suggest almost the same when she claims that an autonomous person is recognized from the fact that he or she has critical interests. According to Jaworska, having critical interests refers to the ability to value, which she distinguishes from mere desiring. While we may think that our desires are not good and we would sometimes even like them to disappear, values are different:

We think it would be a mistake to lose our current values – we hold our values to be correct, or at least correct for us.

Bortolotti et al seem to refer to reflectivity by claiming that a person is the author of his or her belief if he or she adopts an agential stance or agential perspective by giving reasons for it.

The agential perspective is a stance in which reasons are evaluated and evidence is weighed up.

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206 Frankfurt 1988a, 12. See also Brison 1998, 330. Frankfurt also includes in the concept of authenticity a person’s ability to choose which desires to act on. It is, however, questionable whether the ability to engage in self-control is part of authenticity. Oshana (2007, 418-420) questions Frankfurt’s conception by claiming that the individual can notice disaffectedness in his or her life through reflection, whereas too much reflectivity could make the person unautonomous (or unauthentic, if we use my terminology). Oshana neglects the idea that being dissatisfied with one’s life and living in an alien life-situation would signify the individual’s unautonomy. If we utilize the conceptual distinctions presented in chapter 4.1., we would argue that the ability to exercise self-control is a feature of self-fulfilment. The ability to exercise self-control is also linked to the concept of mental competence, since forensic psychiatry argues that a competent person should be able at some level to control his or her behaviour and actions. See Rikoslaki 2003/515), 48; Tiithonen 2007, 655-656. Meyers’ definition (1989, 76), which like Frankfurt’s definition is quite demanding, refers to competence: “Autonomous people must be able to pose and answer the question “What do I really want, need, care about, believe, value, etcetera?”; they must be able to act on the answer; and they must be able to correct themselves when they get the answer wrong. To perform these tasks, people must have autonomy competency – the repertory of coordinated skills that makes self-discovery, self-definition, and self-direction possible.” Feinberg (1973, 14) discusses reflectivity and the ability to exercise self-control, as follows: “when the inhibitor is some higher-ranked desire and that which is frustrated is a desire of lesser importance albeit greater momentary intensity, we identify with the desire that is higher in our personal hierarchy, and consider ourselves to be subject rather than the object of constraint. When the desire to do that which is forbidden is constrained by conscience, by the “internalized authority” of the prohibiting rules themselves, we identify with our consciences, and repel the threat to our personal integrity posed by the refractory lower desire which we “disown” no matter how “internal” it may be.”


208 Jaworska 1999, 115. According to Jaworska (1999, 133), for example, patients with Alzheimer’s, who cannot remember their past life with its interests, may be “capable of the fundamentals of autonomy” in this sense. However, other people have to help these patients, because they are no longer able to lead their lives according to their contemporary and remaining values. If I use the terms presented in chapter 4.1.1. these people are, in my terminology, able of being authentic but not able of self-fulfilment.


According to Bortolotti, a person is the author of a belief or an opinion “if she forms or justifies it on the basis of what she takes to be her best reasons”.\footnote{Bortolotti 2010, 208-211.}

The belief is authored by me, because it is up to me what to believe, and I take responsibility over its content by having formed it or defended it on the basis of what I consider to be my best reasons.\footnote{Bortolotti 2010, 176.}

Blöser et al have developed an approach which is oriented to the capacity to reflect upon one's practical attitudes (desires, preferences, values etc.) in the light of new experience.\footnote{Blöser et al 2010, 239. Blöser et al are discussing autonomy but it seems that their ideas can be applied to the issue of authenticity.} Blöser et al have noted that authenticity requires an ability to consider new experiences as relevant touchstones for one’s values, an ability they call experience-responsive critical reflection (ERICR).\footnote{Blöser et al 2010, 243.} This means that the authenticity of a person is, in a certain way, tested when the person faces and recognizes experiences which challenge that person to reflect upon and reconsider his or her values. At the end of this process a person may reconfirm or abandon his or her values. According to Blöser et al, experiences are a special kind of information and are especially relevant for estimating authenticity because experience “puts us into direct cognitive contact with the world”.\footnote{Blöser et al give an example of an older man who used to think that marriage was necessary for good parenting and children’s well-being. When his son started to live a family life without getting married, and nothing seemed to be wrong with the son’s parenting or the children’s well-being, it was crucial for the older man’s authenticity to be able to engage in experience-responsive critical reflection. Blöser et al 2010, 242-246.}

Monica Betzler has pointed out, in a somewhat similar way, that a person has to have an ability to stand back and disown or re-own his or her authentic values. According to Betzler, even some kind of alienation from one’s own values is sometimes necessary in order to become authentic.\footnote{Betzler 2009, 63. Even though Betzler is discussing values, the idea can be applied to a discussion of beliefs and opinions, as well. From the viewpoint of human rights, value judgements can also be regarded as beliefs or opinions.}

When Lynn Stephens and George Graham define a delusional state as a lack of insight towards lower-order attitudes, it seems that they are describing a lack of ability to engage in reflection. While, for example, people with obsessive-compulsive thoughts are able to reflect upon their problems, people with delusions are unable to recognize that something is wrong with them:

Somewhat similar to obsessive-compulsive thoughts, delusions involve an imprudent or unproductive allocation of a subject’s psychological resources in the management and control of her own thinking and attitudes. Delusions therein prevent the subject from
dealing effectively with self and world. Unlike obsessive subjects, however, delusional subjects identify with the representational content (at the lower order) of their delusions. They do not experience the content as intrusive or as occurring contrary to their will or control. Obsessive subjects recognize that their obsessions disrupt and diminish their lives and they struggle, perhaps with very limited success, to contain their behavioral damage. Delusional subjects, by contrast, lack insight into the nature and personal cost of their lower order attitudes. They may find their delusional contents distressing in various ways, but they do not appreciate that the source of their distress is within themselves (in the lower order contents and in their attitudes toward the contents) and that it indicates that something is wrong with them.217

If the ability to engage in reflective self evaluation is used as a criterion for a psychotic individual’s beliefs and opinions to be considered as authentic, it can be said that if the person has some kind of reflective relationship with some of his or her delusional beliefs and opinions, they might be defined as authentic. For example, if a person is able to consider whether he or she is delusional, this represents a reflective attitude towards delusions even though the person might not reject them. For example, Bortolotti discusses a case where a person had a delusion concerning television programmes.218

The interviewer gently probed him with questions such as ‘Does this make sense to you?’; ‘How do you think this is possible?’, and so on. As a result, the man further elaborated his views, although at some stage he admitted that the situation was confusing, and that he no longer talked to others about it, because they tended not to believe him.219

Even though this person’s reaction may be seen as a sign that he is avoiding reflection, it also seems possible to interpret the situation by saying that he was put into a situation where he had to reflect upon his beliefs. His admission that the situation was confusing can be seen as an indicator that some sort of reflection was taking place. He had also considered other people’s reactions and had eventually decided not to talk about his thoughts with them any more, which also suggests that he had considered the consequences of his actions by reflecting upon his ideas.

Bortolotti also suggests that when people are able to defend their delusions “by appealing to events that have some meaningful connection to the content of their delusional states”, it is possible to consider them as authors of their delusions. Bortolotti presents the case of a woman who claimed that her blood was being taken with a syringe while she was sleeping, and defended this claim by showing spots on her arms. Even though the interviewer said that they were freckles and showed that he himself had freckles, too, the woman still claimed that there were signs of a syringe, even

218 See chapter 4.4.2.
though she also admitted that the interviewer’s freckles looked similar to her own spots. Bortolotti notes that further examination would be needed in order to find out whether the reason which the woman gave to explain her delusion really was “her best reason”. However, Bortolotti points out that the way in which the woman defended her claim does not seem to differ from the way in which so-called non-delusional beliefs are defended in cases where people do not have epistemologically rational reasons for their beliefs.  

An ability to engage in reflective self evaluation also seems to be central in situations where individuals, who have experienced psychosis, develop some understanding about themselves. During and after a psychotic crisis a person has perhaps to give up something that he or she used to be and something that he or she used to do. The new situation asks the person to develop a new approach into him- or herself and life. This process reminds us of an example presented by Betzler about someone called John. For John marriage used to be an important part of his authentic self since he saw himself as a husband who loved his wife. After John’s wife died he had to conceptualize himself as a widower and develop new things in his life to care about. This does not mean, however, that he had been unauthentic before or had developed an unauthentic self after his wife’s death, since “sometimes, circumstances are such that our evaluative responses – however authentic they may have been up to then – cease to be rationally called for”, as Betzler describes it. In the same way, even though there might be “two persons” – the one before psychosis and the one after psychosis – it is not necessary to consider either of them as being unauthentic. Perhaps there is sometimes just a need for change.

Blöser et al’s view is interesting from the viewpoint of shared delusions. They give an example about someone called Lisa, who changes her values depending on her changing environment and experiences: “in the company of vegetarians she becomes a vegetarian, but abandons her

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201 Betzler 2009, 64-65. According to Betzler (2009, 65), emotions play an important role in this process: “Emotions help us to respond to new reasons we have acquired. They thus generate reasons to revise our valuing and transform our self-conception so as to regain authenticity. They manage to do so in that they pick out what is salient in our environment given our evaluative perspective. They thus help us monitor our valuing by immediately registering changes that undermine it. Sometimes, circumstances are such that they may not fulfil the conditions for authenticity, yet our emotions generate reasons to re-interpret those conditions. They help us to disvalue our inauthentic life and generate reasons to transform it into a more authentic one.” The role of feelings has changed in the discussion concerning the self. While the Aristotelian view was that the person should be cultivated so that he has “the right feelings in the right situation at the right time”; the current view about authenticity emphasizes that there are no good or bad feelings. Feelings just are. For example, according to Alice Miller, a full and healthy life requires that the person is able to experience and express the feelings that naturally arise in him- or herself. Guignon 2004, 91-94. The way authenticity was seen in Romanticism emphasized that source of being is found by feelings. Guignon 2004, 51, 59.
vegetarianism in the company of non-vegetarians.” From the viewpoint of authenticity, the problem is that Lisa does not seem to reconsider and then adjust her values but just changes them. It can be asked whether people who suffer from a secondary shared delusion (they share the primary delusion of another person and have not developed the delusion themselves) have a lack of authenticity in the same way as Lisa did. When they are separated from the person who holds the primary delusion, they change their beliefs, which implies that the reason for their unauthenticity was not that they suffered from a delusion, rather their unauthenticity made it possible for them to adopt the delusion. The problem with Lisa’s unauthenticity was not that she held a certain view. The problem was that she both adopted and relinquished it too easily.

However, whether the ability to engage in reflective self evaluation is a feature of authenticity can be questioned. For example, children may be defined as being sufficiently authentic, even though they might not be able to engage in reflection. They may simply lack the mental competence, instead. For example, Blöser et al’s argument that authenticity requires an ability to engage in ECR, might be far too demanding when we discuss freedom of belief and opinion. It seems, that if this demanding criterion was applied in human rights discussion (which Blöser et al do not do but which I will do), it would result in too many people probably being seen as having unauthentic beliefs and opinions and the state might even be regarded as having an obligation actively to help them find their authenticity, even though this might require restricting their negative liberty.

On the other hand, from the externalist viewpoint, an ability to engage in reflective self evaluation does not necessarily mean that the person has authentic beliefs and opinions since brainwashed person may also be able of organizing his or her mental life in a reflective way, as Blöser et al put it:

> The agent’s psychological makeup and hence her resulting capacity for critical reflection might be the result of brainwashing or external mind control.

In the same way it seems possible that a person might develop “a reflective view towards his or her psychotic beliefs” in the process of psychiatric treatment, that is, the person might express a certain “psychological makeup” adopted from the views of nurses and psychiatrists without really being reflective him- or herself. The person may explain how he or she has delusions and hallucinations (because this is what it has been told) and may

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222 Blöser et al 2010, 244.
223 On the other hand, Frankfurt (1988a, 16-17) seems to question the children’s status as persons.
224 Blöser et al 2010, 241; Mele 2005, 533, 539-540. Dworkin (1988, 18) also notes that his idea of second-order reflection is not itself a sufficient requirement for autonomy since reflection may be “influenced by other persons or circumstances in such a fashion that we do not view those evaluations as being the person’s own”.

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even express some kind of reflection without having a real grasp of his or her inner life and experiences.\

4.4.4. Self as a coherent story

It has been also suggested that the authentic self should not be understood as a thing or object but instead as a story which is continuous, ongoing, and open-ended. At the same time as the environment and social relationships influence the self, we shape our identity by “taking over those social interpretations in our active lives and knitting them together into a unique life story”, as Charles Guignon puts it. If the self is a story, it is the narrative’s unity and continuity that defines who the person is. The self is not something to be found. It is something people do. The individual tends to integrate aspects of his or her life into cohesive story; moreover, this is his or her task in life. Bortolotti et al describe this tendency to create self-narratives:

People tell stories about themselves which help them recollect memories about past experiences, identify certain patterns and a sense of direction in their life events, and

225 Even though Blöser et al use examples which consider values, it is worth noting that fundamentally they are discussing what it is to be an autonomous person and to have an ability for ERCR. It is, thus, unclear whether passing the test of ERCR means that the beliefs that the person holds are authentic. For example, in the case of manipulation, the person may hold on his or her beliefs even after they are tested through experiences. Should we think that this person has internalized these originally manipulated beliefs to be his or her own, or should we think that the person has become more autonomous even though he still holds some unauthentic beliefs? It seems that Blöser et al have a latter interpretation in mind since they write about the meaning of experience: “it provides an agent with an opportunity to increase, or regain, her autonomy after cases of manipulation, brainwashing etc.” And, as long as experiences are not manipulated, “they afford her with the opportunity to question her manipulated values and thus to regain at least some autonomy”. See Blöser et al 2010, 248, 250. When it comes to people with psychosis, more questions arise. Firstly, Blöser et al note that their view of autonomy is oriented to the future: autonomy requires the capacity to respond to future experiences. However, if the authenticity of the beliefs and opinions of a person with psychotic disorder is to be tested, it is done now, in the present, and, therefore, experiences which may await the person in the future and which might test the authenticity of that person’s beliefs and opinions, are not available, yet. Secondly, the psychotic person might have the ability to engage in ERCR but since his or her experiences are governed by a psychotic view of reality, reflecting upon those experiences critically does not mean that person is necessarily authentic. Blöser et al say that experiences should not be product of manipulation, which implies that they have some requirements for experiences to be regarded as authentic. It seems that those requirements are connected to rationality. Blöser et al argue that the role of experiences is to challenge counter-evidence, and the role of evidence is central when discussing whether beliefs are in accordance with reality. Blöser et al also emphasize the role of rationality explicitly: “ERCR is important not just for being autonomous, but also for being rational”. Blöser et al 2010, 249-252.


227 Guignon 2004, 130.
have some concept of what kind of person they are, what they have achieved or failed to achieve, and what their future objectives are.  

According to Charles Taylor, the question concerning who we are requires some idea about how we have got here, and where we are going. Only a coherent narrative can make sense of one’s life as a story.  

What I am has to be understood as what I have become. This is normally so even for such everyday matters as knowing where I am. I usually know this partly through my sense of how I have come there. But it is inescapably so for the issue of where I am in moral space. I can’t know in a flash that I have attained perfection, or am halfway there. Of course, there are experiences in which we are carried away in rapture and may believe ourselves spoken to by angels; or less exaltedly, in which we feel a great surge of power and mastery over the difficulties that usually drag us down. But there is always an issue of what to make of these instants, how much illusion or mere ‘tripping’ is involved in them, how genuinely they reflect real growth or goodness. We can only answer this kind of question by seeing how they fit into our surrounding life, that is, what part they play in a narrative of this life.  

Jonathan Glover writes that the autobiographical test is one of the ways that authenticity can be tested. How a person is now does not have to be the same as how he or she used to be, but for authenticity there has to be an account of the evolution of the one out of the other. According to Glover, authentication needs “an active, self-creative autobiographical story, at least in the minimal Aristotelian sense in which my new character or personality grows out of actions I choose to perform”. Thus, the story cannot be passive, such as “they forced me and now I am like I am”.  

However, as Alasdair MacIntyre states, the narrative self of an individual is connected to tradition and, thus, an individual can never be more than a co-author of his or her narrative. Selves make sense when they are seen in the wider context of a historical culture. When people are living out their narratives, they understand them in terms and live them out in such forms which are “appropriate for understanding the actions of others”.  

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228 Bortolotti et al 2012, 108. According to Heidegger, the fact that one dies opens up the possibility to live one’s life as a coherent story, since it will come to an end someday. Confronting death opens the door to an authentic existence. Guignon describes Heidegger’s view of authenticity: “To “become who you are”, as Heidegger sees it, is to identify what really matters in the historical situation in which you find yourself and to take a resolute stand on pursuing those ends.” Guignon 2004, 133-134.

229 According to Taylor, what a person considers good is connected to his or her understanding of his or her life as an unfolding story. Orientations towards certain “goods” create our identity. Taylor, 1989, 47.


231 Glover 2003, 543.


233 MacIntyre 1984, 212-213.
It is also worth noting that formed self-narratives affect a person’s future life and where the person’s story goes. Bortolotti et al give an example of this presenting someone called Claire, who says that she does not want to go to parties because she is too tired and not confident about her driving:

Claire’s self-narrative may be false, but the fact that she can offer plausible reasons for her belief, and recognize herself in that belief, might contribute to changing the truth about what kind of person she is. And at some time in the future, she might become a person who is not confident about her driving and will go to parties only when she is not too tired.234

It has been suggested that at least some delusions are disowned and unauthored beliefs or opinions because they do not seem to be part of the person’s self-narrative. Lisa Bortolotti notes that there is a link between the ability to develop a self-narrative on the one hand and autonomous thinking and acting on the other. First, she refers to an idea that “judging whether a certain attitude is authored and integrated in a subject’s self narrative can help us predict whether that attitude can affect the decision made and the actions performed by that subject” while the focus seems to be on both the past and the present. Second, some thinkers have suggested that a person should have the ability to make choices and decisions which commit his or her future self to a certain course of action.235

Mitchell Silver refers to the idea of a story of the self in determining competence.236 According to Silver, “the search for competency is a search for a meaningful continuation of the story of a self”:

A meaningful continuation doesn’t preclude sudden and dramatic plot twists, or wholesale reinterpretations of what the story up till now has meant. So long as we can make a good autonomous story out of it, we have found a self to serve as the author of the autonomy.237

Silver also notes that decision makers in health care should be very interested in collaborating with colleagues, family members and the patient in order to find out whether there is a meaningful continuation between the patient’s present opinions and his or her past opinions.238 This seems to mean that there is a need for a communal evaluation of the person’s narrative.

According to Bortolotti, most delusions are integrated into the delusional person’s narrative, at least to some extent and with certain

236 This is a good example of a term having several meanings and that some ideas are discussed using several terms. I will use authenticity whereas Silver uses competence.
237 Silver 2002, 466-467.
238 Silver 2002, 468. See also Heal 2012, 13.
limitations: “They may be excessively compartmentalised, for instance, or justified tentatively.”

That is what makes it so difficult to discuss the relationship between delusions, subjects’ commitment to the content of the delusion, and autonomy. As authorship comes in degrees, so does the capacity to manifest the endorsement of the delusional thought in autonomous thought and action.239

Bortolotti also notes that when delusions are integrated into self narratives it may be devastating to give them up:

Suppose I have mistakenly believed for some time that I am a news presenter at the BBC. As a consequence of this delusion, I tell people in the pub about my life in the spotlight, always on TV, and about my good salary and my exotic holidays. But in real life I am jobless, I live on benefits, and I have no real friends. What will happen if I am ‘cured of’ my delusion? I will start doubting that I work for the BBC, but will also appreciate that everything I thought to be true about myself was false. I will start seeing my life as it really is, empty. The effects of making one’s self narrative correspond to reality can be devastating, and many subjects experience serious depression when they acquire insight into their illness.240

It seems that the ability to create a coherent life story is connected to the ability to engage in reflection. For example, people with psychosis who develop an understanding of themselves after the crisis and life changes caused by their psychotic disorder face questions concerning the coherence of their narratives. Questions about who I used to be and where I will go are central for authenticity. On the other hand, creating a coherent story seems to be possible through reflection. Even huge changes like converting from one religion to another can be presented as a coherent story, but some reflection is required here for authentic converting. The person has to be able to explain why he or she took this turn and where he or she is planning to go next and why.241 Therefore, it seems to me that the idea of authenticity which is manifested by the presence of a coherent story might be one way of understanding what the ability to engage in reflective self evaluation is about. When ability to engage in reflective self evaluation is considered from the viewpoint of a coherent story, the focus of reflection is on the person’s history, present and future.

However, Bortolotti et al go further when they distinguish between a capacity to self-governing and success in self-governing. While a capacity to self-governing signifies being the author of one’s beliefs and depends on the coherence of the story, success in self-governing, in addition to coherence of the story, depends on how that person’s self-narrative corresponds to real life

239 Bortolotti 2010, 252.
240 Bortolotti 2010, 256. See also Bortolotti et al 2012, 117.
241 Compare with chapter 4.4.3. See Betzler 2009, 64-65
events.\textsuperscript{242} Thus, it seems that while capacity to self-governing (or authority of one’s beliefs) refers to ideas of epistemological coherence theory, success in self-governing also refers to the ideas of epistemological correspondence theory.\textsuperscript{243}

When it comes to people with delusions, Bortolotti et al claim that they “retain the basic capacity for self-governance but are unlikely to be successful at governing themselves due to their typical failures of rationality and self-knowledge”\textsuperscript{244}. Since a narrative requires coherence and because there are many things which affect a person’s behaviour, a narrative story is sometimes created “at the cost of distorting facts”. The problem with delusions is, according to Bortolotti et al, that the person put too much weight on some of his or her experiences and, in order to retain coherence, he or she has to distort some other experiences. This tendency makes a person with delusions an “unreliable narrator”.\textsuperscript{245} Though in general it is beneficial to create a coherent wholeness from one’s beliefs, it is not so when it comes to delusions:

Delusions that are rationalized become ingrained and may lead to further false beliefs and to avoiding considering evidence that would lead to the revision of the delusions.\textsuperscript{246}

It seems that if the distinction presented in chapter 4.1.1. is applied here, authority of beliefs implies authenticity while successful self-governance implies self-fulfilment. Thus, even though delusions might sometimes be authentic beliefs or thoughts, self-fulfilment might be impossible because a delusional person fails to recognize what reality is really like. It seems, that successful self-fulfilment requires mental competence, namely, sufficient ability to see what follows from one’s actions in reality. However, if we accept that many people with psychosis have authentic beliefs and opinions (because their narratives are sufficiently coherent), it does not seem to be justified to medicate them in order to promote their competence or their ability to achieve self-fulfilment, if the \textit{forum internum} is an absolute right that protects holding of authentic beliefs and opinions.

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{242} Bortolotti et al 2012, 100.
\item \textsuperscript{243} For coherence theory and correspondence theory, see chapter 2.1.2.
\item \textsuperscript{244} Bortolotti et al 2012, 102.
\item \textsuperscript{245} Bortolotti et al 2012, 111-114. Bortolotti et al also refer here to Kapur (2003). For a discussion about Kapur, see chapters 3.2.4. and 5.3.3. See also Glover (2001, 265-273), who describes how belief systems worked during World War II: the rigidity with which one might hold certain beliefs may lead to self-deception and distort views of reality.
\item \textsuperscript{246} Bortolotti et al 2012, 114.
\end{enumerate}
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4.5. Idealistic freedom of belief and opinion?

I will now clarify and summarize the challenges presented by the view of freedom of belief and opinion in terms of authenticity. I have already made many criticisms of the view of freedom of belief and opinions in terms of authenticity. However, I haven’t yet looked carefully at the relationship between authenticity and rationality. Even though it is necessary to make a distinction between the view of freedom of belief and opinion in terms of authenticity and in terms of rationality, as I did in chapter 4.1., it seems that the way in which authenticity is evaluated from an internalist viewpoint, once again puts rationality centre stage.

It seems that self evaluation (chapter 4.4.1.) and recalcitrance (chapter 4.4.2.) seemed to be inadequate or insufficient criteria for evaluating the authenticity of the psychotic individual’s beliefs and opinions. The problem was that, according to these criteria, delusions would be defined as authentic, which from the viewpoint of psychiatry are clearly symptoms which should be treated, even if that means involuntary treatment. The ability to engage in reflective self evaluation (chapter 4.4.3.) and the ability to tell a coherent narrative of oneself (chapter 4.4.4.) seemed to be better criteria for determining the authenticity of the psychotic individual’s beliefs and opinions. However, both of those abilities seem to require rationality from the individual who has those abilities. That is, the person has to consider contra-evidence and defend his or her beliefs or opinions by citing some reasons. Even though these reasons may not be epistemologically justified, they cannot be whatever kinds of expressions since there has to be some kind of link to the content of the delusion. This seems to require rationality. When it comes to narratives, they need to be comprehensible for others in order to be recognized as coherent stories. To be able to create a coherent story requires rationality. It also seems that when these evaluation criteria for authenticity are under consideration connections to the view of psychosis as irrationality are revealed. Incomprehensibility and agential irrationality in particular seem to be very relevant here.\footnote{See chapter 2.1.2. Bortolotti (2010, 63) describes the supposition that the person who believes or thinks something incomprehensible cannot really mean what he or she says: “Subjects with delusions are often charged with having incoherent beliefs systems, or dissonant attitudes. These are cases in which subjects with delusions endorse conflicting statements in the same stretch of conservation, where one statement implies the falsity of the other. In those circumstances, it is tempting to say that the subject’s reports are too badly integrated with the subject’s beliefs to be themselves reports of beliefs, or that the subject is using words and uttering sentences without appreciating their meaning.” Agential rationality is also connected to authenticity (or being an author of one’s beliefs and opinions). However, Bortolotti (2010, 178) points out that authority should be distinguished from agential rationality. The former requires, according to Bortolotti, that the person is able to give his or her best reasons when defending his or her belief. The latter requires that the person is able to give reasons for his or her belief which are intersubjectively}
psychotic people is being considered the concept of rationality is sometimes referred to in one way or another. Psychosis can be defined as a lack of rational autonomy.²⁴⁸

However, the ability to engage in reflective self evaluation and the ability to tell a coherent narrative of oneself as evaluation criteria for authenticity seem to be so demanding that, for example, the beliefs and opinions of children cannot necessarily be evaluated as being authentic if these criteria are applied. However, my suggestion is that we should make a distinction between mental competence (which children, in general, might not sufficiently have) and authenticity (which children, in general, might sufficiently be, at least if we apply Feinberg’s description presented in chapter 4.1.1. and the commonly held view which states that “children are genuine” and in this sense authentic).²⁴⁹ It seems that criteria which require the ability to engage in reflectivity and the ability to create a coherent narrative can be applied only when the beliefs and opinions of adult people with normal intelligence are evaluated. However, one may still ask whether these criteria are too demanding. If these abilities were required from all adults with normal intelligence, in the same way that they are required from individuals with psychosis, in order to conclude that their beliefs and opinions are authentic, it might follow that many people without psychosis would be revealed as holding excessively unauthentic beliefs and opinions. If these people’s views were indeed found to be unauthentic, the state would have a duty to liberate them, even to the point of interfere with their negative liberty in order to do so.

I see two different ways of analysing this problematic conclusion concerning excessively demanding criteria for authenticity. First, authenticity as a concept refers to several traditions which emphasize different features, and in which the view of the Enlightenment and the view of Romanticism are both present. Could it be that the view of Romanticism is emphasized to the

²⁴⁸ See Kaltiala-Heino 1997; Kaltiala-Heino 1995, 13. Reiser (1980, 331) refers to the concept of rationality when he writes: “Psychiatrists should seek public authorization to intervene therapeutically against the wishes of patients when substantial evidence exists that the individual cannot decide the matter rationally and, additionally, when the proposed therapy holds substantial promise of improving the condition in question.”

²⁴⁹ We may of course deny that children are sufficiently authentic. However, in that case we are probably arguing that authenticity is something which requires some abilities or maturity, not something which is described as being who “the person really is”. If we adopt a view of authenticity which is interested in people being sufficiently what they “really are”, children, in general, should be seen as being sufficiently authentic, taking into account that they are children and not adults. We could even ask that if children had the abilities and maturity typical in adults, would they be who they really are as children? This does not mean, of course, that some exceptional children with high abilities should be defined as unauthentic, but I suspect that we cannot, in general, demand such abilities from children.
point where beliefs and opinions with too irrational a content come to the fore? After that point the view of authenticity is rooted more in the tradition of the Enlightenment, which emphasizes and requires more than was the case before. This would mean that people with psychosis should be able to reflect upon and consider their beliefs and opinions in a more rational way than other people are. In this method of analysis, authenticity is applied in two ways: the one rooted in the Enlightenment for psychotic people and the one rooted in Romanticism for others.

When I considered the relationship between competence and rationality in chapter 3.4.2, I came to the conclusion that the shared nature of beliefs and opinions is crucial when a person’s status as a competent decision maker is being evaluated. When it comes to evaluating authenticity, it seems that the focus is more on the formal rationality of beliefs and opinions. Even though it has been emphasized that authentic choices need not be rational, it seems that in order to be interpreted as an authentic choice the person needs to give a thoughtful and coherent explanation of his or her beliefs and opinions in order to show that this is really his or her choice (at least in cases where other people consider the person’s choice unwise). Thus, the ability to rationalize is required when such a person expresses and describes his or her thinking and believing processes to others. This implies that in the case of adult people with normal intelligence the *forum internum* protects believing and thinking *processes* which seem to be sufficiently rational, that is,

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250 Fulford et al describe the same kind of problem when they notice that not all irrationality impairs autonomous choice, since all people are irrational sometimes. They note that in the justification of involuntary treatment it is psychotic irrationality, which matters, but it is not obvious why it is like that. Fulford, Thorton & Graham 2006, 510. They pay attention to the tendency to take the psychiatric diagnosis as a value-free fact and to base the conception of irrationality and lack of competence on the diagnosis. They note, that Beauchamp & Childress, for example, even though they consider rationality as a value-laden concept, do not consider the medical diagnosis as value-laden. However, Fulford et al argue that a diagnosis of psychotic disorder is deeply connected to the concept of rationality and, therefore, the justification of involuntary treatment is deeply value-laden. Fulford, Thorton & Graham 2006, 511-512.

251 See, for example, Feinberg (1973, 50), who describes an imaginary case where one has to decide whether a person’s decision to cut off his or her hand is really an authentic choice: “The point of the procedure would not be to evaluate the wisdom or worthiness of a person’s choice, but rather to determine whether the choice really is his.” See also Feinberg (1986, 67): “An autonomous being has the right to make even unreasonable decisions determining his own lot in life, providing only that his decisions are genuinely voluntary (hence truly his own), and do not injure or limit the freedom of others.” Feinberg (1986, 106) makes the distinction between irrational and unreasonable choices: “If a person is severely retarded or deranged, or suffering from what lawyers call “insanity,” then his “choices” (if the word applies at all) are likely to seem wildly irrational – patently inappropriate means to his own ends, invalid deductions from his own premises, gross departures from his own ideals, or actions based on grotesque delusions and factual distortions. Since the deranged or retarded person is incompetent in such ways, his irrational choices are not truly his - not “fully voluntary”. “Unreasonable choices,” however, are commonly made by fully competent persons in full command of their rational faculties.”
sufficiently coherent, for others. However, performing sufficiently rational processes seems to require the ability to be sufficiently rational.

The crucial question is whether there is a conceptual difference between the view of freedom in terms of authenticity and a view of freedom in terms of rationality. At the first sight it seems that there is. The first view focuses on the process of believing and thinking and on the ability to give a thoughtful and coherent explanation, while the latter view focuses on the content of the beliefs and opinions and on their correspondence with reality. While the first, at least in principle, allows many kinds of contents and focuses on the process (which requires certain abilities), the second one might not care about the process if the conclusions of the person are “right”. The difference between freedom of belief and opinion in terms of authenticity and in terms of rationality can be clarified by referring to a situation “in which a benign manipulator ensures that a prospective knower believes only truths”:

In this scenario, the manipulator monitors the belief formation of the manipulated agent and intervenes unbeknown to her, only if she is on the verge of acquiring a false belief. The prospective knower ends up holding only true beliefs. Yet, her epistemic agency is undermined by the implicit manipulation of her reasoning.\(^{252}\)

On the other hand, if we evaluate and define delusions on the grounds of their content and if we state that delusions are unauthentic beliefs and opinions, which is sometimes the case in psychiatry, we seem to adopt a view of freedom of belief and opinion in terms of rationality. Even though many kinds of contents are allowed, there seem to be some kinds of core beliefs and opinions which the person has to hold in order to be defined as free. The other problem is that even though the process may be emphasized when defining delusions, people are actually interested in and come to evaluate the process only after they are faced with the exceptional content of the beliefs and opinions or exceptional actions (manifestations of contents). In practice, delusional content seem to be some kinds of sign which indicates that everything is not all right with the process. If the contents were more typical, the processes would not necessarily be considered at all. In this way it seems that in practice the view of freedom of belief and opinion in terms of rationality might be adopted even though the view of freedom of belief and opinion in terms of authenticity is defended in theory. Moreover, if an excessively strong epistemological justification (even though it concerns the process of thinking and believing) is required for beliefs or opinions to be defined as authentic, we seem to end up with a society where academic philosophy has, in principle, the power to decide what is defined as free and what is defined as unfree thinking and believing.\(^{253}\)

\(^{252}\) Fulford & Radoilska (2012, 65-66) refer here to a thought experiment set out by Linda Zagzebski.

\(^{253}\) Compare with the problematic relationship between the formal and contentual interpretations of

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The other way to analyse the relationship between the view of freedom of belief and opinion in terms of authenticity and in terms of rationality is to claim that well-being is more crucial and more fundamental requirement for authenticity than rationality. When this is done, it can be argued that the well-being of a child is visible in a different way than the well-being of an adult with normal intelligence. In the latter case there is the idea that well-being brings an ability to be rational. When an adult person with normal intelligence does not appear to be well, the authenticity of his or her beliefs are tested in a way which requires rationality. It seems that the need to evaluate the authenticity of a person’s beliefs and opinions is also increased if the person is rude to others.  

This way of understanding might be connected to the supposition that contributions of the true self are positive. However, if it is thought simply that actions which increase a person’s health promote the person’s own good, it seems to follow that an authentic person would not compromise his or her own health. When healthiness and authenticity come together in this way, the view about freedom turns out to be narrower. It actually seems that decision that result in unhealthy outcomes could not be regarded as the product of free choices and, therefore, outsiders should always guide the person to lead a healthy life and quite often even interfere in that person’s negative liberty in order that he or she will reach this goal. Thus, the view of freedom in terms of authenticity (if it is interpreted in this way) is paternalism (even though it is not called paternalism since the person’s “true will” is not restricted).

It seems that if too strict an epistemological justification is demanded or if it is thought that an individual’s true choices must be those that promote his or her well-being, the threats connected to the view of freedom in terms of rationality (which I described in chapter 4.1.1.) seem to be hiding just around the corner. The threats connected to this structure of thinking is described by Isaiah Berlin when he discusses how the use of coercion might be rationalized:

I may declare that they are actually aiming at what in their benighted state they consciously resist, because there exists within them an occult entity – their latent rational will, or their ‘true’ purpose – and that this entity, although it is belied by all that they overtly feel and do and say, is their ‘real’ self, of which the poor empirical self in space

competence considered in chapter 3.4.2.

254 To claim that well-being is more fundamental requirement for authenticity than rationality could throw some light on why it is not considered a violation of human rights to tell a child that Santa Claus will not bring him or her presents if he or she does not behave properly (which is, conceptually, a form of manipulation). I considered this conceptually problematic issue in chapter 4.1.3.

255 See Guignon 2004, 93-94.

256 See chapters 4.3.2. and 4.3.4.
and time may know nothing or little, and this inner spirit is the only self that deserves to have its wishes taken into account. Once I take this view, I am in a position to ignore the actual wishes of men or societies, to bully, oppress, torture them in the name, and behalf, of their ‘real’ selves.  

There is a threat that the view of the psychotic person’s suspected unauthenticity is misused. How can it be ensured that a patient’s beliefs and opinions, whatever they are, are not interpreted too easily and without questioning as being unauthentic and thus unfree only on the grounds of the diagnosis which he or she has been given? Riittakerttu Kaltiala-Heino has noted that instead of trying to understand what patients try to say and what they say they experience, their views can too easily be labelled as deviant.  

One can ask whether there is a danger that a diagnosis of psychosis provides others with a kind of justification to consider everything that the patient expresses as unauthentic and, thus, unfree. Might there be a danger that the psychotic patient’s expressed wishes will just be ignored or they are not even asked what their wishes are because the nursing staff might think that “it is not worth asking since he or she cannot express anything true, authentic and free anyway because of the psychosis”?  

From the viewpoint of human rights theory, the crucial question is whether human rights which require positive acting from others can be defined as absolute. Is it meaningful to accuse “nature” or “something not human” as a violator of absolute human rights as is the case if psychotic disorder is seen as an alien power which violates the forum internum? If we look at an such absolute right like the right to be free from torture, it would sound weird to accuse “something not human” as violating a person’s absolute human rights if somebody has, for example, fallen from a precipice and suffers for a long time after the accident before he or she finally dies because there is nobody nearby to help him or her, or even if there was, they were unable to relieve the pain. The right to freedom from torture cannot be interpreted in this way. So is it, similarly, inappropriate to argue that the psychotic disorder has violated the person’s right to the forum internum? Psychosis cannot be defined as being juridically responsible for violating someone’s rights. It might be that psychosis can be discussed as a violator only in the metaphorical sense and that this discussion should not be connected at all to juridical thinking. It has been claimed that if there are absolute rights they can only be negative ones which oblige other people in a

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257 Berlin 2005, 180. See also Fulford & Radoińska 2012, 52.
259 For example, it seems that Pietarinen (1995, 45-46) thinks he knows what a drug-addict or a patient with depression wants. Pietarinen speaks about their real interests, which are, according to Pietarinen, to get off drugs (in the case of drug-addicts) and to be free from their depression (in the case of patients with depression). However, does Pietarinen really know that these are those people’s real interests?
negative sense.\footnote{See Feinberg (1973, 88), who states: “It is another question as to whether there are such rights [absolute and exceptionless rights], and what they might be. The most plausible candidates, like the right not to be tortured, will be passive negative rights, that is rights not to be done to by others in certain ways. It is more difficult to think of active negative rights (rights not to be interfered with) or positive rights (rights to be done to in certain ways) as absolute exceptionless. The positive rights to be given certain essentials – food, shelter, security, education – clearly depend upon the existence of an adequate supply, something that cannot be guaranteed categorically and universally...Clarity will best be served, I think, if we keep “absoluteness” out of the definition of “human right.”” It is worth of noting that there might be an absolute moral duty to do something. For example, Kant and Catholic natural lawyers have emphasized the existence of absolute, positive, moral duty. According to Boyle (2001, 74), for Kant, absolute duties are “always in force even though they sometimes cannot prescribe that a particular action should be done” and he continues: “Moreover, they can be formulated as prohibitions against failing to form and act on some plan of self-perfection and beneficence.” However, this is not the same as an absolute legal duty to do or not to do something.}

However, if we don’t consider that psychotic disorder is something that violates the forum internum, it is questionable whether we can defend any justification concerning the involuntary use of antipsychotic medication.

It also seems that if authentic beliefs and opinions are those which promote well-being or those that satisfy a relatively strict criterion of rationality, humanity will be seen in such a positive light that it is worth asking whether this is too idealistic. If authentic beliefs do indeed promote well-being and are, necessarily, rational we seem to be saying that to be bad and irrational are always marks of madness or some other kind of unauthenticity. The view of authenticity seems to ignore impulses which turn out be destructive for at person or to others because they are unauthentic. For example, D. Meyerson has claimed that some views of authenticity ignore the dark side of humanity. According to Meyerson, authenticity should be understood in the light of people’s natural dispositions. An authentic person reflects these natural dispositions in his or her behaviour. However, Meyerson points out that it is not always a good thing to be authentic, since sometimes other values, which are thought to be more important, may conflict with authenticity. The person might have, for example, a natural disposition to violence but he or she should not act violently in what might be seen as an authentic way because other people would suffer.\footnote{Meyerson 1998, 463-465. However, the problematic issue here is how to distinguish between the natural dispositions which the person should be able to reflect in his or her behaviour and the natural dispositions which he or she should not be able to so reflect. At the same time that Meyerson questions the view that there is something valuable in being authentic, she also values authenticity, for example, when she discusses cases in which people have had an upbringing “in which all their natural impulses and interests have been labelled “bad”, and everything they feel is alien to them has been labelled “good””. Other people, whom Meyerson calls luckier, had parents “who were sensitive to their natural dispositions and promoted the development of their natural talents”. Meyerson 1998, 461. So, whilst it is not self-evidently valuable to be authentic, there is, however, some value in authenticity and, as far as I can see, Meyerson does not make it clear, why some qualities of a person should be cultivated and others should not. The obvious point is that}
express a more realistic view of humanity. From this point of view, psychosis could be seen as an authentic experience. However, this does not mean that the person would have a right to be psychotic or act in a psychotic way.

The question arises whether authenticity is a description of a person’s moral duty, a description of what a person ought to be and what he or she should seek. The focus does not seem to be on what the person really is like but more on what he or she ought to be. If authenticity signifies a moral duty to be good, it might be reasonable to claim that a person should be legally allowed to search for his or her authentic self. However, it does not seem reasonable to argue that a person has an absolute legal duty to be authentic in this sense or has an absolute legal right to receive help from others in order to be a good human being.  

If we adopt a more realistic view of authenticity, which would recognize that destructiveness may also be authentic, and if we accept the conclusion that a person may, at least in some cases, be the author of his or her delusions, we seem to face a problem in relation to the forum internum. Namely, if the right to the forum internum signifies the right to hold authentic beliefs and opinions, it would follow that some people with delusions should also be left without involuntary antipsychotic medication in cases where they are seriously incompetent and not able to achieve self-fulfilment. It would not be justified to promote mental competence if it could not be done without interfering with authentic beliefs and opinions. Since absolute rights should be defined in such a way that conflicts between them are conceptually

other people’s rights restrict the authentic behaviour of people, but when it comes to the need to restrict impulses which are connected to a person’s own good and his or her view concerning what is best for him or her, the question regarding what impulses should not be expressed and which should is more difficult. See Meyerson 1998, 460-464. Moreover, since Meyerson concentrates on questions concerning behaviour which reflects natural dispositions, it is difficult to say what kinds of beliefs reflect our natural dispositions. Therefore, it seems difficult to apply Meyerson’s view to the context of freedom of belief and opinion. Feinberg (1986, 33) also refers to the idea of reflecting natural dispositions when he writes that an authentic person selects his or her life style to match his or her temperament. Schechtman (2004, 415) also describes authenticity as something which is natural to a person. However, she states some requirements for what can be defined as natural and thus authentic, and one of these is that inclinations that are going to constitute part of someone’s true self “must not have their origin in an obvious physical or psychological pathology”, and she identifies brain tumors, physical addictions, obsessive-compulsive disorder, and similar sources of impulsive desire as specific examples. Thus, Schechtman’s description seems to consider authenticity as an ideal which leads to a narrowing of what might be regarded as natural and authentic inclinations. Second, since Schechtman mentions, for example, addiction and obsessive-compulsive disorder as unauthentic states, the requirements of authenticity are potentially more demanding than the requirements in current jurisprudence. Since non- or involuntary treatment is not justified in cases where a person suffers from addiction or obsessive-compulsive disorder, it implies that people with these disorders are considered sufficiently authentic to make their own decisions.

See Guignon 2009, 141, 150.
impossible, it seems that the right to the *forum internum* cannot signify both authenticity and a negative right to mental competence. Thus, it seems that to define the *forum internum* in terms of a negative right to mental competence, as I suggested in chapter 3.4.4., might be a better way to protect the individual with psychosis than defining it in terms of authenticity.

Even though both the concepts of authenticity and mental competence are difficult to define and evaluate, mental competence seems to have clearer and more general requirements than authenticity does. It also seems that the concept of authenticity refers to being as such: who you really are. The concept of mental competence, instead, refers to the abilities as such as they occur to us. When looked at in this way the concept of mental competence seems to be more applicable to legal thinking than the concept of authenticity is.

Moreover, the view of freedom of belief and opinion in terms of authenticity does not value the aspect of sharedness as much as the view of negative liberty does, since the idea is that shared beliefs and opinions can be a threat to authenticity. The person may be manipulated, and thus, unauthentic. However the question arises as to whether the background supposition which highlights the independence of the person is unrealistic. Are people really independent and is independence even a goal of humanity? Thus, is there something wrong with the background suppositions if freedom of belief and opinion is understood in terms of authenticity? Could, for example, problematic situations of manipulation be defined conceptually in a different way so that sharedness would not be defined as such a threat from the beginning as seems to be the case when authenticity is discussed? For example, when the problem in being manipulated is a lack of proper information, we can discuss, in the context of negative liberty, whether the person is sufficiently competent to give informed consent. Moreover, as a use of power, influencing someone by means of manipulative techniques can also be seen problematic from the viewpoint of capability, which I will discuss in chapter 5. In this case, problematic philosophical suppositions concerning the

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261 See Feinberg 1973, 87. When it comes to the absolute right not to be tortured, Feinberg notes that “conflicts” between absolute rights are possible only as creations of human beings: for example, there might be in a case of blackmail a situation where one person is required to torture somebody and if he or she does not do so, somebody else somewhere else will torture somebody else. In that case, there seems to be a conflict between different people’s absolute right to be free from torture. However, Feinberg notes that in these kinds of cases the conflict is not real because the bad thing that will happen if the person does not torture somebody is caused by other people’s acts and so it is those people who are responsible for the violation of someone’s absolute rights, not the person who decides not to torture the other person despite there being bad consequences. If something bad happens it is, thus, the fault of those people who cause this bad thing to happen. According to Feinberg, “nothing in nature itself can ever bring such a conflict into existence”.

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“true self” are not needed, which is the reason why the view of capability might be more applicable in legal human rights theory.

Thus, it seems that there are several problems in the view of freedom of belief and opinion in terms of authenticity. These problems might be the reason why the view of authenticity has not been adopted in human rights theory, at least not explicitly. These problems are also the reason why I tend to reject understanding freedom of belief and opinion in terms of authenticity. If we consider the view of freedom of belief and opinion in the negative sense as being too narrow, the view of freedom in terms of authenticity is not where the interpretation of the freedom of belief and opinion should be widened.
5. The psychotic individual’s freedom of belief and opinion in terms of capability

In chapter 5, I ask whether it might be useful to widen the view of freedom of belief and opinion in the negative sense to the direction of capability. I will define how freedom of belief and opinion and the impediments to it are understood and what factors in psychotic people’s lives turn out to be meaningful if freedom of belief and opinion is discussed in terms of capability. I also clarify on what kinds of discourses, concepts and presuppositions this view is based and what kinds of challenges we face when we discuss capability in the context of human rights theory.

5.1. The concept of capability

In this subchapter, I define the concept of capability as a human right and consider how it might be realized and its limitations. In the end, I describe how freedom of belief and opinion is understood in terms of capability. The purpose here is to consider the concept of capability and freedom of belief and opinion in terms of capability in general. I will proceed to apply this view to the context of individuals with psychosis in later subchapters.

5.1.1. Definitions of capability

The term capability comes from the term capable, which has roots in the Late Latin word *capabilis*, which means receptive and to be able to grasp or hold.\(^1\) In this study freedom in terms of capability signifies that the individual is capable of choosing a way of life which he or she considers valuable and which is worthy of human dignity.

The capability approach towards freedom has been represented for example by Amartya Sen, who argues that a person is free when he or she is able to lead his or her life in such a way that life is valuable to him or her.\(^2\) According to Martha Nussbaum, the capability approach, also known as the capabilities approach and the human development approach, is interested in what people are actually able to do and to be and what real opportunities are

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\(^1\) Online Etymology Dictionary: Capability, Capable.

\(^2\) Sen 2000, 9-10. Sen (2009, 228) describes freedom, as follows: “Freedom is valuable for at least two different reasons. First, more freedom gives us more opportunity to pursue our objectives — those things that we value. It helps, for example, in our ability to decide to live as we would like and to promote the ends that we may want to advance...Second, we may attach importance to the process of choice itself.”
available to them. When freedom is understood in terms of capability, different aspects of human life are brought together. Sen’s central claim is that the different kinds of freedoms strengthen each other, while Nussbaum emphasizes that “the most important elements of people’s quality of life are plural and qualitatively distinct: health, bodily integrity, education, and other aspects of individual lives cannot be reduced to a single metric without distortion”. This is also the reason why Nussbaum prefers the term “capabilities approach” instead of “capability approach”. I will use the term capability in the singular when I focus on defining a concept of freedom or discuss the freedom of belief and opinion. When I discuss the capabilities approach in general, I will use the plural.

The intertwining nature of human rights has also been recognized in human rights theory. For example, civil and political rights (CP rights) and economic, social and cultural rights (ESC rights) are often reconciled in the international research on human rights. The purpose of all human rights has been seen to be the same, since all rights seek to secure as wide a degree of factual freedom and safety as possible. It is common to argue in the discussing human rights that human rights from different generations constitute a single wholeness. Therefore, they support and need each other. The developers of the capabilities approach have suggested that its nature is political and that it could be seen as a kind of human rights approach. Nussbaum notes that human rights have often been linked to the idea of human dignity in a way similar to that found in the capabilities approach. The capabilities approach also has universal nature: capabilities are considered important for each and every citizen in each and every nation.

Freedom in terms of capability can be divided in to internal capabilities and external opportunities or conditions. According to Nussbaum, internal capabilities are personality traits, intellectual and emotional capacities, states of bodily fitness and health, internalized learning, and skills of perception and movement. Nussbaum describes internal capabilities:

they are trained or developed traits and abilities, developed, in most cases, in interaction with the social, economic, familial, and political environment. They include such traits as

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3 Nussbaum 2011, x, 18-19. See also Sen (1985, 138), who describes capabilities as something which specify what a person can or cannot do or can or cannot be.
4 Nussbaum 2011, 18; Sen 2000, 3-11.
5 However, I acknowledge that in the context of the capabilities approach it is not possible to make a clear distinction between this particular human right and other human rights since they are intertwined with each other.
7 Nussbaum 2006, 78. See also Nussbaum 2006, 91, 155, 284-285. On the relationship between the ideas of human dignity and human rights, see chapter 2.2.2.
Vasanti’s learned political skill, or her skill in sewing; her newfound selfconfidence and her freedom from her earlier fear.9

External opportunities or external conditions are, according to Nussbaum, social, political and economic conditions which allow a range of choices and which together with internal capabilities may be defined as combined capabilities.10 According to Sen, freedom depends on social and economic arrangements, which includes, for example, facilities for education and health care. Sen also points out that the “freedom to participate in economic interchange has a basic role in social living”.11 Nussbaum emphasizes the role of social conditions by describing the case of Vasanti:

During her marriage, Vasanti was cut off from all relationships except the highly unequal one with her abusive husband. She did not have friends, she was unable to work, she did not participate in politics. This is the lot of many women in abusive relationships, but it is particularly common for women whose caste status makes it shameful for them to seek employment outside the home. Uppercaste women like Vasanti are often worse off than lower-caste women, who can circulate freely.12

Social values and prevailing mores, such as gender equity, the nature of child care, family size, fertility patterns and the treatment of the environment also influence freedom.13

Internal capabilities and external opportunities affect each other. This can be seen in Sen’s claim that the capability to achieve functions constitutes the person’s freedom to have well-being. He calls this aspect of freedom “well-being freedom”. Relevant functions to this well-being freedom are, according to Sen, being adequately nourished, being in good health, avoiding escapable morbidity and premature mortality, among others.14 It is clear that, for example, the external opportunity of being adequately nourished influences one’s internal capabilities. On the other hand, if a person has sufficient internal capabilities he or she may have better opportunities to ensure that he or she is adequately nourished in a situation where it is challenging to be nourished.

Those who defend the capabilities approach make a distinction between capabilities and functionings. According to Nussbaum, functionings are beings and doings which are the outgrowths or realizations of capabilities.15 However, capabilities are “spheres of freedom and choice”, as

9 Nussbaum 2011, 21. Vasanti is a woman whose life Nussbaum uses as an example.
10 Nussbaum 2011, 22; Nussbaum 2000, 84-85.
11 Sen uses the concept of instrumental freedoms to describe distinct types of freedom, namely political freedoms, economic facilities, social opportunities, transparency guarantees and protective security. Sen 2000, 3-11.
12 Nussbaum 2011, 9.
13 Sen also notes that public discussion and social interactions influence values. Sen 2000, 9.
15 “Functioning is an active realization of one or more capabilities. Functionings need not be
Nussbaum puts it. Freedom in terms of capability is not the freedom to do something particular, but the freedom to choose, which assumes an opportunity to select. According to Nussbaum, options are freedoms.\textsuperscript{16} Sen describes the idea, as follows:

> The focus of the capability approach is thus not just on what a person actually ends up doing, but also on what she is in fact able to do, whether or not she chooses to make use of that opportunity.\textsuperscript{17}

Nussbaum compares a person starving and a person fasting to explain the difference between functionings and capabilities:

> a person who is starving and a person who is fasting have the same type of functioning where nutrition is concerned, but they do not have the same capability, because the person who fasts is able not to fast, and the starving person has no choice.\textsuperscript{18}

Sen also emphasizes that the choices that are available should be something the person values, things that he or she may value doing or being. A person has to be free to determine what he or she wants and values and ultimately what he or she decides to choose.\textsuperscript{19} Nussbaum states, that a good society “ commits itself to respect for people’s powers of self-definition”.\textsuperscript{20} It seems that Harvard Lillehammer’s discussion concerning choice autonomy comes close to the view of freedom in terms of capability:

> an agent has choice autonomy with respect to a given option only if the agent is faced with a non-empty set of (in the relevant circumstances) reasonable options between which to choose.\textsuperscript{21}

In chapter 3.3.4. (in the context of freedom of belief and thought in the negative sense), I mentioned that there is a wide view of the right to self-determination which includes a right to negative liberty and a right to

\textsuperscript{16} Nussbaum writes: “Some political views deny this: they hold that the right thing for government to do is to make people lead healthy lives, do worthwhile activities, exercise religion, and so on. We deny this: we say that capabilities, not functionings, are the appropriate political goals, because room is thereby left for the exercise of human freedom. There is a huge moral difference between a policy that promotes health and one that promotes health capabilities – the latter, not the former, honors the person’s lifestyle choices.” Nussbaum 2011, 25-26.

\textsuperscript{17} Sen 2009, 235. See also Sen 1985, 139.

\textsuperscript{18} Nussbaum 2011, 25.

\textsuperscript{19} Sen 2009, 231-232.

\textsuperscript{20} Nussbaum 2011, 18.

\textsuperscript{21} Italics Lillehammer’s. Lillehammer 2012, 197.
competence. It seems that this wide view of self-determination is quite similar to the view of freedom in terms of capability. In the wide view of the right to self-determination, competence is not only mental competence (which is seen as a requirement of freedom in the negative sense), but also includes competence of action, which has also been called autonomous action, as is the case with Veikko Launis:

Autonomy of action means that the person is able to realize the plans which he or she has built up on the grounds of his or her own beliefs and wants. This requires, apart from an ability to engage in physical action, also many kinds of knowledge and skills. One should also be able to control different kinds of emotions like fear and insecurity.  

One could also discuss the possibility to act autonomously, which Juhani Pietarinen describes, as follows:

We could call a person autonomous when he or she is able to plan his or her life and at least in some degree realize his or her plans, which means that he or she is able to set goals for his or her action and choose the means for realizing the goals.

It seems that in these descriptions competence, or autonomy, is regarded as a wider concept than that of mental competence that is a requirement of negative liberty. The view of freedom in terms of authenticity might also be included in these definitions of competence or autonomy (since Launis writes about a person’s own beliefs and wants and Pietarinen about his or her plans), but as far as I can see, freedom can be discussed in terms of capability without discussing it in terms of authenticity (and it is not clear whether Launis and Pietarinen combine these views of freedom in this context). Thus, it is possible to adopt a view of freedom in terms of capability and still reject the view of freedom in terms of authenticity.

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24 It can also be claimed that without sufficient education, the recognition of individual talents and respecting differences which provide equal opportunities, it is challenging for a person to live an authentic life which provides self-fulfilment. See Guignon 2004, 161-162.

25 Lillehammer (2012, 201-204) points out that authenticity and competence are often seen as requirements of capability (he speaks about agent autonomy and choice autonomy), since it has been claimed that only choices which have an autonomous source should be respected. However, he gives plenty of reasons why a person’s ability to make choices should be supported and that the choices he or she has made should be valued even though he or she might not be considered sufficiently competent and authentic. For example, respecting these choices helps the other person become more competent and authentic, and the frustrations and unpleasant feelings which a person might experience if he or she is not allowed to make choices might be avoided. However, it
However the view of freedom in terms of capability and the wide view of the right to self-determination also seem to be different. In the wide view of the right to self-determination there is a background supposition that the human being is independent (connected to the view of freedom in the negative sense), which is not shared by the capabilities approach. Nussbaum emphasizes that sociability and vulnerability, even dependency, are central parts of humanity.26 This reminds us of how relational autonomy is discussed in feminist perspectives. From a feminist viewpoint, personhood is formed in human relationships, “which may endorse or inhibit autonomy”, as Eeva Nyrövaara puts it.27

The situation where the individual is capable of choosing a way of life which he or she considers valuable and which is worthy of human dignity seems to have two sides. One side is that nobody prevents the individual from doing something that he or she would otherwise do. Right to freedom in the negative sense seems to protect this side. The other side is that in order to choose a way of life which the person considers valuable and which is worthy of human dignity, he or she needs some resources and help from others. This means that an individual’s right to freedom in terms of capability creates also positive obligations for other people.28 Nussbaum comments “we are all under a collective obligation to provide the people of the world with what they need”.29 This obligation is emphasized by defenders of the capabilities approach when discussing social injustice and the rights of those who need more help than others in order to be capable. Nussbaum argues:

Finally, the approach is concerned with entrenched social injustice and inequality, especially capability failures that are results of discrimination or marginalization. It ascribes an urgent task to government and public policy – namely, to improve the quality of life for all people, as defined by their capabilities.30

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26 Nussbaum 2006, 159-160.
27 Nyrövaara 2011, 101. Bolton & Banner (2012, 93) describe relational autonomy by saying that “individual identity is socially embedded and intersubjective, and thus the proper domain of autonomy is within the relations and dynamics one has with others and with the social and historical conditions in which one is embedded”.
28 According to Nussbaum (2006, 280), all people have a duty to promote all the capabilities of all people. However, when it comes to legal discussion, the question is whether some people have legal duties whilst others don’t. If legal duties were totally shared with everyone, we should ask who we put the court if there are failures in fulfilling shared juridical duties. Nussbaum (2006, 307-308) notes that institutions and structures are needed in order to carry out duties.
30 Nussbaum 2011, 18-19. Italic Nussbaum’s. Nussbaum (2011, 24) writes: “Those who need more help to get above the threshold get more help. In the case of people with cognitive disabilities, the
In the Finnish discussion of self-determination, this positive obligation of others is implied, for example, by Juhani Pietarinen, who notes that self-determination also requires that there is the possibility of getting help so that it is possible for a person to reach his or her goals. Pietarinen also argues that it is the citizen’s fundamental freedoms which obligates the state to protect the health service, nursing staff to nurse and all the other citizens to participate in the protection of the health service. This follows from the idea that a citizen’s fundamental freedoms in health care are human dignity and self-determination.

The capabilities approach is rooted in the protection of human dignity, to which a concept Pietarinen also referred. According to Nussbaum, the dignity of the human being and a life worthy of that dignity is the starting point of the capabilities approach: capabilities are ways of realizing a life with human dignity, and, thus, capabilities and dignity are intertwined. According to Nussbaum, the capabilities approach strives:

to provide the philosophical underpinning for an account of core human entitlements that should be respected and implemented by the governments of all nations, as a bare minimum of what respect for human dignity requires.

I would describe the intertwined nature of capabilities and human dignity in the capabilities approach, by utilizing a concept of potentiality, as follows: If being lacks a remarkable amount of potentials for human capabilities, we necessarily cannot call this being a human being. On the other hand, a being’s sufficient potential for some central human capabilities signifies human dignity which obligates other people to support the developing of their capabilities.

In order to establish what is crucial for achieving a life worthy of human dignity, one must also specify what kinds of human potentials are

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31 Pietarinen 1995, 40-42.
32 See Pietarinen 1995, 47, 50. It is interesting that Pietarinen builds his claim concerning the relationship between freedom and health services on John Rawls’s view of freedom. According to Rawls, every citizen should have an equal right to as much freedom as possible providing it respects other citizens’ freedom. It seems that even though Pietarinen exploits Rawls’ principle of justice he does not follow Rawls’ definition of freedom since Rawls does not define freedom in terms of capabilities in the way Pietarinen seems to do. In this context Rawls would probably discuss justice instead of freedom. See Pietarinen 1995, 47.
33 Nussbaum 2006, 70, 74, 161-162.
34 Nussbaum 2006, 70.
35 See Nussbaum 2006, 187-190. For more discussion on the view of humanity in the capabilities approach, see chapter 5.4.4.
understood as human rights. Since people may wish impossible things and have idle fantasies, it is necessary to concentrate on important capabilities. Nussbaum states that while, for example, a capability to vote can be defined as an important capability, some other capabilities are trivial (like a capability to drive a motorcycle without a helmet) and others should be inhibited by law (like a capability to discriminate on grounds of race or sex or disability and a capability to pollute the environment). The capabilities approach seeks protection for capabilities “which are the ones that a minimally just society will endeavor to nurture and support”, as Nussbaum puts it. Nussbaum also argues that there is a “threshold level of each capability”. According to Nussbaum, the minimal social goal should be that each citizen is above this capability threshold.

While Sen avoids presenting a list of capabilities (though he discusses many important capabilities, such as the freedom to be well nourished and to live disease-free lives), Nussbaum does identify some central capabilities. Her list includes life, bodily health, bodily integrity, senses,
imagination, and thought, emotions, practical reason, affiliation, other species, play and control over one’s environment. Nussbaum argues that all of these central capabilities are implicit in the idea of a life worthy of human dignity and they give shape and content to the abstract idea of dignity. These capabilities are, according to Nussbaum, the source of political principles for a liberal pluralistic society. They are free from any specific metaphysical grounding, which means that they can be accepted by people whose views of the good differ. Even though this would be true to a certain extent, it also seems that the capabilities approach defines in more detail what humanity is like and what kind of life is worthy of human dignity than is the case, for example, when freedom is understood in the negative sense. When freedom is understood in the negative sense this kind of universal view concerning what is important for human beings in general is narrower than in the capabilities approach. I would not claim that the capabilities approach is free from any specific metaphysical groundings, because it is rooted in a view

45 “Being able to use the senses, to imagine, think, and reason – and to do things in a “truly human” way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing works and events of one’s own choice, religious, literary, musical, and so forth. Being able to use one’s mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid nonbeneficial pain.” Nussbaum 2011, 33.
46 “Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one’s emotional development blighted by fear and anxiety.” Nussbaum 2011, 33-34.
47 “Being able to form a conception of the good and to engage in critical reflection about the planning of one’s life. (This entails protection for the liberty of conscience and religious observance.)” Nussbaum 2011, 34.
48 “(A) Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.) (B) Having the social bases of self-respect and nonhumiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of nondiscrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, national origin.” Nussbaum 2011, 34.
49 “Being able to live with concern for and in relation to animals, plants, and the world of nature.” Nussbaum 2011, 34.
50 “Being able to laugh, to play, to enjoy recreational activities.” Nussbaum 2011, 34.
51 “(A) Political. Being able to participate affectively in political choices that govern one’s life; having the right of political participation, protections of free speech and association. (B) Material. Being able to hold property (both land and movable goods), and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.” Nussbaum 2011, 34.
52 Nussbaum 2006, 70, 75, 79.
of humanity and human dignity which might well be considered metaphysical. I prefer to discuss whether and to what extent we have to be free from any specific metaphysical groundings in order to create a widely shared and accepted theory of human rights.

5.1.2. Obstacles to capabilities

When freedom is understood in terms of capability many kinds of factors which decrease a person’s capability of choosing a way of life which he or she considers valuable and which is worthy of human dignity can be defined as obstacles to freedom.53 In the previous chapter I noted that capability can be divided into internal capabilities and external opportunities or conditions. Following this distinction, it is also possible to describe different kinds of obstacles to capabilities.

When it comes to external opportunities, in Amartya Sen’s writings the focus seems to be on the Third World’s restrictive circumstances. He mentions, for example, poverty, tyranny, poor economic opportunities, systematic social deprivation and neglect of public facilities as sources of unfreedom.54 Sen writes:

Sometimes the lack of substantive freedoms relates directly to economic poverty, which robs people of the freedom to satisfy hunger, or to achieve sufficient nutrition, or to obtain remedies for treatable illnesses, or the opportunity to be adequately clothed or sheltered, or to enjoy clean water or sanitary facilities. In other cases, the unfreedom links closely to the lack of public facilities and social care, such as the absence of epidemiological programs, or of organized arrangements for health care or educational facilities, or of effective institutions for the maintenance of local peace and order.55

According to Sen, extreme poverty is a form of economic unfreedom which leads a person easily to a situation where his or her other freedoms are in danger. Sen talks about a man called Kader Mia, who had to go to a dangerous area in order to find a job because his family had nothing to eat. He was killed. According to Sen, “the penalty of his economic unfreedom turned out to be death.”56

53 When I discussed freedom in terms of negative liberty and authenticity I discussed interferences with freedom in order to emphasize that in unfreedom somebody or something intrudes upon a person’s freedom and that this intrusion penetrates to the core of freedom and does not necessarily just restrict some particular aspect of freedom. When it comes to capability, it seems more suitable to discuss obstacles to freedom, because it is not always a matter of somebody or something intruding upon a person’s capabilities, but that a person’s capabilities are weakened by many other factors and multidimensional processes.

54 Sen 2000, 3.


56 Sen 2000, 8. See also Van Parijs (1995, 22), who describes how a lack of freedom results from what I call here a lack of external opportunities: “If I am penniless, I am not really free to join the
Martha Nussbaum mentions implicitly obstacles to internal capabilities such as a lack of skills, a lack of self-confidence and fear.\textsuperscript{57} Van Parijs describes such obstacles:

Addictions or tendencies to burst into fits of anger or to indulge in spiteful behaviour may genuinely reduce a person’s ability to do whatever she might want to do, and the inability to resist such tendencies can therefore count as a freedom-restricting obstacle.\textsuperscript{58}

If we utilize Joel Feinberg’s distinction concerning different kinds of constraints, we can say that obstacles in the form of external opportunities can be created actively by other people or by the state, and, in that case, they are positive external constraints (barred windows, locked doors, pointed bayonets). If external opportunities are limited because of circumstances which are not clearly created by other people or are created by them indirectly,\textsuperscript{59} we can call them negative external constraints (lack of money, lack of transportation). The obstacles in the form of internal capabilities may be, on the one hand, positive internal constraints (headache, obsessive thoughts, compulsive desires) and, on the other hand, negative internal constraints (ignorance, weakness, deficiencies in talent or skill).\textsuperscript{60}

Since external opportunities and internal capabilities are intertwined with each other, it is clear that the different sorts of obstacles to capabilities are bound up with each other, as well. For example, Sen points out, that “economic unfreedom can breed social unfreedom, just as social and political unfreedom can also foster economic unfreedom”.\textsuperscript{61} Nussbaum reveals that both external and internal obstacles are crucial. For example, in some societies the internal capabilities of citizens are promoted by education so that people are capable of exercising free speech concerning political matters or exercising their right to freedom of religion. However, if the government represses free speech and if it does not protect religious freedom, people are in practice prevented from using their internal capability to exercise free expression and free religious worship. If social, political, familiar and economic conditions are bad, they may stunt the development of internal abilities or warp their development. It is also possible that society creates a

\textsuperscript{57} See Nussbaum 2011, 21.
\textsuperscript{58} Van Parijs 1995, 24.
\textsuperscript{59} However, it depends on the ideology where the border between human and non-human restrictions is drawn. For example, poverty can be seen on the one hand simply as a state of affairs. On the other hand, it can be seen as the result of unjust policies and, therefore, as an obstacle clearly created by other people.
\textsuperscript{60} See Feinberg 1973, 13.
\textsuperscript{61} Sen 2000, 8.
“context of choice” but fails to support the development of people’s internal capabilities.\textsuperscript{62}

Some states in India are like this: open to those who want to participate but terrible at delivering the basic health care and education that would enable them to do so.\textsuperscript{63}

Nussbaum also points out that people may adapt their preferences in relation to what they are told they are able to do, which means that they do not recognize an unjust situation even though they suffer from it themselves:

People adjust their preferences to what they think they can achieve, and also to what their society tells them a suitable achievement is for someone like them. Women and other deprived people frequently exhibit such “adaptive preferences” formed under unjust background conditions. These preferences will typically validate the status quo.\textsuperscript{64}

Even though the capabilities approach usually focuses on the challenges that people living in poor countries face, Sen and Nussbaum think that it is also applicable in richer countries. Sen notes that even in richer societies some groups may lack necessary capabilities compared with the majority.\textsuperscript{65} According to Nussbaum, all nations “contain struggles for lives worthy of human dignity, and all contain struggles for equality and justice”.\textsuperscript{66}

It is worth noting that in the same way that capabilities are linked with the idea of seeking a life worthy of human dignity and the idea that there are goals which are important for individuals to aim for, there are also obstacles which prevent and weaken these important capabilities. Obstacles to capabilities have something to do with injustice.\textsuperscript{67} For example, it is sign of injustice if person in a wheelchair has no access to public spaces. For developers of the capabilities approach, the reason for this injustice is social: it is an unjust society that does not provide sufficient access for people in wheelchairs.\textsuperscript{68}

In any discussion about the obstacles to people having or exercising capabilities, one theme to consider is whether people should be prevented from using their capability if it seems that they will make unwise

\textsuperscript{62} Nussbaum 2011, 21-22, 30-31.
\textsuperscript{63} Nussbaum 2011, 22.
\textsuperscript{64} Nussbaum 2006, 73. In some cases a lack of some internal capabilities may be an obstacle for the use of other internal capabilities: “It is also possible for a person to live in a political and social environment in which she could realize an internal capability (for example, criticizing the government) but lack the developed ability to think critically or speak publicly.” Nussbaum 2011, 21-22.
\textsuperscript{65} Sen 2000, 6.
\textsuperscript{66} Nussbaum 2011, 15-16.
\textsuperscript{67} See Feinberg (1973, 9), who discusses the need to draw a border between freedom and unfreedom: “Although the line between inabilities that are also unfreemdoms and those that are not is obviously hard to draw, we should make every effort to draw it with precision, for unless some incapacities are not considered to be unfreemdoms, perfect freedom itself will be an utterly empty and unapproachable ideal.” Italics Feinberg’s.
\textsuperscript{68} See Nussbaum 2006, 165.
choices. According to Nussbaum, individuals should be able to make unhealthy or even dangerous choices when these choices only concern the individual involved, but she thinks, that individuals should not be allowed to choose to be treated without dignity. The capabilities approach would not, for example, approve somebody accepting money for being humiliated or somebody would selling him- or herself into slavery. These choices would be so contrary to human dignity and self-respect that Nussbaum argues that they would be inappropriate.\(^69\) Moreover, in the case of children and people with severe mental impairment, Nussbaum argues that functionings rather than capabilities are the goal. The idea is that certain functions should be protected in order to protect future capability.\(^70\) Thus, it seems that the capabilities approach is openly paternalistic approach, to a certain degree. There are certain directions which a person cannot choose. Since the concept of capability is linked with the idea of choosing a life worthy of human dignity it would be conceptually inconsistent if a person was permitted to realize his or her capabilities in a way which was against his or her human dignity.

5.1.3. Freedom of belief and opinion in terms of capability

Freedom of belief and opinion has classically been understood in the negative sense. However, from the viewpoint of current human rights discussion, where CP rights and ESC rights are often reconciled, it is meaningful to claim that freedom of belief and opinion cannot and should not be understood strictly and only as a CP or negative right, since it is connected to ESC rights, as well.\(^71\) Thus, one can discuss factual freedom of belief and opinion, or as I will do here, freedom of belief and opinion in terms of capability. Martha Nussbaum describes freedom of belief and opinion in the context of the capabilities approach, by noting that these rights should be not understood only in the negative sense, since securing the rights is “an affirmative task”:

The right to political participation, the right to the free exercise of religion, the right of free speech – these and others are all best thought of as secured to people only when the

\(^{69}\) Nussbaum 2011, 26; Nussbaum 2006, 171-172. See Feinberg (1986, 69), who seems to have a different opinion: “A rational adult could have very good reasons for giving away all of his worldly goods, or even terminating his own life, or in the most extreme hypothetical case, even for selling himself into slavery, and thus perhaps irrevocably closing his most fecund options...In any case, if the chooser is an autonomous adult deciding voluntarily, the choice must be his to make and not ours, and the responsibility too is his to take.”

\(^{70}\) See Nussbaum 2006, 171-172. I will return to the relationship between functioning and capability in chapter 5.4.3.

\(^{71}\) See Karapuu 1999, 68-69; Perusoikeuskomitean mietintö 1992, 51-52.
relevant capabilities to function are present. In other words, to secure a right to citizens in these areas is to put them in a position of capability to function in that area.\footnote{Nussbaum 2006, 287. Nussbaum (2006, 289) also comments the tradition where a distinction has been made between two generations of rights: “even if one did not believe the two spheres to be conceptually interdependent, one might hold that freedom of speech and political freedom have material prerequisites, even in a developed society. One might argue, for example, that people who have inadequate or unequal access to education have not been fully given freedom of speech, since illiterate people are unlikely to be able to exercise political speech on a basis of equality with others.”}

Since the view of freedom in the negative sense is included in the view of freedom in terms of capability, I will describe in this and later chapters issues which arise in a discussion when freedom of belief and opinion is understood in terms of capability but which were not mentioned in the discussion of freedom in the negative sense.\footnote{It might be defined as an obstacle to freedom of belief and opinion in the negative sense, for example, if women, even though they had a nominal right to political participation, are threatened by violence if they leave their home. See and compare with Nussbaum 2006, 287.} This means that I will concentrate on the area of ESC rights. I will also briefly discuss the relationship between freedom of belief and opinion in the negative sense and freedom of belief and opinion in terms of capability. When I consider the challenges faced by close-knit religious communities from the viewpoint of capability, I will also compare this view with ideas which I presented in the discussion of authenticity.

When we look at Nussbaum’s list of capabilities, we notice that freedom of belief and opinion touches many of the capabilities mentioned on the list. Freedom of belief and opinion deals, firstly, with capability in terms of the senses, imagination and thought which signifies an ability to use the senses, to imagine, think, and reason in a way informed and cultivated by an adequate education. It also signifies an ability to use one’s imagination and thought in connection with experiencing and producing works and events of one’s own choice and an ability to speech, manifestations and exercise in political, artistic and religious contexts. Second, a capability to engage in practical reasoning is significant in freedom of belief and opinion. It means the capability to form a conception of what is good and to engage in critical reflection in planning one’s life. Third, a capability to engage in affiliation, which includes, for example, an ability to live with and towards others, engage in various forms of social interaction and to have the social basis for self-respect, is also crucial for freedom of belief and opinion. The capability to control one’s environment, which includes, for example, the ability to participate effectively in political choices, is part of freedom of belief and opinion. A capability to express one’s emotions seems to have a significant role in freedom of belief and opinion. It means the capability to have attachments to things and other people, to love, to grieve, to experience
longing, gratitude and justified anger and “not having one’s emotional development blighted by fear and anxiety”, as Nussbaum expresses it.74

When freedom of belief and opinion is understood in terms of capability, it is meaningful to consider the alternatives which a person within a religious or some other kind of ideological community has and his or her capability to make choices. It is worth emphasizing that, in general, being an active member of a religious community probably correlates with better health, including mental health.75 We may suppose that, in general, there are no conflicts between membership in some ideological or religious community and being sufficiently capable to make choices. Equally, one could discuss whether the state could cooperate more with ideological and religious communities in order to promote its citizens’ capabilities.76 Nussbaum also emphasizes that people who adhere to authoritarian religions should also be respected without being made to feel denigrated.77

However, there are also situations where the individual’s capabilities to choose his or her beliefs and lifestyle are limited in a religious or ideological community for social and psychological reasons. Social reasons may limit a person’s capability to make a choice, for example, if the individual was born and grew up in a religious community closed off from the outside world. Even though this individual could, in principle, leave the community and choose some other beliefs and lifestyle, he or she may, in practice, consider it almost impossible to leave the community and his or her relationships there. In extreme cases the members of a religious or ideological community may also decide to cut their contacts with a person who does not follow the rules and beliefs of the community even though the person who has left might be a family member.78 Therefore, it is meaningful to ask whether the

74 See Nussbaum 2011, 33-34.
75 See Hackney & Sanders 2003; Koenig & Larson 2001; Teinonen 2007, 47-51, 148-149. However, it has been pointed out that the relationship between religion and health is a difficult subject for research since both religion and health are holistic concepts. It is not self evident what is actually being researched: for example, private spirituality is a different thing than social religious activity. It is not clear what has caused what. Even though there might be a statistical correlation between religion and good health, it is not clear if religion has caused this good health. Moreover, the relationship between religion and mental health is controversial since there are also results which suggest that religious people (especially young adults) suffer more from mental health problems. However, it may be that people with problems look to religion for help or that they have found that in a religious context they have an opportunity to express themselves. See Teinonen 2007, 47-56.
76 For example, Päivänsalo (2014) has suggested the possibility of collaborating with religious actors in order to protect and promote the right to health.
77 Nussbaum discusses how the capabilities approach can be accepted by people with different kinds of religious beliefs or metaphysical ideas. For example the Amish, Roman Catholics, and other believing citizens can, according to Nussbaum, agree about central capabilities. See Nussbaum 2006, 297.
78 This case is a form of social punishment. It is questionable whether the state can prevent every kind of social punishment without interfering in other people's liberty in an unjust way. See
individual’s freedom of belief and opinion can be realized in such a closed community. The individual who has grown up in a more open community and who has a social life also outside it, has, in practice, more opportunities to and abilities needed for changing his or her beliefs and lifestyle. The possibility of choice is central in the capabilities approach, as the following example given by Nussbaum shows:

A Muslim woman may prefer to remain veiled, and the approach says nothing against this, provided that there are sufficient political, educational, and other capabilities present to ensure that the choice is a choice.

Psychological reasons may weaken a person’s capabilities for choice if his or her religiosity is undeveloped so that it does not meet the challenges of the adult life. The person may also find it psychologically difficult to give up some doctrine or idea. For example, if the person is very distressed about the possibility of ending up in hell if he or she does not adopt some particular beliefs, he or she might lack capability. The individual’s freedom of belief and opinion in terms of capability can also be seen as restricted in the situation where a poor individual receives charity from a religious community or aid from a political party, and becomes in this way dependent and adopts some of their views, even though he or she was not, in principle, forced to adopt them.

When we discuss close-knit groups, there seems to be a grey area between the view of freedom in terms of authenticity and the view of freedom in terms of capability. For authenticity and for capability there may be something problematic about close-knit groups. However, the differences between these approaches can be defined, as follows: When freedom of belief and opinion is understood in terms of authenticity, the main concern is that manipulation distorts a person’s authentic beliefs and opinions. However,

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Feinberg 1973, 32. There is also a need to avoid legal moralism. See Feinberg (1973, 36-41) for more details.

Nussbaum (2008, 140-145) considers the capability of choice of children who have grown up in an Amish community. Nussbaum suggests that a certain amount of basic compulsory education outside the community would promote the children’s capability when it comes to choosing whether they want to stay in the community or leave it, and also their capability to live outside the community in the event that they chose to do so. Nussbaum (2006, 175) emphasizes that “one way of setting the threshold right will be to look at the other capabilities that are affected: thus, a court deciding the limits of religious free exercise might legitimately consider the fundamental right of all children to education, and so forth”. When it comes to the question whether parents can take their children out of school in order to educate them in a religious way, Nussbaum (2008, 145) defends an education which would give them capabilities “for a life in which they may be part of that community, but also may not”. Nussbaum (2008, 140-145) seems to prioritize the development of the children's capabilities over the parents' liberty to educate their children as they wish.

Nussbaum 2006, 298.

See Teinonen 2007, 114, 122, 125.
from the viewpoint of capability, it is emphasized that a person living in a close-knit group has limited choices because of unbalanced power relationships, fear of social neglecting of others and also a lack of economic resources influenced, for example, by the gender roles of the community.

On the other hand, it can be also claimed that the person who does not learn to prioritize any religious or ideological beliefs lacks a capability to take a stand. His or her “own opinion” is always that of an outsider and the best he or she is able to say is that “there are several different kinds of beliefs and opinions”. However, a person may consider it impossible to adopt some of them and to join with others who have taken the same stand. Moreover, the individual who has no (acknowledged) religious or ideological education or upbringing at all may have difficulties in dealing with religious and ideological questions later in life. Therefore, avoiding religious and ideological discussions and rituals can also be a problem from the viewpoint of freedom of belief and opinion in terms of capability.

The question about the opportunities available to an individual to make a choice in a religious or some other ideological community is conceptually challenging. It might be asked, whether it should be the legal duty of a religious community not to weaken its members’ capability. It seems that this sort of suggestion is included, for example, in a memorandum of the Finnish League of Human Rights about the teachings of the Leastadian Revivalist Movement, which considers birth control a sin, which the league argues violates human rights.\footnote{The Finnish League of Human Rights reports that some members of the community think that the teaching that states that birth control is a sin is social coercion. The teaching violates, according to the League, human rights because it is against privacy and sexual self-determination. The League also points out that the teachers in the community are more powerful than individual members. See The Finnish League of Human Rights 2009.} If the view of freedom of belief and opinion in terms of capability is adopted, I would prefer an approach which gives liberty to religious and ideological communities to teach about their views, but, at the same time, sees promoting the capabilities of every human being as the duty of the state. This would mean that the state would have to ensure the right of every citizen to education, where capabilities would be promoted, and would also ensure that there was sufficient health care and social services for every one. If people grow to be capable, they are also sufficiently capable of dealing with religious teaching which, for example, might promote the view that birth control is a sin. If this was the case, there would be no need to interfere with liberty and restrict the right of religious communities and individuals to teach their religious views. A more difficult question is how to teach and bring up children and other citizens whose capabilities for choice are not sufficiently developed. Even though it might be allowed to teach about hell, sin and other similar themes, should the state somehow restrict the ways in which such
themes are taught? For example, if the reality of hell is described in a very emotional way, the question arises whether some kind of emotional damage might be caused to the child.\textsuperscript{83}

The view of freedom of belief and opinion in terms of capability seems to be conceptually challenging. The first conceptual challenge concerns the borders between different kinds of rights: since everything influences everything else, it is difficult to describe the nature and borders of particular rights. It seems impossible to say, for example, where the right to freedom of belief and opinion ends and where the right to mental health begins. On the one hand, some capabilities mentioned in Nussbaum’s list seem to be connected to freedom of belief and opinion more than others, as was noted above. On the other hand, these same capabilities are also deeply connected to mental health. From the viewpoint of the capabilities approach, this kind of overlap might be seen as inherent to the nature of human rights.\textsuperscript{84} However, the overlap makes it difficult to discuss single particular rights and their relationship to other particular rights.

It has been asked whether there is a tendency in the capabilities approach to include in the concept of freedom many different kinds of issues which are considered good. According to Berlin, the way of understanding freedom or liberty in the positive sense mixes the different kinds of good things with each other. However, Berlin argues that:

Liberty is liberty, not equality or fairness or justice or culture or human happiness or a quiet conscience.\textsuperscript{85}

In the capabilities approach this threat is acknowledged by noting that not all good things but only the most important capabilities should be understood as human rights. However, since the concept of freedom in terms of capability is understood in a wider sense than is the case when freedom is discussed in the negative sense, the critique presented by Berlin leads us to ask whether freedom should be discussed at all in terms of capabilities, and whether freedom (understood in the negative sense) should be seen instead as one part of capability approach. In this case, it would be easier to discuss relationships between different kinds of capabilities and human rights, of which freedom (understood in the negative sense) would only be one.

\textsuperscript{83} The danger of emotional damage might also arise in a situation where a parent says to his or her child, for example, “if you don't do what I say, I will leave and won't ever come back”. Should the liberty of parents and communities liberty be restricted in order to avoid situations which might be emotionally damaging for the child?

\textsuperscript{84} According to Nussbaum (2006, 175), different capabilities are understood as a coherent overall set, not as mutually conflicting.

\textsuperscript{85} In Berlin's model, the term positive freedom seems to include aspects of freedom in terms of authenticity, freedom in terms of rationality and freedom in terms of capability as discussed in this study. Berlin 2005, 169-170, 172. See also Feinberg 1973, 9.
The second conceptual challenge concerns the relationships between rights and duties. If something is acknowledged to be somebody’s right, there should also be a corresponding duty on the part of someone else. We should then ask which issues involve duties, and whose duties are they. What kinds of negative duties and what kinds of positive duties are possible when we discuss freedom of belief and opinion as a human right? When freedom of belief and opinion is understood in terms of capability, it has been discussed, for example, whether the state also has a positive obligation to create appropriate conditions where individuals and communities could easily manifest, express and exercise their beliefs and where their use of freedom could flourish.  

However, different kinds of opportunities and internal capabilities might be seen as important in order to realize freedom of belief and opinion. For example, if going on a pilgrimage is crucially important in somebody’s religion or personal beliefs, he or she needs economic resources to do so. To attend ideological discussions requires that there are people with whom one can engage in discussion. Developing ideas, forming a conception of what is good and engaging in critical reflection in planning one’s life are possible only if the person has sufficient mental abilities. A suitable education and upbringing that encourages creative and analytical thinking supports this ability. To go to a temple of the Hare Krishna movement regularly requires that there is a temple quite nearby, and so on.

When we say that freedom of belief and opinion is a human right, the crucial question is what different kinds of opportunities and internal capabilities should be defined as sufficiently important and general to be defined as rights and which the state and other people have a duty to promote or at least not to weaken. For example, one could argue that it is the duty of the state to ensure that each human being is sufficiently educated and that their internal capabilities to exercise their freedom of belief and opinion are, in this way, sufficiently developed. However, the question arises, to what extent is it the legal duty of the state and other people to promote the internal capabilities of citizens and to what extent are the people themselves responsible for their own development. For example, the state cannot force an individual to develop his or her capability to form a conception of the “good” if he or she is not interested in doing so. If the individual’s capability in this area turns out to

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86 Evans 2001, 69. According to Nussbaum (2006, 275), the capabilities approach begins with rights and derives duties from them. If there are certain rights, there is also “some sort of collective obligation to make sure that people get what they are due”. However, I see that even though rights might be the starting point instead of duties, considering duties might help to make the concept of a right clearer. On the other hand, starting from duties may lead to a lack of ambition when we face problems which seem difficult to solve. As Nussbaum (2006, 280) puts it, concentrating on duties “is likely to make our ethical thinking stop short”.

87 Compare with Nussbaum 2006, 73.
be very weak, is it a sign of some form of injustice for which the state and other people are responsible?

It is also questionable whether it is the duty of the state to ensure that religious people can go on, for example, a pilgrimage (even though it might be the duty of the state to ensure that the basic needs of a human being are satisfied).88 When it comes to people’s ideological affiliation, the state cannot ensure that other people will share an individual’s beliefs, since this would seriously interfere with other people’s freedom of choice. Other people cannot be forced to share somebody else’s beliefs. Even though sharing one’s beliefs in a community may be acknowledged as important, the state cannot arrange, for example, that a solitary member of the Hare Krishna movement has a temple to use if there are no other members of the movement in that area. The state cannot move other members closer to him or her nor can it move him or her closer to other members. On the other hand, it would be possible for the state to support minorities so that they would be less threatened by the possibility that their way of life might cease to exist.89 The relationship between capability and functionings also seems to be relevant here. It might be claimed that it is part of functioning that a person actually has somebody to share his or her beliefs with. Thus, the problem in the case above is not in the area of capabilities, but in the area of functionings. However, if the person is not able to realize his or her capability to exercise his or her affiliation in a satisfactory way because there is nobody to share his or her beliefs with, it might be asked if capability is too impractical an idea. It seems that distinguishing capability clearly from functionings is not easy.

The third conceptual challenge seems to be how to understand the place of negative liberty in freedom of belief and opinion when it is understood in terms of capability. Should negative liberty be stressed somehow or not? Should somebody’s negative liberty be restricted in order to protect an other person’s freedom in terms of capability? For example, should the state prevent religious teaching (interference with negative liberty) which some people might consider oppressive?90 Moreover, is it justified to interfere

88 In Finland, social workers have to consider if Romany women who receive income support may also receive supplementary income support for buying a special Romany skirt, since the skirt is described as a special need of Romany women.

89 Compare with Nussbaum (2006, 358) when she comments on the case of Wisconsin v. Yoder which dealt with Amish parents who had asked permission to withdraw their children from school.

90 However, this does not seem to be something which Nussbaum (2008, 360) would suggest, since she states that law in a liberal democracy cannot tell people that they have to respect one another. According to Nussbaum, it cannot penalize them for being even intolerant, unless that leads them to violate the rights of others. However, the good laws set limits on people's ability to act on their intolerant and inegalitarian views. See also Nussbaum 2008, 169. The other option is that the state would not give resources to communities which use their liberty in a way that could be defined as oppressive. In this case, the people responsible for their community’s teaching would have to consider whether they stopped a certain kind of teaching or whether they would accept being
with somebody’s negative liberty in order to promote his or her freedom of belief and opinion in terms of capability? For example, if somebody does not want to be educated for religious reasons, could the state force him or her to go to school?91 Or could the state prevent a person from donating all his or her money to a political party? Questions concerning the relationship between negative liberty and capability seem to be linked with the discussion concerning the relationship between capabilities and functionings, and I will return to that theme in chapter 5.4.3.

From the viewpoint of the liberal tradition, it might be claimed that negative liberty is the strongest area of capability.92 Nussbaum seems to value liberty in the negative sense when she discusses her list of central capabilities:

Major liberties that protect pluralism are central items on the list: the freedom of speech, the freedom of association, the freedom of conscience. By placing them on the list we give them a central and nonnegotiable place.93

Nussbaum also states that some parts of freedom of belief and opinion should be equal for all.94 This stand is rooted in the idea that everyone has an equal human dignity:

given less resources. For example, certain Finnish religious organizations did not receive funding from the Finnish Ministry of Education and Culture after they had engaged in a campaign which encouraged young people not to live according to their homosexual orientation. See Ahonen 2012. Nussbaum (2011, 35) would probably prefer this solution, since she states, that “capabilities belong first and foremost to individual persons, and only derivatively to groups”. This means that “the goal is to produce capabilities for each and every person, and not to use some people as a means to the capabilities of others or of the whole”. It seems to follow that the capabilities of an ideological community cannot be supported by the state if as a consequence the individual members’ capabilities are restricted. Moreover, Nussbaum would probably demand that the state should not interfere with a community's liberty to teach in certain way but that it should educate children in particular, in order to promote their capability for choice. Nussbaum (2006, 412-413) herself suggests that by education people could adopt the views of humanity and human rights that are presented in the capabilities approach. Nussbaum notes that this could be seen as indoctrination but claims that since some values and ideas are taught anyway, the question is only about the nature of the values and ideas.

91 The other question is whether it is conceptually possible to promote internal capabilities which are promoted in education, by force.

92 See Taylor (1984, 114-116), who states that, according to Kant, it is unjustified paternalism if a person’s autonomy is restricted in order to promote his or her own happiness. In the theory of justice presented by Rawls, the principle of maximal freedom understood in the negative sense is also prioritized over the principle which suggests that social and economical inequalities should be evened out. See Rawls 1988, 46-47.

93 Nussbaum 2006, 80. On the other hand, according to Nussbaum (2006, 76), the list of central capabilities “is open-ended and has undergone modification over time; no doubt it will undergo further modification in the light of criticism.”

94 In some other respects, capabilities need not be equal. When it comes to capabilities which are connected to property and instrumental goods, it is enough that capabilities are adequate and appropriate. Nussbaum 2006, 293-295.

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It appears that all the political, religious, and civil liberties can be adequately secured only if they are equally secured. To give some groups of people unequal voting rights, or unequal religious liberty, is to set them up in a position of subordination and indignity vis-à-vis others. It is to fail to recognize their equal human dignity.\textsuperscript{95}

Nussbaum strongly defends liberty when she discusses Muslim women’s right to wear the burqa and Muslim girls’ right to wear the jilbab.\textsuperscript{96}

It can be, however, asked whether the idea that there is a “strongest area” of freedom of belief and opinion in the negative sense is in accordance with the view that emphasizes that all rights and all capabilities are intertwined with each other.\textsuperscript{97} According to Nussbaum, each and every capability is a fundamental entitlement of citizens, and are “all necessary for a decent and dignified human life”. She calls her listed capabilities as “radically nonfungible” and states: “lacks in one area cannot be made up simply by giving people a larger amount of another capability”.\textsuperscript{98} Generally Nussbaum states that if we face a conflict between an individual’s capabilities it is a “sign that society has gone wrong somewhere”.\textsuperscript{99}

\textsuperscript{95} Nussbaum 2006, 292-293.
\textsuperscript{96} The role of negative liberty seems to be quite unclear in Nussbaum's thought. When Nussbaum defends Muslim women's right to wear the burqa and Muslim girls' right to wear the jilbab she does not bring up questions about gender equality and women's capabilities in Islamic communities, but instead assumes that the wearing of a burqa or a jilbab is the expression of a woman's or a girl's choice freely undertaken (which it might well be, of course). However, when Nussbaum considers the views of some Christian communities against homosexual acts, she seems to have a less positive evaluation concerning religious expression and members' capability of choice (in fact, Nussbaum questions the religious nature of the religious opposition to homosexual acts and suggests that it should be seen, instead, as an expression of panic). Nussbaum seems to express different kinds of attitudes towards different kinds of religiously argued expressions and actions. According to Nussbaum, the wish to ban the wearing of burqas is an expression of fear and so is seeing something problematic in homosexual acts. However, she does not seem to think that the practice of wearing burqas might also be an expression of fear inside Islamic communities. See Nussbaum 2008, 334-351. See also Nussbaum 2012, 3-5, 117-121. The question is whether Nussbaum considers different religious communities fairly or whether she chooses to present some religious communities, practices and views in a positive light and some in a negative light. It seems that Nussbaum is more willing to see the acts of minorities in a positive light whilst considering the acts of majorities as signs of fear. For example, according to Nussbaum (2012, 121), banning the wearing of a Muslim head-covering in Turkey was probably justified whilst banning it in Europe and the United States was not.
\textsuperscript{97} When it comes to the relationship between freedom in the negative sense and freedom in terms of capability, Sen (2009, 300) questions the way in which negative liberty has been prioritized over other important things by Rawls: “Why must any violation of liberty, significant as it is, invariably be judged to be more crucial for a person – or for a society – than suffering from intense hunger, starvation, epidemics and other calamities?...we have to distinguish between giving some priority to liberty (not treating it merely as one of the components in the large bag of 'primary goods', since liberty is so central to our personal lives), and the 'extremist' demand of placing a lexicographic priority on liberty, treating the slightest gain of liberty – no matter how small – as enough reason to make huge sacrifices in other amenities of a good life – no matter how large.” (Italics Sen).
\textsuperscript{98} Nussbaum 2006, 72-75, 166-167. See also Nussbaum's (2006, 164-165, 179) discussion in relation to Rawls' theory of justice.
\textsuperscript{99} Nussbaum 2006, 401. In a situation where it is not possible to support capabilities or there is a
When it comes to the role of negative liberty among capabilities, it is important to note that there may be no general solutions. Even though the capabilities approach is, according to Nussbaum, applicable in different cultures, its application may differ in each case. There is not necessarily a common principle that would apply to all situations since the threshold level of capabilities may shift in different times and it may be set differently in different societies with different histories and circumstances:

Thus a free-speech right that seems appropriate for Germany (allowing the prohibition of antisemitistic speech and political organizing) would be too restrictive in the different climate of the United States; both nations seem to have made reasonable choices in this area, in the light of their histories.\(^{100}\)

For example, Jennifer Ruger has criticized the capabilities approach for its unspecified nature. It does not seem to be clear how different kinds of capabilities should be weighed against each other and against functionings.\(^{101}\)

Because of its unspecified nature, it is possible to raise issues which might be potentially important for understanding the freedom of belief and opinion, as I have done in this chapter and as will do in the following chapters, but it seems difficult to evaluate how relevant these issues are from the viewpoint of the capabilities approach and how they should be weighed in the human rights discussion.

### 5.2. Psychosis and the individual’s capabilities

In this chapter I describe the consequences of psychotic disorder for the individual’s freedom of belief and opinion understood in terms of capability. When mental health is defined and discussed, the ability to form emotional

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\(^{100}\) Nussbaum 2006, 180. According to Nussbaum (2011, 41-42), “the Capability Approach tells us what to consider salient, but it does not dictate a final assignment of weights and a sharp-edged decision...Even at the level of threshold-drawing, the ordinary political process of a well-functioning democracy plays, rightly, an ineliminable role.”

\(^{101}\) See Ruger 2010, 55-58.
social relationships and engage in communication with others as well as the ability to work and engage in social participation are considered crucial. The WHO defines mental health as:

a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

It has also been pointed out that health, in general, signifies an ability to plan one’s life and realize life goals. Since definitions of mental health and health in general refer to aspects which are important for capabilities, it seems clear, that a lack of mental health signifies, respectively, that a person’s capabilities are weakened.

The consequences of psychotic disorder seem to be deep and holistic, and they concern both internal capabilities and external opportunities. It is part of the nature of capability that internal capabilities and external opportunities as well as different kinds of capabilities are linked with each other. However, in the process of becoming a chronic psychotic individual in particular, various obstacles to internal capabilities and external opportunities are linked with each other. If capabilities are weakened, it is difficult to say how much the reason lies in the psychotic disorder itself, how much the psychotic person’s own attitude and that of other people’s towards disorder and life influences it, and what different kinds of practical opportunities or lack of them, such as the opportunity to work or the opportunity to choose between different treatment options might signify.

It is worth of noting that whatever the reason for a person’s weak capabilities is in psychosis, it is a sign of injustice. It seems that from the viewpoint of the capabilities approach, the individual with psychotic disorder can be compared in this respect with a person in a wheelchair. Martha Nussbaum notes that the reason the person in a wheelchair has less

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102 See, for example, Lehtonen & Lönqvist 2007, 28.
103 The WHO: Promoting Mental Health 2005.
104 See, for example, Nordenfelt’s (2007, 54) definition of health: “A is completely healthy if, and only if, A is in a bodily and mental state which is such that A has the second-order ability to realize all his or her vital goals given a set of standard or otherwise reasonable circumstances.” See also Laitinen (1996, 24), who argues that health is an objectively desirable value, since it is necessary for realizing important things in our life plan.
105 See Iso-Koivisto 2004, 40-41. In the context of the philosophy of psychiatry, the link between internal and external influences on capabilities is recognized. So, for example, Bolton & Banner (2012, 94) argue that: “Internal states of incapacity may be caused substantially by external factors, such as neglect or abuse. We also tend to internalize how we are treated by others into our self-view. Or again, people who are ill have some degree of incapacity because of their illness, and still more on top because of the stigma and social exclusion that may go with the illness diagnosis...in various ways and contexts mechanisms of social advantage tend to promote a positive self-image of self-efficacy, while mechanisms of social exclusion foster self-doubt and incapacity.”

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capabilities than others, is social. Society has not provided wheelchair access in public spaces.\textsuperscript{106} In the same way it can be claimed that the reasons are social if the capabilities of the individual with psychosis are weakened: society has not offered the individual with psychosis access to the capabilities.\textsuperscript{107}

There are two notable points to make about the formulations used in human rights conventions and in the ethical principles set out for psychiatry. First, when the concept of freedom is used in these documents it is not compulsory to interpret it in terms of capability. It always seems to be possible to interpret the concept of freedom in these documents only in the negative sense. Second, when freedom of belief and opinion is understood in terms of capability, even the principles and texts where the term freedom (or autonomy or self-determination) is not used at all, can be understood to refer freedom in terms of capability. Thus, I will recognize freedom in terms of capability to be present in those documents even in some places where the term freedom is not used. I will also do this when I use other kinds of materials, but when it comes to official documents I think it is even more crucial to be aware of how we interpret them.

In the following section, I will first discuss how psychotic disorder may weaken the individual’s internal capabilities. After that I consider whether psychosis might also bring the person some internal capabilities. Then I will discuss social challenges faced by a psychotic person, such as his or her economic situation and dependency on other people, and how they are linked to his or her freedom of belief and opinion. At the end, I will clarify what kind of effect stigmatization has on the freedom of belief and opinion.

5.2.1. Psychosis as an obstacle to internal capabilities

Psychotic disorder may weaken the individual’s internal capabilities to enjoy and exercise his or her freedom of belief and opinion in many ways. The Explanatory Memorandum to the RCE states that:

\textsuperscript{106} Nussbaum 2006, 165. When it comes to people with mental impairments, Nussbaum (2006, 99-100) argues that society is challenged to promote their capabilities in two ways. First, since people with mental impairments have special needs, atypical social arrangements and a variety of care should be arranged in order to ensure people the capability to lead “fully integrated and productive lives”, as Nussbaum puts it. Second, a just society should not stigmatize people with mental impairments or stunt their development. Instead “it would support their health, education, and full participation in social and even, when possible, political life.”

\textsuperscript{107} In addition, Sen points out that the capabilities approach is also relevant for groups of people in rich countries who have a lack of necessary instrumental freedoms compared with the majority. People with psychotic disorder can be seen as such a group. See Sen 2000, 6.
Mental disorders can have significant effects on a person’s emotions, perceptions, and capacities to think and to reason.\textsuperscript{108}

First, delusions influence the ability to act in reality and engage in social relationships in a meaningful way. If a person’s view of reality does not correspond with the way in which other people see it, it may be difficult for that person to choose a way of life which he or she has some value. When the individual’s view of reality is not sufficiently shared with others, things simply do not turn out the way the person with delusions would like them to since other people (and the world generally) do not act as he or she thought they did or would.\textsuperscript{109} In chapter 4.4.4. I noted that even though a person might be the author of his or her delusions, he or she is not necessarily able to achieve self-fulfilment, namely, to govern him- or herself successfully, if his or her self-narrative does not correspond to real life events.\textsuperscript{110} Grant Gillett describes how psychosis may influence that person’s social abilities since he or she loses touch with other people:

bombarded by stimulations which do not resolve into familiar patterns and people who no longer seem to be saying anything comprehensible or straightforward. The world may seem overly crammed with promise or meaning and with clamours for attention and resolution that are elusive.\textsuperscript{111}

Second, even though the person has some insight, delusions and hallucinations may be seen by the individual as temptations, which he or she tries to fight against, sometimes unsuccessfully. Gillet notes how voices that are usually “just in the background” and part of a person’s own controlled thinking, may sometimes “seem to have taken on a life of their own with urgent and desperately important messages to convey”.\textsuperscript{112} In some cases a person with psychotic disorder decides to consider carefully what to believe and he or she may even refrain from creating ideas in order to avoid delusions. For example, when John Nash learned to discriminate and reject his paranoid ideas and attitudes, he rejected politically orientated thinking “as essentially a hopeless waste of intellectual effort” at the same time.\textsuperscript{113} A person with a past of religious activity and religiously oriented delusions may later think that religiosity does not suit him or her. Religion may seem like a drug which lead to delusions.\textsuperscript{114} In this sense psychosis may in some cases prevent the

\textsuperscript{108} The Explanatory Memorandum to the RCE 2004, 1.
\textsuperscript{109} See Bolton & Banner (2012, 94), who list “beliefs that track the world accurately enough” as one aspect needed in rational agency.
\textsuperscript{110} Bortolotti et al 2012, 102.
\textsuperscript{111} Gillett 2012, 242.
\textsuperscript{112} Gillett 2012, 242.
\textsuperscript{114} See, for example, the patient, interviewed by Iso-Koivisto (2004, 85), who suspected that her psychosis was influenced by a bad spiritual season. An other patient, also interviewed by Iso-
person from continuing with, adopting or developing political, ideological or religious ideas.

Third, even though psychotic disorder is a different challenge than mental impairment, it has been noted that in many cases psychosis may weaken an individual’s cognitive abilities, such as their reasoning abilities and the ability to pay attention and concentrate. According to Lauri Kuosmanen, these cognitive impairments hamper the realization of basic human rights.  

Radden and Sadler put it, as follows:

If only temporarily and partially, severely ill psychiatric patients are often deprived of the capabilities required for an exercise of autonomy and of their best defenses against exploitation: their judgement in matters concerning their immediate and long-term self-interest; their reasoning ability, their insight into their own condition, their self-control, their personal and psychic integration, their capacity to communicate their concerns and needs to others, and their perceptions of other people’s responses.

Fourth, at least some psychotic disorders are associated with feeling powerless, which can be described as apathy, insensitivity or “to be like a vegetable, not a human being”, as one of the patients interviewed by Iso-Koivisto puts it:

My feeling is that I have nothing or that I don’t enjoy anything and I don’t have any zest for life. I just go from one place to another as if I was numb. It is not possible to read any newspapers or concentrate on anything. If you read, after a while you cannot remember what you read about.

In an interview five years later, the same patient said about himself:

The year 1992 could have seen me under my gravestone...He has been brain-dead for five years...He has been a vegetable.

Iso-Koivisto notes that the experience about time may change after the first psychotic episode if the person becomes chronically psychotic. For example, the experience of one interviewed patient was, that “there is a plenty of time but for some reason it is not enough for anything”. Gillett points out that}

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Koivisto (2004, 91), found that he started to hear voices after he had started praying for help with his emotional life.

Kuosmanen 2009, 11.

Radden & Sadler 2010, 34-35. According to Bolton & Banner (2012, 94), psychosis signifies a breakdown of autonomous action because “of an internal proximate cause or reason, within the person, as opposed to an external cause or reason”

“Se nyt on semmonen, ettei niinkuu oo mitään, ei mistään nauti, eikä oo mitään semmosia elämisen haluja, sitä menee semmosena puuduttetuna paikasta toiseen. Eikä mitään lehtii pysty lukemaan, ei mihinkään keskittyminen, jos luet niin et muista vähän ajan päästä yhtään mitään mistä luit.”


“hautakiveen vuosiluvun 1992 olisi voimat lyödä...ollut viisi vuotta aivokuollut...Jää käsvisks.” Iso-Koivisto 2004, 93. Translation by Mari Stenlund.

psychosis can severely disrupt an essentially dynamic and interactive pattern of being.

For instance, one might face an impasse: the world ahead is presided over by a demand and an expectation to meet it in some very limited way.120

A person may also feel powerless in relation to his or her hallucinations. Romme and Escher describe voices as a problem:

The voices seemed to represent a social-emotional problem that these people have not been able to resolve. This contributes to the sense of powerlessness they feel in relation to their voices, which then become very dominant. A range of problems follows, including loss of concentration, lack of or inappropriate feelings, social isolation, and problem behaviour.121

Moreover, a person with psychotic depression completely lacks any energy, which Bolton and Banner describe as a phenomenon “that spans the mind-body divide”. Moreover, he or she “feels despair and hopelessness, sees no point in getting up”. According to Bolton and Banner, these matters are not under the individual’s control or if they are then only partly and occasionally.122

Responding to the psychotic individual’s weakened internal capabilities the capabilities approach challenges society to find better treatments and better approaches which would help people to develop their internal capabilities. I will discuss treatments which promote capabilities in chapters 5.3.2., 5.3.3. and 5.3.4. However, there are three important points here. First, even though other people can help a psychotic person to develop his or her internal capabilities and are obliged to try and find different ways to help such a person, there is little they can do if the person decides not to “go along” with their suggestions. Thus, we might ask whether the person with psychosis has some duties when it comes to developing his or her internal capabilities. Is the patient with psychosis expected to be in a certain sense virtuous in order to become a holder of his or her internal capabilities?123 Or does this expect too much at least from some patients? On the other hand,

120 Gillett 2012, 242.
122 Bolton & Banner 2012, 82. In these kinds of cases we could define psychotic disorder as a form of internal constraint, the “enemy within”, described by Feinberg (1973, 14): “If we are prevented by some internal element – an impulse, a craving, a weakened condition, an intense but illicit desire, a neurotic compulsion – from doing that which we think is the best thing to do, then the internal inhibitor is treated as an alien force, a kind of “enemy within”.”
123 See Radden & Sadler 2010, 5, note 1. About being a virtuous patient in the context of psychotherapy, see Waring 2012. See also Kuosmanen (2009, 11), who suggests that patients might be seen as co-producers of health. Radden & Sadler (2010, 35) note that psychotic people may have courage, persistence, ingenuity and often be effective in their battle with their disorder, and live with it and manage it.

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could such ideas about duties and virtues of a person with psychosis, encourage that person to develop?

Second, it is crucial to emphasize that when freedom of belief and opinion as a human right is discussed, the goal is to ensure sufficient internal capabilities, not ideal internal capabilities. This means that not all ideas about what people could and should be in order for them to be seen as autonomous are relevant when internal capabilities are discussed in the context of human rights. For example, Grant Gillett seems to present ideas about a person having a “strong will” which cannot be applied as such in the human rights context. According to Gillett, the autonomous person has an ability to control his or her actions and desires in order to avoid doing things which makes him or her unhappy. However, capabilities signify something more ordinary. It is part of the reality of human life to do things which might make one unhappy. Perhaps in the context of capabilities we could speak, in some sense, about a person’s will being strong enough to be able to live a life worthy of human dignity. However, we have to keep in mind that the capabilities approach regards human beings as vulnerable. Thus, it would be against this background supposition if we had in mind an ideal about strong or independent humanity with unrealistic abilities. It cannot be a goal.

Third, internal capabilities are linked to mental competence and authenticity. For example, some of the negative influences that a psychotic disorder has on a person’s internal capabilities signify a lack of mental competence, namely, a lack of abilities which the person needs to make decisions. However, when internal capabilities are discussed in terms of capability, the focus is on the person’s ability to choose a way of life which he or she values. Mere mental competence does not seem to ensure that the person would have sufficient internal capabilities to do that. It also seems that the ability to engage in reflection and the ability to create a coherent self-narration, which I presented were criteria for evaluating authenticity, could be seen as internal capabilities needed in freedom of belief and opinion, especially when discussing the capability to engage in practical reasoning. However, in authenticity the focus is on whether a person’s beliefs and opinions are really his or her own. When internal capabilities are discussed, the focus is on abilities which the person has or does not have. Moreover, in the capabilities approach, though particular internal capabilities are seen as important for the individual, they don’t have such the decisive role that they have for mental competence and authenticity. For mental competence and

\[124\] See Gillett 2012, 240-245.

\[125\] For definitions of mental competence and a discussion about how psychosis influences it, see chapters 3.3.4. and 3.4.1.

\[126\] See chapters 4.4.3. and 4.4.4.

\[127\] About the capability for practical reasoning, see chapter 5.1.3.
authenticity certain abilities place the border between sufficient and insufficient mental competence or authenticity, and the way the person is treated depends crucially on which side of the border he or she seems to be. In the capabilities approach there is a tendency to avoid strictly establishing borders between sufficient and insufficient internal capabilities.

5.2.2. Psychotic capabilities: greater awareness and problem-solving ability

When discussing how psychotic disorder influences internal capabilities, we need to remember that it is not one-sided issue. Not all the consequences of psychosis are negative. Instead, in some cases psychosis may feed certain internal capabilities of the individual.

First, psychosis may be associated with a psychotic person becoming more aware of life and feeling that his or her life has more meaning. Sihtij Kapur’s theory of psychosis illustrates this. Kapur defines psychosis as a state of aberrant salience connected to the role of dopamine.\textsuperscript{128} Kapur’s theory is based on the idea that dopamine is a mediator of motivational salience. According to this idea, dopamine has a central role in the process whereby the psychotic individual considers some events and ideas in the external world as important. On the grounds of many studies, there is a strong possibility that the role of dopamine is neuro-biologically important in the state of psychosis.\textsuperscript{129} Kapur defines dopamine’s action in psychotic states thus:

Dopamine \textit{mediates} the process of salience acquisition and expression, but under normal circumstances it does not create the process. It is proposed that in psychosis there is a dysregulated dopamine transmission that leads to stimulus-independent release of dopamine. This neurochemical aberration usurps the normal process of contextually driven salience attribution and leads to aberrant assignment of salience to external objects and internal representations. Thus, dopamine, which under normal conditions is a mediator of contextually relevant saliences, in the psychotic state becomes a creator of saliences, albeit aberrant ones.\textsuperscript{130}

When Kapur describes the experiences of psychotic individuals, he seems to suggest that some of them become able to think about and understand the world in a new way. For example, some patients with schizophrenia have said, according to Kapur, that they developed greater awareness or that their brain “awoke”, that they noticed new things or that

\textsuperscript{128} He defines the psychotic state of an individual with schizophrenia but supposes that his theory can also explain other psychotic states, connected to other psychotic disorders. Kapur 2003, 13, 18.

\textsuperscript{129} However, even though it seems that dopamine has a role in psychosis-in schizophrenia, Kapur notes that its role is not necessarily exclusive or primary. Kapur 2003, 14.

\textsuperscript{130} Kapur 2003, 15.
they could put a piece of the puzzle together.  

Glenn Roberts found that people who had lived with delusional beliefs for a long time found that their life was very meaningful. Even though their quality of life was weak measured objectively, Roberts found that they considered their life almost as worthwhile as Anglicans who were deeply committed to their Christian faith. According to Roberts, his results confirm the impression “that for some there may be satisfaction in psychosis and that the formation of delusions is adaptive, a creative achievement rather than affliction”.  

Bill Fulford and Lubomira Radoilska also discuss what I call here “psychotic capabilities”. According to them, the British Psychological Society has argued that psychotic experiences as such should be regarded as the basis for problem-solving capacity. This does not mean that there is no such thing as psychotic disorder, and this does not mean that a psychotic experience may also turn out to be destructive for the individual. However, as Fulford and Radoilska put it:

Delusions and other psychotic experiences for all their significance as symptoms of mental disorder may also be not only normal but positively life enhancing.

Psychosis may also be experienced as a positive crisis which awakens the person to realize how pointless his or her life used to be. It is worth noting that experiencing a psychotic disorder may change a person’s view about what is valuable, and, thus, psychosis may influence the way the person would like to realize his or her capabilities. Eeva Iso-Koivisto reports that it is possible that a psychotic experience might lead to the person seeing more options and even increases active agency. One patient interviewed by Iso-Koivisto described her psychosis as a personal crisis in relation to all kinds of “smart systems”, institutions and society in general. Psychosis lead her to consider the meaning of existence. Before she was unable to answer questions concerning the meaning of existence and felt that everything she did was meaningful. Through psychosis she realized for the first time that not everything she used to do was meaningful. Grant Gillett points out that for many people with mental disorder “experiences of marginalization have caused a re-evaluation of the values around which their lives are organized and that distances them from an all-in conception of reason-governed action in terms of the choices regarded by most as normal rather than pathological”.

These “psychotic capabilities” could be seen as meaningful, in the context of capability, for one’s senses, imagination and thought, which

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131 See Kapur 2003, 15.
133 Fulford & Radoilska consider that pathological delusions are autonomy-impairing while non-pathological delusions are autonomy preserving. Fulford & Radoilska 2012, 65.
134 Iso-Koivisto 2004, 84.
135 Gillett 2012, 233.
signifies, among other things, the ability to use one’s imagination and thought in connection with experiencing. This does not mean that a person should be encouraged to experience psychosis, but it might mean that an approach which sees psychotic disorder only as something negative that has to be treated, will not see other effects that psychosis may have on the individual’s life.

5.2.3. Social roles in communities

Psychosis influences a person’s internal capabilities, and has consequences for the person’s various social roles in different communities and in society in general. For example, the Explanatory Memorandum to the RCE, notes, that since “mental disorders can have significant effects on a person’s emotions, perceptions, and capacities to think and to reason” there may be:

important consequences for the person’s private and family life, as well as consequences in the person’s other social roles, for example his or her employment.\(^\text{136}\)

Lauri Kuosmanen points out that people with severe mental problems have fewer opportunities to have their voice heard in society.\(^\text{137}\) Ethical principles also refer to the idea that people with psychotic disorder are in a vulnerable position and therefore need special protection. According to the PUN:

All persons with mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.\(^\text{138}\)

These effects on the person’s social roles may also concern freedom of belief and opinion. When it comes to private and family life, there may be a risk that the person with psychosis becomes more dependent on other family members. One might ask to what extent a person with psychotic disorder should take other people’s wishes into account when he or she makes choices (especially if the person is not able to live independently in his or her own apartment)? In some cases, the person with psychotic disorder may follow the opinions and beliefs of family members without really considering them him- or herself.

When it comes to other social roles, for example, in ideological and religious communities, there may also be a tendency “not to take so seriously” the opinions and experiences of people with psychotic disorder. Even though a

\(^{136}\) Explanatory Memorandum to the RCE 2004, Article 1.

\(^{137}\) Kuosmanen 2009, 15-16.

\(^{138}\) PUN 1991, Principle 1:3. See Heal (2012, 20-21), who discusses a person taking part in a worthwhile experiment voluntarily because it might help others but which turns out to be boring or mildly unpleasant. Whilst it might be acceptable to encourage people with “robust mental health” to carry on, it would feel unpleasant to encourage people with mental disorder to do so.
person with psychotic disorder may be tolerated by a community, there may be a long way to go to until he or she is taken seriously. I suppose that a person with psychotic disorder may easily get stuck in the role of being a psychotic person in the community, which may prevent that person from adopting some other roles. For example, I suppose that for people with psychotic disorder it is difficult to stand in an election, act as a public speaker and teach or lead groups, unless they do this in their role as a patient with the goal of influencing somehow mental health policies or other related issues. I suspect that ideological and religious communities do not usually give people with psychotic disorder or people who have a history of psychotic disorder an active role. In cases where the person with psychosis is legally under someone else’s guardianship, there are also legal restrictions which determine the person’s roles. For example, according to the Finnish Law on Association, a person who is under someone else’s guardianship cannot represent the Association.\textsuperscript{139} In the materials which I have used in my study, hardly any consideration is given to the social influences of psychotic disorder and, thus, I have had to suspect myself quite a lot. The way how psychotic disorder influences the social roles in the area of freedom of belief and opinion through social roles should be researched and discussed more. These aspects are crucially important for capability.

When it comes to relationships between economic vulnerability and freedom of belief and opinion,\textsuperscript{140} the psychotic individual’s freedom in terms of capability and his or her freedom in the negative sense may be in conflict. For example, if an individual with manic disorder wants to donate a huge amount of money to a religious community, political party or ideological group, the nursing staff has to consider whether to prevent this or not. They also have to consider whether this is a sign that the person is being exploited or whether it is something the psychotic individual wants to do as a way of participating in some community.\textsuperscript{141} It has been suggested that some people are more vulnerable than others and more easily influenced. For example, it has been suggested that weak people or people with problems are easily manipulated.\textsuperscript{142} From the viewpoint of the capabilities approach, the question is not whether vulnerable people adopt beliefs which are alien to them. Instead, the question is whether vulnerable people should be protected from

\textsuperscript{139} Yhdistyslaki 1989/503, 36§.
\textsuperscript{140} See Explanatory Memorandum to the RCE 2004, Article 7:55-57. The PUN (1991, Principle 13:4) notices that “the labour of patient in a mental health facility shall not be exploited.”
\textsuperscript{141} From the viewpoint of the capabilities approach, the central question in evaluating this might be to consider how the donating of this money will influence the psychotic individual's options to choose afterwards what to do. If the person donates so much that his or her capability to make important choices is impaired, preventing him or her from donating the money might be necessary in order to protect his or her future capabilities.
\textsuperscript{142} See Beltram 2005, 297.
adopting beliefs and practices which reduce their capabilities and are not good
for them.

On the other hand, ideological and religious communities may also
recognize that people need to develop their capabilities. There may be people
in these communities who give their time in order to understand the person’s
individual situation. These communities may also give people something to do
so that they are able to use their gifts. Moreover, communities may promote
the psychotic individual’s health, mental health included. At least, when it
comes to compliance or adherence to psychiatric treatment, the role of a
religious community seems to be important. According to Borras et al, people
with schizophrenia who considered religion important in their life and actively
attended religious group activities were the most adherent group in psychiatric
treatment. Nonadherent patients with schizophrenia were more often people
who considered religion important but did not actively attend religious groups.
Thus, it seems that so-called private religiousness among patients with
schizophrenia correlates more often with nonadherence, while social
religiosity among patients with schizophrenia correlates more often with
adherence. The nonadherent patients more often saw conflicts between their
religion and the taking of medication than adherent patients did.\textsuperscript{143} From the
viewpoint of mental health and capabilities, it might be reasonable to
encourage religious patients to be socially active in their religious group. It
might be that in most religious communities, the psychotic person’s religious
views develop in a more healthy direction if he or she gets feedback and has
somebody to talk with about religious issues.\textsuperscript{144}

In western societies in particular work life gives people
opportunities and influences their social roles in society. Therefore it is
meaningful to ask how capable psychotic individuals in general are in
deciding how to spend their time. To what extent does limited resources (in
money and status) determine what psychotic individuals are able to be and do?
Since psychotic disorder increases the risk of the person being unemployed
and incapacity for work, people with psychotic disorder are in a relatively
weak economic position. Poverty reduces the individual’s external
opportunities. When it comes to freedom of belief and opinion, a person with
economic problems has, for example, limited opportunities to engage in
ideological and religious activity if these activities cost something. He or she
will also have fewer possibilities to buy ideological and religious books, and

\textsuperscript{143} Borras et al 2007, 1240-1242.

\textsuperscript{144} Borras et al (2007, 1240, 1242) noted that only 36\% of the patients with schizophrenia discussed
spiritual issues with psychiatrists even though more than two thirds of the patients considered
spirituality very important in everyday life. See also Teinonen (2007, 149-150), who argues that
individualistic spirituality may be a risk for health because a person’s own fears and feelings of
guilt often influence his or her image of God. According to Teinonen, people usually need other
people to help them create a healthy image of God.
so on. However, to lose one’s job might have even more serious effects. For many people work signifies doing something meaningful and developing oneself, at least if the work is important and match the person’s abilities.\textsuperscript{145} Moreover, work is often associated with the idea that the person is an important and valued member of society. The lack of status that being out of work brings may also influence the way in which a person with psychotic disorder regards him- or herself. If the person feels that he or she is not important or valued, it is quite likely that the person will have a low opinion of him- or herself and feel that his or her opinions in general are not valued. This seems to be deeply connected to self-respect.

One might ask whether the state has an obligation to promote psychotic people’s opportunities to work.\textsuperscript{146} The state could, for example, promote opportunities for psychotic people to work as part-time workers without, for example, the risk of losing their pension or some other economic benefit. If a person is forced to retire because of mental health problems, it is often difficult to return to work life without losing the “secure” economic position of being a pensioner. In many cases the risk may be too high. For example, if the person receives a salary that is just a little “too much” he or she may lose his or her pension, which may be too risky for many people who are not sure about their prospects for work in the long run. The state could also reduce the risks for employers who decide to employ people with psychotic disorders.\textsuperscript{147}

Moreover, the state could promote a civil society where people’s opportunities and social roles would not be so closely tied to their occupational status. For example, a good library system serves people who are not able to buy the books themselves and their intellectual development. Moreover, there could be various kinds of free courses where it would be possible to develop one’s thinking, such as literature and writing courses and courses in philosophy, ethics and art. Moreover, the state could be obliged to

\textsuperscript{145} For example, offering work which does not really need to be done at all or which is well below the person’s abilities, may be humiliating for the person.

\textsuperscript{146} The Explanatory Memorandum to the RCE (2004, Article 3:40) clarifies that positive measures that benefit the psychotic patient should not be understood as discrimination, since the principle of non-discrimination cannot prohibit “positive measures that may be implemented with the aim of re-establishing a balance in favour of those at a disadvantage on the grounds of their past or present mental disorder. Hence, special measures undertaken to protect the rights or secure the advancement of persons with mental disorder should not be regarded as discriminatory.” The idea seems to be that the psychotic individual is not equal with others since he or she does not have the same opportunities as others. Therefore, improving these opportunities is not discrimination even though other people do not get the same help. The goal is not to give psychotic individuals more opportunities than other people. The goal is to narrow the gap between the psychotic individual’s capabilities and other people’s capabilities.

\textsuperscript{147} Problems of employment are also connected to stigmatization. I will discuss this further in the next subchapter.
give extra support to education so that people with psychotic disorder had more opportunities to develop intellectually. The state might also be legally obliged to support (for example, financially) different kinds of social groups and networks where people with psychotic disorder could come together and discuss their ideas.\textsuperscript{148} These sorts of activities could be partly provided by ideological or religious communities or by other kinds of organization in which case the state could support these organizations.\textsuperscript{149} Developing civil society in this way could help individuals with psychotic disorder who are not able to work. These people also have an important resource, namely, a lot of free time, which they could, with some support, use in a way which they might consider meaningful in order to realize their capabilities.\textsuperscript{150}

The psychotic individual’s freedom of belief and opinion is not just something that is supported officially by the state. Even though people in general might not have legal duties to promote psychotic people’s freedom of belief and opinion, it might still be seen as a wider cultural, ethical challenge to support people with psychosis to participate in, and be more social with other members of society. According to Grant Gillett, recovery is holistic which means that “nothing is incidental, and everything contributes to everything else, even something as minimal as becoming competent at walking the neighbour’s dog”.\textsuperscript{151}

A chance to get to know somebody better, a cue that you are welcome to participate in some activity, a suggestion that you make yourself known in some context or other where others may create social affordances for you, these things can be missed or not seen for what they are if a person has become alienated from others in certain ways. If the world is not in focus for you in the familiar way it is for others (as in psychosis)...you may not be able to determine the way your life goes with any degree of freedom whatsoever.\textsuperscript{152}

Thus, all of us could be asked to help people with a psychotic disorder by making ourselves available, so that they would have someone to turn to if and

\textsuperscript{148} See Wagner & King (2005, 143), who note that some patients with psychotic disorder find it important to share their experiences and views in group therapy. They reported that their understanding of their illness was developed in these groups, they were also better able to accept their illness, and even their self-esteem improved. However some patients preferred to find the information about mental disorders and reflect upon their lives by themselves.

\textsuperscript{149} At the same time, these resources should be kept socially open for people with mental problems. This challenge is connected to the problem of stigmatization.

\textsuperscript{150} It has been noted that an individual’s experience of time is connected to his or her state of integration. According to Estroff (referred by Iso-Koivistio), a person with “a lack of time” is integrated into society while the person who has a lot of empty and unstructured time is less integrated. However, Iso-Koivistio also notes that an individual’s experience of time may change after the first psychotic episode if the person becomes chronically ill. Iso-Koivistio 2006, 142; Iso-Koivistio 2004, 113. See also chapter 5.2.1.

\textsuperscript{151} Gillett 2012, 238.

\textsuperscript{152} Gillett 2012, 239.
when required. Even if there was no legal duty to do so, it might be, however, an ethical duty.

5.2.4. The stigma of psychotic individuals

The question about a psychotic person’s limited social engagement is connected to the problem of stigmatization, which can be determined as something which reduces the psychotic person’s capabilities. Stigma is produced when somebody’s psychotic disorder becomes known to other people. If it becomes generally known that someone is or has been a mental patient, this may prevent that person from returning to the life he or she had before becoming ill. Martha Nussbaum refers to stigmatization as a sign of an unjust society, which weakens capabilities. Even though she is discussing people with physical and mental impairment there is no reason to suspect that she would consider the stigmatization of people with psychotic disorder any differently. Nussbaum refers to Erving Goffman’s classic study which shows that in stigmatization the individuality and even the humanity of “the other” is denied:

the entire encounter with such a person is articulated in terms of the stigmatized trait, and we come to believe that the person with the stigma is not fully or really human. When such a person performs the most normal actions of a human life, “normals” often express surprise, as if they were saying, “Fancy that! In some ways you’re just like a human being!”

Unlike people who are diagnosed as having some kind of somatic illness like pneumonia, people who are diagnosed as psychotic may carry the diagnosis for the rest of their life. Rem Edwards sees stigmatization as a result of how power is used by psychiatrists and in mental health institutions:

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153 Kuosmanen (2009, 15) refers to the WHO (2005) when he notes that the stigma related to mental illness is one of the reasons why extensive human suffering is associated with severe mental health problems. Kuosmanen (2009, 11) also points out that stigma has hampered the realization of basic human rights. See also Välimäki 1998, 59. See also the Explanatory Memorandum to the RCE (2004, Article 1), which notes that mental disorder may have important consequences for a person’s private and family life and other social roles.

154 Iso-Koivisto points out that after experiencing psychosis the meaning of different roles is crucial for recovery. If a person loses his or her role at work or at school, hobbies, home, and close relationships, in extreme cases only the role of the patient remains. Iso-Koivisto 2004, 41; Kaltiala-Heino 1995, 11.


156 Nussbaum 2006, 191. According to Radden & Sadler (2010, 36-37) “psychiatric disorder magnifies the patient's vulnerability through its effect on the attributes associated (misguidedly or not) with personhood”.

it serves to isolate socially those persons to whom labels of lunacy are applied; and it often generates enormous mistrust and alienation between them and their family and friends. It permanently stigmatizes those so characterized and negatively affects for years to come their opportunities for such basic amenities as self respect, employment, promotion, housing, education, marriage, and general social trust and acceptance. It dehumanizes and degrades those to whom it is applied, allowing us to regard and treat the mentally ill as slightly less than human.\textsuperscript{158}

One part of stigmatization has been the undesirable effects of antipsychotic medication which have been socially disabling.\textsuperscript{159} If a person with psychotic disorder is displaced from social life and society by stigmatization, developing new ideas together with others and having some influence in society and in social life may turn out to be impossible.

It has been claimed that the stigma attached to mental illness has more influence on the patient’s future than the illness itself. Various incapacities connected to psychosis may be to some degree “an artifact of stigma, negative social attitudes, and diminished expectations, rather than symptoms of the disorder”, as Jennifer Radden and John Sadler put it.\textsuperscript{160} They describe the roots of the stigmatization found in Western cultures today:

They value the capabilities on which agency, personhood, and self-identity depend; they also prefer independence over dependence, rationality over illogic, communicative transparency over unintelligibility, self-control over impulsiveness, agency over passivity, and unity of the psyche over its fracture and disintegration. Only if we acknowledge this can we recognize how deep and intransigent are the roots of stigma over mental disorder.\textsuperscript{161}

According to Radden, the threat of stigma leads one to consider the importance of privacy in mental health care. Information concerning a person’s diagnosis and treatment and whether there are such at all, should be

\textsuperscript{158} Edwards 1997, 50. Radden (2012, 133) also lists different areas in the “outside world” where stigma has effects on the person’s life, namely, housing, educational and work opportunities, on the street, in shops, on the underground. However, these so-called external harms also have more personal consequences. They affect relationships, opportunities for love and friendship and “access to many of the pleasures of human companionship and informal association”, as Radden puts it. See also Iso-Koivisto (2004, 75) who recalls the experience of one of the patients interviewed who suspected that the use of antipsychotic medication was preventing him from creating romantic relationships. He was wondering how he would explain the fact that he has a particular medication at home, if he started to date somebody someday.

\textsuperscript{159} In newer antipsychotics there are fewer undesirable effects, which has reduced some of the problems connected to taking such medication. Kader & Pantelis 2009, 342-343; Partonen et al 2007, 729-731; Iso-Koivisto 2004, 106.

\textsuperscript{160} Radden & Sadler 2010, 35; Kaltiala-Heino 1995, 11.

\textsuperscript{161} Radden & Sadler 2010, 44.
kept private.\textsuperscript{162} Radden describes the relationship between privacy and freedom:

If I cannot get work in a daycare centre because my medical record is alluded to by a referee; or my girlfriend breaks off the engagement when her mother finds out I have a history of mental illness; or I am dropped from the bowling team when it’s rumoured I take antipsychotic medication – options are closed to me. When these outcomes are the results not of my voluntary disclosures, but of breaches of confidentiality, the scope of my freedom is decreased.\textsuperscript{163}

Radden points out that it is not only what has already become known to others, but also the risk of something becoming known that is crucially important for a person’s freedom:

My freedom is diminished not only if I am prevented from doing what I want, but if my fear of being prevented stops me from trying.\textsuperscript{164}

According to Radden, the fear of being stigmatized and finding oneself in a situation where one does not know whether other people know about one’s mental disorder, creates a sense of insecurity about where to go, what to do, what to say and how to present oneself. As Radden puts it, “fear of stigma may prevent the recovered patient from pursuing goals in ways compatible with her defining values”.\textsuperscript{165}

When interviewed after treatment about one quarter of the patients in Riittakerttu Kaltiala-Heino’s study reported that there were negative effects from hospitalization on family life, social relationships, work and leisure time activities. Even though the patients considered their capability to have a social life to be better after treatment, most patients also thought that other people did not treat them normally. It becomes more difficult to cope with mental illness in society because of the prejudices associated with illness.\textsuperscript{166}

It seems that stigmatization may lead to the existential needs of people with psychosis being ignored. Luciane Wagner and Michael King noted in their study that people with psychotic disorder considered existential

\textsuperscript{162} Radden 2012, 133. On the other hand, emphasizing privacy especially in matters of psychiatry may also sustain the phenomenon of stigmatization in society. One might ask whether in the event that some issues are to be kept secret, does this mean that they are shameful (which might account for the threat of being stigmatized in the first place) or are they just neutral private matters. It might also be possible that, at least in some cases, openness about one's disorder might reduce the chances of stigmatization.

\textsuperscript{163} Radden points out that it depends on the philosophical view whether privacy is considered a means to freedom, whether privacy affects the worth of freedom or whether privacy confers freedom. Radden 2012, 135-136.

\textsuperscript{164} Radden 2012, 136.

\textsuperscript{165} Radden 2012, 137.

\textsuperscript{166} Positive changes in social life of patients have been reported in many studies but in Finland the effect of hospitalization on social intercourse have been mostly negative. Kaltiala-Heino 1995, 105, 114.
questions as most important theme when their needs were the topic of discussion. However, carers (including both formal carers such as mental health workers and informal carers such as family members) often regarded such questions as symptoms of the disorder or as the results of failures, for example, with the medication. They also emphasized the need for health, housing, leisure and work and considered existential issues only in a secondary role.\footnote{Wagner & King 2005, 141, For example, in the principles for the treatment of mental health patients set down by The Finnish Association for Mental Health, what is meant by a patient's “good life” seems to focus on socio-economic issues whilst his or her existential needs are not discussed. Attention is also paid to the patient's right to receive appropriate treatment in a timely manner. See Mielenterveyspotilaan oikeudet 2001, 13, 17-19.\footnote{See Wagner and King (2005, 142-143) who listed, among others, these issues as existential needs.\footnote{Kaltiala-Heino refers to theories of labelling, which define stigmatization as a social process between the individual and his or her surroundings. In that process “others respond to the individual's actions in a labelling way so that evidence of serious mental disturbance is collected, and the patient's responses to labelling lead to more deviant behaviour”. The process might result in treatment in a psychiatric hospital and, thus, the person is “officially” labelled. Kaltiala-Heino 1995, 11-12, 84. According to Kaltiala-Heino (1995, 68), some patients may deny that they are ill because they are afraid of such labelling. See also Wagner & King (2005, 143), who noted that almost all patients with psychosis were “reluctant to discuss having schizophrenia, for fear of being seen as 'wild' and being rejected".}} In these cases the diagnosis may be seen as a label which influences how carers understand the existential considerations of patients. Since having existential considerations is central in humanity, one might even ask whether people with psychosis are not seen as being fully human, if their existential considerations are ignored, even though they themselves prioritize them. The tendency to prioritize health, housing, leisure and work over existential needs can also be seen in some ethical principles guiding psychiatric care.\footnote{Kaltiala-Heino 1995, 11-12, 84. According to Kaltiala-Heino (1995, 68), some patients may deny that they are ill because they are afraid of such labelling. See also Wagner & King (2005, 143), who noted that almost all patients with psychosis were “reluctant to discuss having schizophrenia, for fear of being seen as 'wild' and being rejected".} However, the reason for this might be that, for example, health, housing and leisure are sufficiently “concrete” issues to be considered as rights. This might also be the reason why existential needs are not recognized in treatment. These needs may ask too many difficult questions, which carers cannot answer. It might be easier to arrange housing and “something nice to do” (even if these things are important) than to discuss the meaning of illness, the purpose of life, the need to be “somebody” or a disappointment linked with an experienced inability to have sexual relationships, a family and children.\footnote{Wagner & King 2005, 141, For example, in the principles for the treatment of mental health patients set down by The Finnish Association for Mental Health, what is meant by a patient's “good life” seems to focus on socio-economic issues whilst his or her existential needs are not discussed. Attention is also paid to the patient's right to receive appropriate treatment in a timely manner. See Mielenterveyspotilaan oikeudet 2001, 13, 17-19.\footnote{See Wagner and King (2005, 142-143) who listed, among others, these issues as existential needs.\footnote{Kaltiala-Heino refers to theories of labelling, which define stigmatization as a social process between the individual and his or her surroundings. In that process “others respond to the individual's actions in a labelling way so that evidence of serious mental disturbance is collected, and the patient's responses to labelling lead to more deviant behaviour”. The process might result in treatment in a psychiatric hospital and, thus, the person is “officially” labelled. Kaltiala-Heino 1995, 11-12, 84. According to Kaltiala-Heino (1995, 68), some patients may deny that they are ill because they are afraid of such labelling. See also Wagner & King (2005, 143), who noted that almost all patients with psychosis were “reluctant to discuss having schizophrenia, for fear of being seen as 'wild' and being rejected".}}

Even if nobody knows that a person has been in a psychiatric hospital, a stigma may be produced because the person starts to see him- or herself “as an inferior, nonautonomous person”.\footnote{Kaltiala-Heino refers to theories of labelling, which define stigmatization as a social process between the individual and his or her surroundings. In that process “others respond to the individual's actions in a labelling way so that evidence of serious mental disturbance is collected, and the patient's responses to labelling lead to more deviant behaviour”. The process might result in treatment in a psychiatric hospital and, thus, the person is “officially” labelled. Kaltiala-Heino 1995, 11-12, 84. According to Kaltiala-Heino (1995, 68), some patients may deny that they are ill because they are afraid of such labelling. See also Wagner & King (2005, 143), who noted that almost all patients with psychosis were “reluctant to discuss having schizophrenia, for fear of being seen as 'wild' and being rejected".}

The experience may be that “psychosis comes with me everywhere”. One patient interviewed in Iso-Koivisto’s study said that “every day something to do with psychosis springs to mind”. Even though nobody else looks back at those times, suddenly when
driving a car the insistent thought “I am mad” comes into his mind.\textsuperscript{171} If the diagnosis of psychotic disorder seizes upon the issue of identity, the person’s life story turns out to consist of such things as his or her first psychosis and subsequent relapses. In this kind of story there is no possibility of change and the person, his or her close friends, family members and mental health workers do not even expect it to change.\textsuperscript{172} If there is no possibility of change after the process of stigmatization, there also seems to be no room for creativity, learning new things and developing one’s ideas. In this way, stigmatization may seriously threaten the person’s freedom of belief and opinion in terms of capability.

Even though it seems that stigmatization reduces capabilities, we still need to ask whether stigmatization is against people’s human rights. Since stigmatization is a complex process where almost everyone is involved in one way or another, in most cases it would be impossible to charge somebody with stigmatizing someone. In most cases, stigmatization might be regarded as a social problem which belongs to the area of ethics rather than a legal problem. However, from the viewpoint of the capabilities approach, the state might still have a legal obligation to prevent stigmatization somehow.

\section*{5.3. Treatment and the capabilities of an individual with psychosis}

One of the central ways in which the state influences the capabilities of people with psychotic disorder, is through psychiatric treatment. In this chapter, I consider, first, the ways capabilities are impaired by treatment. After that I discuss how treatment may support the freedom of belief and opinion of people with psychosis.

\subsection*{5.3.1. Unbalanced power structures, humiliation and alienation}

It has been claimed that psychiatrists and mental institutions have a significant amount of power over people who are vulnerable and in a weak position in society. Lauri Kuosmanen argues that unbalanced power structures reduce the freedom of psychiatric patients.\textsuperscript{173} John Sadler notes how the use of power often becomes a goal and patients are left without the possibility of defending themselves:

\begin{flushleft}
\textsuperscript{171} Iso-Koivisto 2004, 98. \\
\textsuperscript{172} See Iso-Koivisto 2004, 42. \\
\textsuperscript{173} Kuosmanen 2009, 11. See also Edwards 1997, 50.
\end{flushleft}

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The ability to declare someone’s behavior and experience as ‘ill’ or ‘disordered’ confers significant social power. The use of power brings its own controversy, and often becomes a goal in itself. With the power of psychiatric diagnosis, patients/clients’ lives and lifestyles are at stake. Those who may be most vulnerable – the recipients of mental health services – often have the least direct input into a construct that will have a profound impact on them.\textsuperscript{174}

Jennifer Radden and John Sadler note that the arrangements in psychiatric practice give unchecked power to the professional practitioner (for example, private meetings where intimate details are considered). Thus, there is the risk that the practitioner becomes the exploiter.\textsuperscript{175}

Riittakerttu Kaltiala-Heino notes that in some cases the use of coercion in psychiatric treatment has harmful psychological effects, such as demoralisation, humiliation and the feeling of being punished.\textsuperscript{176} Kuosmanen et al report of same kinds of influences:

The patients’ feelings about deprivation of their liberty were negative. They reported being distressed and sad because they were not able to leave the ward freely. From their perspective, confiscation of their property was unnecessary and ‘hair-splitting’, and they felt humiliated by being able to have their personal belongings and money at their disposal only at certain times. They regarded coercive measures as an excess of self-defence and an unnecessary exercise of power.\textsuperscript{177}

If the use of coercion leads to such feelings, the question arises whether it is possible to justify the use of coercion by arguing that the patient has a right to treatment. If treatment creates feelings of humiliation and punishment, it would seem to be an inappropriate measure for achieving better mental health. Kaltiala-Heino also notes in her study that patients who were hospitalized involuntarily were looked after by less educated members of the nursing staff than the patients who were voluntary patients.\textsuperscript{178} Kaltiala-Heino suggests that there might be a certain attitude towards involuntary patients which states:

that they are not worth using the time of the better educated, or not seen as interesting by more educated staff members.\textsuperscript{179}

\textsuperscript{174} Sadler 2005, 4.
\textsuperscript{175} Radden & Sadler 2010, 16-17.
\textsuperscript{176} Kaltiala-Heino et al 2000, 214. Moreover, Kaltiala-Heino (1997) notes that sometimes the reason for the use of coercion is a lack of alternative treatment. For example, if there were enough services for treating people as outpatients and if services were flexible enough, it would not always be necessary to use coercion.
\textsuperscript{177} Kuosmanen et al 2007, 602.
\textsuperscript{178} Kaltiala-Heino notes that this difference in the nursing staff’s education may be explained by arrangements that ensure that a patient is treated by a member of staff who is the same sex as the patient, and male staff are less educated than female staff. It may also be that male staff tend to work on wards with involuntary patients.
\textsuperscript{179} Kaltiala-Heino 1995, 94.
Kaltiala-Heino’s study reveals that nursing staff considered involuntary patients more difficult to deal with than voluntary patients. Since nursing staff know the status of the patient this might influence the attitude of the nursing staff towards them.\(^\text{180}\)

Even though there may not be direct coercion of a patient, the structures of psychiatric care may make the patient feel that he or she is being put under pressure or being ignored. Kaltiala-Heino et al note, for example, that lengthy negotiations concerning medication may feel coercive even though the patient finally “chooses” peroral medication.\(^\text{181}\) Kaltiala-Heino also found that only a quarter of the patients were satisfied with the opportunity they had to influence treatment plans. The majority felt that they lacked the opportunity to participate and had even stopped trying.\(^\text{182}\) According to Kaltiala-Heino, patients have a quite passive role after their hospitalization. They are objects of “happening” instead of being active actors who do, want and participate:

Patients have accepted that in the current type of crisis the correct solution is to remove the individual concerned and to place him in hospital to be treated although they do not in fact themselves perceive any need for this.\(^\text{183}\)

Marius Romme criticizes any use of a diagnosis that alienates people from their own experiences about what is going on:

it makes them a passive victim of disease; it inhibits an individual’s existing capability and potential and so impedes recovery.\(^\text{184}\)

Many patients also felt that they had not been given enough information.\(^\text{185}\) Jennifer Radden and John Sadler note that a person with psychosis often has reduced communicative capabilities which is particularly pronounced in situations where he or she is uncertain about what is going on and how to proceed.\(^\text{186}\)

\(^{180}\) Kaltiala-Heino 1995, 95.

\(^{181}\) Kaltiala-Heino et al 2000, 216. Compare with British law, which requires that physical force has to be used before medication is defined as forced medication. See Fulford, Thornton & Graham 2006, 550-551. See also Iso-Koivisto 2004, 74.

\(^{182}\) Kaltiala-Heino 1995, 75-76, 104-105.

\(^{183}\) Kaltiala-Heino 1995, 68. Kaltiala-Heino (1995, 68, 83) notes that even patients who do not feel mentally ill may accept hospitalization. She suggests that patients may have an ambivalent relationship with their illness and have an unclear view about it. In this situation the patient may be quite easily convinced by professionals and even relatives that there is a need for treatment. Kaltiala-Heino points out that a “discrepancy between the patient's estimation of his situation and his explanation of what happened could be seen as evidence of the power of the medical profession”.

\(^{184}\) Romme 2009, 25.

\(^{185}\) Kaltiala-Heino 1995, 84.

\(^{186}\) Radden & Sadler 2010, 37.
Some effects of antipsychotic medication can also be problematic from the viewpoint of freedom of belief and opinion in terms of capability. According to Linda Kader and Christos Pantelis, double-blind, controlled studies of antipsychotic medication show that less than half the patients derive any direct benefit from the drug they have been prescribed, and it is difficult to find the right medication without increasing the risks of undesirable effects of the medication.\textsuperscript{187} Sibtij Kapur seems to think that antipsychotic medication may reduce the individual’s motivation, desires and pleasures:

A high salience of the objects and ideas that one loves and desires is the important force that drives humans and their social interactions. It is quite conceivable that the same mechanism (i.e., dampered salience) that takes the fire out of the symptoms also dampens the drives of life's normal motivations, desires, and pleasures. Obviously, the effects are not symmetrical, i.e., drugs do not dampen normal saliences to the same degree they dampen aberrant saliences, yet I know of no drugs that selectively and exclusively affect one and not the other in animals.\textsuperscript{188}

Marius Romme and Sandra Escher have pointed out that if the role of antipsychotic medication is emphasized too much the patient may become psychologically dependent on them. Even though medication may be necessary in many cases, patients should be encouraged to find more permanent ways of dealing with their disorder. They might develop a stronger agency in relation to their disorder and thus deal with it.\textsuperscript{189} The question also arises, how far the use of medication is chosen for economic reasons. It may appear to be cheaper to treat people with antipsychotics than with psychotherapy or other kinds of discussion methods. Would there be a greater variety of treatment options and better treatment if money was less a concern and more consideration was given to the psychotic patients capabilities?

\subsection*{5.3.2. Realizing freedom of belief and opinion in psychiatric facilities}

From the viewpoint of freedom of belief and opinion in terms of capability, there is a challenge to develop treatments which support the patient to realize a way of life which he or she values.\textsuperscript{190} Martha Nussbaum describes good care

\begin{itemize}
  \item Kader & Pantelis 2009, 340-343. Kader & Pantelis refer to an article published in 1989, so it is possible that patients find newer antipsychotics to be more beneficial. See also Ford 1980, 334.
  \item Kapur argues that this particular effect of antipsychotic medicine is one of the reasons why many individuals with schizophrenia have a higher risk of resorting to drug abuse. Drug abuse might be seen as one way for a patient to bear or even counteract the dampered salience brought about by medication. Kapur 2003, 18.
  \item Romme & Escher 2000, 16.
  \item See Pietarinen (1995, 43-44), who considers that the right to receive help is a dimension of self-
\end{itemize}

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as something which addresses the entire range of a person’s central
capabilities\textsuperscript{191} taking into account the particular needs of each individual.
According to Nussbaum, good care provides stimulation for the senses,
imagination, and thought, constitutes a valuable form of attachment and
encourages social and political affiliations, supports control over one’s
political environment, promotes the capacity to engage in practical reasoning
and make choices and protects the patient’s self-respect.\textsuperscript{192}

I have noted that non- or involuntary treatment interferes with a
person’s freedom of belief and opinion in the sense of negative liberty in
many ways.\textsuperscript{193} However, a psychotic person’s stay in a mental health facility
can also be looked at from the viewpoint of capabilities. In this case, the focus
is on how non- or involuntary treatment and a stay in hospital might influence
the person’s capabilities to choose of way of life which he or she values. If the
patient is hospitalized non- or involuntarily, there are special challenges since
the patient cannot choose whether he or she is in hospital or not.

From the viewpoint of capability, the principle of least restriction\textsuperscript{194}
and the rule to respect the patient’s conviction\textsuperscript{195} are understood not only as
principles which create negative obligations, but also positive obligations for
outsiders: the nursing staff has to improve the patients’ circumstances so that
they have the same opportunities to use their rights as other people. This
obligation in legislation and ethical principles also includes the obligation to
ensure that the living conditions of the psychotic patient during treatment are
as normal as possible. Among other things, the RCE notes that:

Facilities designed for the placement of persons with mental disorder should provide each
such person, taking into account his or her state of health and the need to protect the
safety of others, with an environment and living conditions as close as possible to those
of persons of similar age, gender and culture in the community.\textsuperscript{196}

The PUN also recognizes that the patient has a right to treatment
which is suitable given his or her cultural background. While the PUN notes that the environment and living conditions in a mental health facility should

\textsuperscript{191} See the list of central capabilities in chapter 5.1.1.
\textsuperscript{192} Nussbaum 2006, 168-169.
\textsuperscript{193} See chapters 3.2.2., 3.2.3. and 3.2.4.
\textsuperscript{194} On the principle of least restriction, see the Mental Health Act 1116/1990, 22a§; RCE 2004,
Article 8; Madrid Declaration 1996, 1; PUN 1991, Principle 9:1. See also chapter 3.2.1.
\textsuperscript{195} See the PUN (1991, Principle 13:1), which states: “Every patient in a mental health facility shall,
in particular, have the right to full respect for his or her...freedom of religion or belief.” According
to the Act on the Status and Rights of Patients (Laki potilaan asemasta ja oikeuksista 1992/785,
3§): “The care of the patient has to be arranged so and he/she shall also otherwise be treated so
that his/her human dignity is not violated and that his/her conviction and privacy is respected.”
\textsuperscript{196} RCE 2004, Article 9:1.
be as close as possible to those found in normal life, it also mentions certain facilities that should be ensured, in particular.\textsuperscript{197} However, no special attention is given to the opportunity to practice one’s religion or participate in political activities during treatment. It does not even mention that during elections, the individual’s right to vote should be protected or that voting facilities should be arranged in the mental health unit. It seems that the psychotic individual’s opportunities to exercise his or her freedom of belief and opinion by voting and practising his or her religion has not been considered to be as important as his or her opportunities to engage in leisure activities, education, consuming and work.

However, the Explanatory Memorandum to the RCE points out that the catering arrangements for a psychiatric facility should take patients’ beliefs into account.\textsuperscript{198} In the sense of negative liberty this means that patients should not be coerced into eating food which they believe to be unsuitable and they should not be prevented from arranging food which they consider suitable. However, it would be more reasonable to interpret the RCE’s recommendation from the viewpoint of capability. In this case it would obligate the nursing staff to arrange suitable food for patients.\textsuperscript{199}

There are also other opportunities the nursing staff together with religious and ideological helpers could arrange for patients in non- or involuntary treatment. For example, prayer rooms could be built, discussion groups could be held, masses and services could be organized, literature could be purchased for a hospital’s library, movies could be shown, access to the internet could be arranged as could education, just to mention a few examples.\textsuperscript{200} However, I think that many mental health practitioners might

\textsuperscript{197} The PUN (1991, Principle 7:1-3) notes: “1. Every patient shall have a right to be treated and cared for, as far as possible, in the community in which he or she lives. 2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible. 3. Every patient shall have the right to treatment suited to his or her cultural background.” The PUN (1991, Principle 13:2) also points out that: “The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include: a) Facilities for recreational and leisure activities; b) Facilities for education; c) Facilities to purchase or receive items for daily living, recreation and communication; d) Facilities, and encouragement to use such facilities, for a patient’s engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.”

\textsuperscript{198} For example, Muslim patients do not eat pork. Some patients may also be convinced vegetarians, etc.

\textsuperscript{199} See the Explanatory Memorandum to the RCE 2004, Article 9:66.

\textsuperscript{200} One part of that might be patient education which supports patients’ awareness of their rights and increases well-being, compliance, coping with illness and the quality of life. However, according to Kuosmanen (2009, 25, 52), it is unclear how patient education relates to the experienced level of personal liberty and whether it decreases the level of deprivation of patient’s liberty in

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consider that if issues concerning politics, religion and ideology were more visible during treatment this would represent a threat to patients’ recovery. I have, instead, faced rules which forbid public discussions concerning religion and politics in mental health facilities. Even though the purpose of these rules is to protect patients and create a peaceful atmosphere to assist recovery and to avoid conflicts between patients, the question remains whether patients’ needs are also being ignored in the area of freedom of belief and opinion. If discussions concerning religion and politics are kept in a private area, it is problematic from the viewpoint of capability to affiliation and expression since patients are advised not to share their beliefs and ideas with others or they are advised to do so only in some restricted area with particular people. The question arises whether the attitudes of mental health workers might even discourage people with psychotic disorder from being politically, religiously and ideologically active. If such discouragement is present, is being active ideologically seen as a threat to the person’s mental health and recovery? Or are society and communities also protected from “psychotic activity”, since patients who are in a passive role may be more easily tolerated in communities? Moreover, the question arises whether ignorance of ideological themes of discussion and discouragement, if they occur, may lead to patients looking for help concerning religious and ideological issues in places and from people who may harm them. I think we need more discussion about whether open and more public dialogue about opinions, beliefs and values really is a threat to patients or whether it would promote patients’ capabilities in these areas.

It is also worth noting that there will probably not be any simple and general solutions for supporting the psychotic person’s freedom of belief and opinion in terms of capability. In cases where a patient asks for help to reach their religious, political or ideological goals, the nursing staff have to consider whether they will help or not. For example, in some cases they will have to take the need to protect the patient’s reputation and privacy into account, as well as what is good for others. Jennifer Radden reports about a hospitalized patient who wanted to preach the Gospel to people around her and wanted help to do so:

Explaning this directive to me, she urged me to share her revelation with her elderly mother and her school-age daughters. I explained that I was reluctant to do so, and that whatever the truth of these messages, her loved ones would be bothered by them. She was distressed over my decision, seeing me as an agent of the devil for my failure to tell the world of her revelation – this was a message from God, she stressed, and not to be kept secret.20

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It is not clear how this situation should be resolved and how the patient’s capabilities would be best supported.

Appropriate medication increases patients’ ability to choose a way of life they value. From the viewpoint of the capabilities approach, freedom of belief and opinion obliges actors responsible for the development of new medication to develop better treatments which would be effective in promoting abilities which the psychotic disorder has weakened with as little risk and with as few undesirable effects as possible. Antipsychotic medication can be considered as first aid, given in an emergency, which increases the chances of recovery. This is how Ford, for example, defines the liberating meaning of medication:

They can get many people over the hump of severe immobilization and free them up for discussion of their problems.202

The role of antipsychotics as a first aid is, firstly, to improve any cognitive deficits connected, for example, to schizophrenia.203 Second, antipsychotic medication may make it easier for a person to give up his or her delusions. Sihtij Kapur claims that antipsychotics provide a platform for the psychological and cognitive process whereby the individual can work through his or her delusions and hallucinations. Kapur supposes that this psychological and cognitive process follows similar stages in any case where the individual gives up cherished beliefs or overcomes frightening fears. According to Kapur “it may involve processes of extinction, encapsulation, and belief transformation”.204 However, Eeva Iso-Koivisto notes that for some patients the possibility of coming off their medication or controlling the dosage themselves signifies subjectivity and agency.205 Thus, from the viewpoint of capabilities it seems important that the patient knows that he or she is not forced to use medication but that it is something that the patient can consent to. Moreover, psychiatric treatment should not be based on medication in an unbalanced way. Even if medication promotes capabilities, it does so only in part. According to Marius Romme and Sandra Escher, it is important that patients with psychosis learn to talk about their experiences and to deal with them so that they become leaders of their lives. They claim that this ability is supported by putting psychotic experiences into the context of people’s life problems and treating their personal philosophy with interest and respect:

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203 See Kader & Pantelis 2009, 342-343. See also Iso-Koivisto 2004, 73. One patient interviewed by Iso-Koivisto (2004, 74) found that after starting medication her thoughts did not run through her mind, as much any more.
204 Kapur 2003, 17.
205 Iso-Koivisto 2004, 103.
we noticed how liberating voice-hearers found it to be able to express their intense experiences freely. They find it exhilarating to have someone listen to them with interest and respect, not argue away what they have to say, to express disbelief or contradict them. In other words, to be with people who can accept that there might be different realities for different people.206

5.3.3. Participation in decision making

It is also important to note that a psychotic person may need help in making decisions. Patients interviewed in Maritta Välimäki’s study reported that this was an important aspect of self-determination. One of the patients said that “it’s good that we talk [with staff] about things, that we don’t get to decide everything by ourselves just like that.” For another patient, self-determination meant that “there’s someone there to talk with or something. Like that you can get things sorted out for yourself”. Välimäki defines shared self-determination as situations where patients share their rights with nursing staff either in full or in part, and work together with nursing staff and are supported by them. It’s team-work and mutual support.207 Välimäki argues that nurses are patients’ advocates:

open dialogue with nursing staff, making proposals or even making decisions on the patient’s behalf may be an integral part of the patient’s right to self-determination. Indeed it is suggested here that it is perfectly legitimate to refer to self-determination even in the case of dependent and incompetent patients – even though this is a very vulnerable sort of self-determination that can be easily restricted.208

The idea of shared self-determination can also be recognized in the definition of autonomy presented by Guy Widdershoven and Tineke Abma when they define autonomy as moral development, which, in turn, is dialogical and practical learning.209 If autonomy is understood in this sense, it is crucial that a patient is able to reflect on his or her values and find a way of practically dealing with his or her situation. However, the patient may need help in order “to develop a new and better understanding of his situation and a more adequate way of dealing with it”.210 Widdershoven and Abma emphasize the dialogical nature of this process. Though the patient’s wishes and decisions are a starting point, they are not taken as granted, since the patient

206 Romme & Escher 2000, 10, 14.
207 Välimäki 1998, 64-65. See also Iso-Koivisto (2004, 111), who notes that a patient may also need help after a psychotic episode in order to consider his or her self and social identity.
208 Välimäki 1998, 65. Kuosmanen (2009, 13) also refers to the idea that nursing staff play the role of advocates: They can offer relevant information to the patient and encourage him or her to engage in collaboration and active involvement.
may also learn to see what matters in life. In a dialogue the patient may change his or her view, and carers may do so, too. In some situations care professionals have to help the patient to refrain from getting involved in some situations “which may tempt them to do things they will regret later”. The professional may persuade the patient to be cooperative by offering convincing reasons. Widdershoven and Abma suggest that “the aim of the deliberation between physician and patient is to discuss facts and values, and come to an agreement”. They refer to a patient who agreed to use medication which had undesirable effects because it helped him to realize his new values.\(^{211}\) Widdershoven and Abma also emphasize that in a dialogue, the focus should be on concrete interests and concerns:

Such a dialogue is not a theoretical exchange of viewpoints, but a practical process of negotiation about concrete actions.\(^{212}\)

From the viewpoint of the capabilities approach, it is not necessarily a threat to a patient’s freedom of belief and opinion if decisions are made together. People are seen as fundamentally social and even dependent on others, and being independent is not seen as an ideal in the way it is when the nature of humanity is discussed in the contexts of negative liberty and authenticity.\(^{213}\) However, Martha Nussbaum emphasizes that in cases where a person is dependent on others to the extent that he or she needs a guardian, the point of guardianship should be to promote the person’s access to all the central capabilities and to support the person’s opportunities to choose:

The norm should always be to put the person herself in a position to choose functioning of the relevant sort. Where that is not possible, temporarily or permanently, the sort of guardianship to strive for will be one that is narrowly tailored to assist the person where assistance is needed, in a way that invites the person to participate as much as possible in decisionmaking and choice.\(^{214}\)

Lauri Kuosmanen states that it is important that the patient’s capability for choice is supported as much as possible “even in ostensibly minor matters”.\(^{215}\) Jane Heal emphasizes the importance of supporting the patient’s sense of self-worth by “calling on whatever concepts and awareness they still have which enable them to take part in projects where they can see themselves as


\(^{212}\) Widdershoven & Abma 2012, 229.

\(^{213}\) People are, according to Nussbaum, fundamentally social. They share goals with each other and, thus, their “goods” are not separate, but common issues. The capabilities approach recognizes that human relationships include symmetrical relationships and asymmetrical relationships. In both relationships there can be reciprocity and truly human functioning. Nussbaum 2006, 91, 160.

\(^{214}\) Nussbaum 2006, 199. Nussbaum (2006, 189) also points out that even if people prefer dependency, other people should offer them alternatives.

\(^{215}\) Kuosmanen 2009, 21-22.

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contributing to something important or having some worthwhile status”. In discussing elderly patients with Alzheimer’s she points out:

They should not just be fed, kept warm and clean, and otherwise ignored, but should be drawn in as cooperators, enabled to feel valued.216

In situations where a person is defined as incompetent or unauthentic or not capable of deciding about his or her treatment, there is a threat that nursing staff will simply assume what he or she would prefer. When doing this, they may be guided more by what they themselves value than what the person in question is like or would value. This was clearly the case with an example presented by Elisabeth Fistein when nursing staff just supposed that Mrs Day would probably flourish in an environment where she would have the opportunity to make friends, even though Mrs Day had, according to her sons, always lived on her own and been independent.217

In order to help people with psychotic disorder to be more capable in their social life, Riittakerittu Kaltiala-Heino suggests that there should be strategies to maintain the social roles of patients. As Kaltiala-Heino puts it, “to be passive and let others act does not enhance gaining an active hold on one’s own affairs”. According to Kaltiala-Heino, actively participating in treatment planning might increase a patient’s activity and improve the social outcome by training him or her to take hold of his or her own life. Kaltiala-Heino emphasizes the role of mental health workers who need to control their paternalistic drives and let the patients, instead, take responsibility for themselves:

Patient passivity is not likely to be changed by the patients, who bear the restrictions of the illness and possess less power in the health care system.218

According to Kaltiala-Heino, efforts should be made, for example, to find understandable ways of giving information to patients.219

5.3.4. The consumer model and individualized care

The capabilities approach focuses on the individual’s opportunity to choose and ability to realize goals. Thus it seems, that the consumer model and individualized care in psychiatric treatment are also relevant topics when discussing the psychotic individual’s freedom of belief and opinion.

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216 Heal 2012, 21.
217 Fistein 2012, 172, 184, 187.
In the consumer model, people with psychosis are seen as consumers of mental health services who are invited to give feedback and express their opinions concerning these services. Mental health practitioners are seen as advisers, coaches or collaborators who assist the person to achieve his or her self-defined life goals. Jennifer Radden and John Sadler note that the consumer model can be applied only partly in cases where a patient suffers from psychosis because they may be temporarily or partially deprived “of the very capabilities required for an exercise of autonomy”. However, Radden and Sadler note that patients’ capabilities have too often been underestimated. According to them, one should recognize that people with psychotic disorders probably become autonomous consumers at some point in their treatment. Moreover, one might ask whether a patient should have more options even if he or she has been sent for involuntary treatment. For example, could a patient choose the psychiatrist who treats him or her? If this kind of significant power was given to patients who are sent for involuntary treatment would it make the treatment more successful, would it reduce the chances of them feeling humiliated and would it increase their self-respect? For example, if a patient was worried about how his or her religious beliefs would be considered during treatment, he or she could choose a psychiatrist who he or she would trust and who he or she felt safe discussing this issue with. People with less severe mental disorders have more options to choose their psychiatrist or psychotherapist even though their fate usually depends less on them.

One part of being a consumer of mental health services is having the possibility of complaining if there seems to be something wrong with the treatment. Lauri Kuosmanen points out that in psychiatry, patients’ options for complaining are relatively weak. Even though there is a legal right to complain, many factors can prevent a psychotic person from exercising this right. Some patients are pessimistic when it comes to the question of how complaint procedures work. Some are unsure about what they can expect from their treatment in the first place. Some fear that there will be negative consequences if they complain: the quality of their care may fall or reprisals might follow. Therefore, there might be tendency rather to keep quiet and adapt to the situation. The complaint procedure may be too complicated and too demanding for some patients because of the unbalanced power structures in psychiatric hospitals, a lack of access to information about the complaint

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222 Widdershoven & Abma (2012, 229) seem to be open to something like that since they note that if it is necessary “the care situation should be adjusted, for example when a patient does not want to be helped by a certain professional, but is open to another”. However, could the opportunity to choose one’s psychiatrist be open to all those who seemed capable of making such a choice?
procedure and the slow evaluation of complaints once made. Kuosmanen suggests that the complaint system, in general, should be simplified.\textsuperscript{223}

Even though the consumer model seems to provide more options to people with psychosis, the need for deeper service user involvement in psychiatry has been recognized. Instead of seeing patients consuming services which somebody else has planned for them, they could also have the power to decide what the content of these services should be. Hickey and Kipping call this deeper involvement the democratization approach.\textsuperscript{224} Moreover, patients could have more opportunities to speak out for themselves when different psychiatric definitions are given and when mental health research is made. Maritta Välimäki describes how some patients were delighted when they were asked about their views about self-determination, and said that it was the first time that someone had shown an interest in what they thought. Välimäki also notes that many patients were capable of offering important insights into the concepts and definitions that are used in mental health nursing.\textsuperscript{225}

Emphasizing service user involvement seems to go hand in hand with the idea of individualized care. When the focus is on consuming, the idea is that the treatment offered has to be in line with the individual’s wishes.\textsuperscript{226} The important idea behind individualization is that people are not (stigmatized) “types” but individuals.\textsuperscript{227} When it comes to treatments and the needs of people with psychosis, Roger Peele and Paul Chodoff describe the background idea of individualization, which has brought, according to them, more treatment options for psychiatric patients:

Any statement that ‘The mentally ill need...’ is suspect because they comprise such a heterogeneous group. Even those who espouse hospital-based treatment, for example, can cite success stories of reluctant patients being discharged into the community but then becoming relatively independent and productive as a result. If the goal is concern for the individual, blanket statements about what all psychiatric patients need in terms of care are not meaningful or useful.\textsuperscript{228}

\textsuperscript{221} Kuosmanen 2009, 21, 24, 50-51, 53.
\textsuperscript{222} Involvement in decision making may also have a therapeutic value for the patient. Hickey & Kipping 1998, 84-85. See also Kuosmanen (2009, 11-12), who states that one main goal of service user involvement should be to decrease the burden of mental illness on the individual and on society.
\textsuperscript{223} Välimäki 1998, 64-65. See also Fulford, Thornton & Graham 2006, 602.
\textsuperscript{224} Peele & Chodoff 2009, 215.
\textsuperscript{225} Nussbaum (2006, 191) discusses this in the context of people with mental impairments. According to Nussbaum (2006, 207), “respect for individuality has to be paramount, if the goals inherent in the capabilities approach are to be realized”.
\textsuperscript{226} Peele & Chodoff 2009, 225-226.
Fulford et al argue that different patients have different values. Service users are not a homogeneous group with similar values. They are all individuals with values of their own.\footnote{Fulford, Thornton & Graham 2006, 477. It is also worth noting that mental health is an area of healthcare where the values of individuals differ relatively widely. Fulford, Thornton & Graham 2006, 479.}

However, in the context of the capabilities approach, the focus of individualized care, which is considered crucially important by Martha Nussbaum, is not on fulfilling the individual’s dreams but on his or her agency. Instead of satisfaction of the patient Nussbaum emphasizes how important it is for the patient to have the opportunity to be active in the world even if the patient experienced some frustration.\footnote{Nussbaum 2006, 73-74. When it comes to people with down syndrome, for example, according to Nussbaum (2011, 30), human dignity guides one to make policy choices which protect and support agency rather than choices that infantilize people and treat them as passive recipients of benefits.} Elizabeth Fistein also notes that people with impaired capacity for autonomous agency would not be able to flourish in an environment where “all their wishes were respected”, since they are not always able to work out how to achieve the state of affairs that they value or care about. Moreover, people are not always aware of the threats and risks associated with pursuing their goals.\footnote{Fistein 2012, 186.}

Jennifer Radden and John Sadler also point out that the psychiatrist cannot adopt the patient’s views as such if they do not correspond with his or her own views about what is wrong and what solutions might work.\footnote{Radden & Sadler 2010, 39, 57-58.} The psychiatrist is still obliged to understand what the patient’s point of view is:

But she can be asked to try to understand, and to respect, these alternative perspectives, recognizing the degree of controversy attaching to these ideas, and understanding the source of that controversy – the extent to which they rest not only on discoverable empirical realities but on deeply held moral and philosophical attitudes and beliefs. Accordingly, she can be expected to approach her own stance with an appropriate humility, allowing herself to meet the patient “where she is,” and to negotiate treatment with explicit reference to the patient’s values and perspective.\footnote{Radden & Sadler 2010, 58.}

Fulford et al also emphasize that it is important to know what the patient’s wishes and goals are even if the patient will not be helped to realize them. They also point out that too often goals are misunderstood or are simply assumed without asking patients what they really are:

Ethical reasoning, in particular, has too often been based on little more than taken-for-granted intuitions about what people want, feel, fear, and so forth, rather than on what they actually want, feel, fear, and so forth.\footnote{Fulford et al even state that the most dangerous lack of insight in mental health is not a lack of insight of patients with psychosis, but “professionals’ continuing lack of insight into service users’ needs.”}

\textbf{301}
5.4. Challenges presented by the capabilities approach in the context of human rights discussion

When freedom of belief and opinion is understood in terms of capability, it is not clear how far this view is applicable in juridical human rights discussion. In this chapter, I consider the challenges of the capabilities approach when freedom of belief and opinion is discussed. First, it is unclear to what extent capabilities are legal rights and to what extent they are ethical goods. Second, the problem of the capabilities approach seems to be that it does not answer clearly how the *forum internum* should be understood and whether it should be defined as an absolute right. Third, the relationship between capabilities and functionings seems to be unclear. However, since a view of humanity in the capabilities approach seems to be relevant for understanding the situation of individuals with psychosis, it leads one to consider whether the capabilities approach could be developed further in order to understand freedom of belief and opinion. In the end, I consider whether ideas presented in the context of values-based practice could be utilized when developing the capabilities approach.

5.4.1. Legal or ethical rights?

When the psychotic individual’s freedom of belief and opinion is discussed in terms of capability, the challenge seems to be that it is unclear what exactly should be protected by law. It seems that capabilities are weakened because other people are suspicious, because mental health workers and other people are not sufficiently virtuous and so on. However, it is unclear how these problems could be solved by legislation. Even if there were some legal solutions, the attitudes of those who follow the rules of law rather than what the law rules seems to be more crucial for psychotic individuals’ capabilities. There seems to be a challenge for the capabilities approach: Psychotic people’s freedom of belief and opinion in terms of capability is very much an ethical question which cannot be solved by law. However, since freedom of belief and opinion is a legal right, it should be understood in such a way that it is possible for it to be protected by law.

It seems that this challenge can be described by considering the relationship between principalism and virtue ethics as a background supposition to different views of freedom. In principalism some declared general moral norms or action guides are central.\(^\text{235}\) It seems that legislation is

\[^{235}\text{real needs”}. Fulford, Thornton & Graham 2006, 475-477.\]
based on principalism, and when freedom of belief and opinion is discussed in the negative sense or in terms of authenticity, the principalist approach seems to be applied. However, when freedom of belief and opinion is understood in terms of capability, a background supposition also seems to lean on virtue ethics since virtues are required for a right to be realized.236 The focus is on the mental health practitioner’s character, such as honesty, compassion, integrity, courage and fairness.237 Even though some juridical principles can be derived from virtues like these (for example a patient’s right to information requires some kind of honesty and integrity on the practitioner’s side), a person cannot be ruled to be virtuous by legislation, not at least on the deep level described by Jennifer Radden and John Sadler:

In addition to the knowledge and skill demanded by the psychiatrist’s role are feelings, and emotional attitudes, and responses that are conveyed not only through words but also through such nonverbal attributes as demeanor and body language – emotive listening, for example. Inner states, and dispositions to feel and respond in particular ways, and the ability to convey these nonverbally, are essential to fostering and maintaining the alliance that we have seen is necessary for effective practice.238

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236 Nussbaum is sometimes seen as virtue ethicist. See, for example, Hurdhouse 2012; Hallamaa 1994, 176. Nussbaum (1999, 163) herself states that virtue ethics is not a separate category in relation to consequentialist and deontological ethics, since those principalist approaches also include ideas about virtue.

237 See Radden & Sadler 2010, 62; Oakley 2001, 93. Radden & Sadler suggest that virtue ethics is important for psychiatrists because 1) they deal with patients who are at risk of exploitation, 2) mental disorders influence communicative capacities which require patience, compassion and understanding from the practitioner, 3) some symptoms are painless or even pleasurable (mania), so additional vigilance and extra perseverance are demanded, 4) extra truthworthiness and care over confidentiality is needed when dealing with personal and private details because mental disorders are controversial issues which are subject to misunderstandings and stigma, 5) mental disorder influences autonomy, mood and reasoning capabilities, so extra moral seriousness and effort is required 6) gravitas or wisdom is needed because the psychiatrist is not only a healer but also a moralist who is an arbiter over society's central values like autonomy and rationality and 7) psychiatrists have the power to restrain and treat adult patients against their wishes. Radden & Sadler 2010, 14. Sometimes the ethics of care is seen as a branch of virtue ethics. Manning (2001, 98-99) lists five features of ethics of care, namely moral attention (attention to the situation in all its complexity, becoming aware of all the details), sympathetic understanding (sympathizing and even identifying with the person and putting oneself in the other person's situation and thinking what one would hope that others would do in one's place), relationship awareness (recognizing that the other person is in a relationship and in different kinds of relationships with carer and being aware of all the personal relationships which the person has and strengthen these relationships), accommodation (since many people are involved and it is not clear how to help, one has to accommodate the needs of all by doing what you think is best, while at the same time giving everyone concerned a sense of being involved and considered in the process), response (making the caring evident through actions which one takes in responding to the person's need). See also Beauchamp 2009, 31.

238 Radden & Sadler 2010, 64.
When human rights and law are discussed, it is also a challenge for the capabilities approach to ensure that a psychotic person’s capabilities are promoted in individual situations and that each individual case receives due ethical consideration. On the one hand, as Nussbaum sees it, this is one of the strengths of the capabilities approach:

People vary greatly in their needs for resources and care, and the same person may have widely varying needs depending on her time of life. The ability of the capabilities approach to recognize this diversity was one of the strengths that initially commended it over other approaches.

On the other hand, legal rights should be declared in general by recognizing general rules to protect, for example, individuals with psychosis. It would be too idealistic to assume in a legal context that mental health workers have sufficient virtue in order to make good decisions in individual situations, even though in many cases they, of course, might have such virtues. However, mental health legislation and ethical guidelines are created precisely in order to protect people, since abuse does occasionally occur. Moreover, it is questionable how far we may have a general legal duty to take into account each person’s individual situation in psychiatric treatment, or in general, for example in ideological communities. It is, certainly, part of good communication and good care to take the another person’s situation into account, but can it be a reasonable legal duty?

Even though there might not be a legal duty to be virtuous, it might be considered that it is the state’s duty to create structures which help people to be more virtuous. This might be one of the reasons for providing a basic education for all its citizens. However, the virtues of people working in the field of psychiatry could be especially promoted in their education and by creating structures in the treatment context which would challenge us to engage in ethical discussions. Developing virtues in psychiatric education has been suggested, for example, by Jennifer Radden and John Sadler, who argue that we are not in control of all our virtues in the sense that we can command ourselves to be virtuous. We cannot, for example, command ourselves to feel empathy. However, the way in which we grow up and the experiences we have in life influence our ability to be empathic. Moreover, it is possible to

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239 See Nussbaum 2006, 169-170. When Laitinen (1996, 7-8) describes the moral problem of a psychiatrist who has to decide whether to send the patient for involuntary treatment or not, he notes that his or her decision is always made in a state of uncertainty. The psychiatrist can try to deal with this uncertainty by collecting more information or considering the goodness and badness of different options in each case.


241 If there were such a duty, any public expression of one’s opinions would be very challenging for other people. It might be difficult for people to say or teach anything about sensitive themes since there would always be a risk that some individual in a vulnerable situation might be harmed.
deepen and enhance empathy as it is with other virtues. This is why developing virtues is, according to Radden and Sadler, an important part of psychiatric education.\footnote{Radden & Sadler 2010, 63-65.} When discussing the kind of psychiatric treatment that the patients’ freedom of belief and opinion in terms of capability requires, the question also arises whether society has the resources to ensure such treatment. Are the demands presented by the capabilities approach to the state reasonable? From the viewpoint of the capabilities approach, states should have quite high ambitions when it comes to promoting capabilities. Nussbaum suggests that a system of civil service could be a good idea. Young people would have a legal duty to take care of others. It seems that Nussbaum would be ready to restrict certain aspects of other people’s negative liberty in order to promote the capabilities of all. She understands that “the idea that two or three years of life would actually be given to others” sounds absurd for many. However, she reminds us that “this work is being done every day, usually by people who are far less able than the middle-class young to afford the drain on time and energy that it imposes”.\footnote{Nussbaum notes that in the same way as in many countries there is obligatory military service, there could be an obligatory care-giving service for both men and women. Nussbaum 2006, 213-214.} So, it seems that in the context of the capabilities approach there might be a willingness to create more legal duties for people in order to protect and promote capabilities.

\subsection*{5.4.2. What about the forum internum? Capability and absolute rights}

When freedom of belief and opinion is understood in terms of capability, it is unclear what the \textit{forum internum} might signify and whether it can be defined as an absolute right.

On the one hand, in so far as the background suppositions of the capabilities approach lean on virtue ethics, the idea of some absolute rights or absolute rules can be questioned. According to Justin Oakley, “virtue ethics need not claim that there is only one true account of what a virtuous person would be and do, for it can allow that, sometimes, whichever of two courses of action one chooses, one would be acting rightly”. Virtue ethics has been criticized for allowing actions which are not justified. People with good intentions may do bad things even though they mean good. Virtue ethics alone, it is claimed, is incomplete and has to be connected with deontological or utilitarian approaches. However, it can also be asked whether a person who
does a bad thing even though he or she meant to do a good thing was really
virtuous, at least sufficiently, when all the different kinds of virtues are taken
into account. 244 When it comes to the list of capabilities presented by
Nussbaum, it seems that none of the listed central capabilities are defined as
absolute since the list is, according to Nussbaum, open-ended and “subject to
ongoing revision and rethinking, in the way that any society’s account of its
most fundamental entitlements is always subject to supplementation (or
deletion)” . 245 Nussbaum also emphasizes that since the elements of a life with
human dignity are plural and not single, no single capability can be prioritized
over others:

It would be a grave error to single out any one of the ten to bear the weight of indexing
relative social positions: all are minimum requirements of a life with dignity, and all are
distinct in quality. 246

The tendency to avoid prioritizing some capabilities over others conflicts with
the view that there are some absolute rights, because absolute rights are
prioritized rights. It seems that, according to Nussbaum, prioritizing some
capabilities would weaken the position of others. It is, actually, worth asking
whether the distinction made between the forum internum and the forum
externum actually leads to a weakening of the position of the right to the
forum externum. It could be argued that the forum externum can be restricted
because “the core of the right is still intact”. The idea is then that it is not so
serious if people are prevented from manifesting their beliefs and opinions,
since they can still “hold their views in their minds” (if this is how the forum
internum is understood).

However, there seems to be some kind of tension in Nussbaum’s
thinking, since she also emphasizes the role of certain liberties, namely,
freedom of speech, freedom of association and freedom of conscience in the
capabilities approach and claims that they have a “nonnegotiable place”. Thus,
at the same time as the list of capabilities is open for deletion, some of them
are nonnegotiable. However, since Nussbaum also seems to claim that there
should be something in persons which was inviolable, 247 the idea that there are

244 For example, in discussions concerning abortion and euthanasia the lack of absolute rules is
significant in virtue ethics approaches when they concentrate on the reasons why a person makes
certain decisions and questions concerning the quality of life. Oakley 2001, 94-95.
245 Nussbaum 2006, 78.
246 Nussbaum 2006, 84-85.
247 Nussbaum (2006, 342) criticizes utilitarian approaches for not protecting individuals and for not
seeing something inviolable in persons: “Slavery, the lifelong subordination of some to others –
none of this is ruled out by the theory’s core conception of justice, which treats all satisfactions as
fungible in a single system.” See also Radden & Sadler (2010, 69), who also welcome rules and
principles in psychiatric ethics in order to codify what is minimally acceptable conduct and to
establish minimal standards.
some absolute rights could probably be defended in the context of the capabilities approach.

Because prioritizing is persistently avoided in the capabilities approach, it is unclear what these possible absolute rights could be. I can assume that since capabilities signify that the individual is capable of choosing a way of life which he or she values and which is worthy of human dignity, absolute rights could deal with self-respect and the ability to ascribe values and to value something. Could one absolutely prohibit the exploitation of another person’s capabilities? In such an instance of exploitation, an other person or other people seek control somebody. An absolute prohibition of slavery could be derived from such an idea. Or, treating somebody in a humiliating way in order to benefit others, could be absolutely prohibited, as well. Thus, an absolute prohibition of torture could also be adopted in the context of the capabilities approach as something which absolutely violates the kind of life which is worthy of human dignity. However, what could the forum internum signify? Could it, signify, at least partly, the negative right to mental competence, as I suggested when discussing negative liberty? If the terms presented in the context of the capabilities approach were used, could it mean that if the person’s neuro-biological preconditions to engage in practical reasoning were intentionally destroyed, this would constitute a violation of absolute human rights? In the context of the capabilities approach, this absolute negative right could be widened to include abilities to experience emotions, exercise one’s imagination and the ability to have relationships with others. These internal capabilities could be protected from the interference of other people. Even though the individual might have no right to hold a delusion, he or she does have, however, the right to such internal capabilities which he or she uses when he or she forms delusions.\footnote{It seems to be in this way also when mental competence is discussed. The person has to have some abilities required in mental competence in order to be able to form delusions.}

Thus, for example in situations where delusions seriously weaken capabilities, measures which relieve psychotic symptoms and which interfere with internal capabilities could not be used. However, since the capabilities approach seems to be very unclear about absolute rights, we cannot go further with the suppositions presented above. For now, this lack of clarity is a significant challenge for the capabilities approach. The law has to be clearer than the capabilities approach seems to be, and thus there is need for further discussion.

5.4.3. Capabilities or functionings?

The capabilities approach lacks clarity concerning the relationship between capabilities and functionings. When it comes to capabilities linked with
freedom of belief and opinion which deal with participation and actively manifesting one’s values, Nussbaum clearly states that it would be dictatorial and illiberal to make people function in these areas. People have to be capable of choosing whether they, for example, participate in political activity or express their religious ideas or whether they prefer not to function in these ways:

with items such as political participation, religious functioning, and play, it seems obvious that it is the capability or opportunity to engage in such activities that is the appropriate social goal.249

According to Nussbaum, people should also be able to choose whether they act in a healthy way or not.250 However, when it comes to internal capabilities such as practical reasoning and the ability to use the senses, to imagine and to think, it is more challenging to distinguish between capability and functioning. How could someone have the capability to engage in practical reasoning if he or she does not put his or her practical reasoning to use? What does it mean to be capable of imagining and thinking if a person does not imagine or think? Nussbaum recognizes these conceptual challenges but stands for the principle of promoting the “opportunity to plan life for oneself, and to achieve emotional health, but not to preclude choices citizens may make to lead lives that inspire fear or involve deference to authority”. According to Nussbaum, it is clearly only the area of self-respect and dignity itself where functioning is needed. Nussbaum states that people should not be able to choose whether they are treated respectfully or not. This means that it should not be possible to lose respect.251 However, since it seems that self-respect is intertwined with all the central capabilities in one a way or another, it is unclear how widely functioning actually stretches as a goal.

Moreover, for some people, such as children and people with severe mental impairments Nussbaum defines functioning as a goal. She defends compulsory health care for them:

It seems clear that in many instances many of these people cannot make choices about their health care, or consent to sexual relations, or make an assessment of the riskiness of a job or occupation. So there will be many areas, for many of these people, in which functioning, rather than capability, will be an appropriate goal.252

249 Nussbaum 2006, 171.
250 It seems that the role of health as capability and functioning is open for discussion in the capabilities approach. Nussbaum herself states: “advocates of a capabilities approach differ about whether the appropriate goal is capability or functioning. My own view is that people should be given ample opportunities to lead a healthy lifestyle, but the choice should be left up to them; they should not be penalized for unhealthy choices.” Nussbaum 2006, 79-80.
251 Nussbaum 2011, 26; Nussbaum 2006, 172.
Nussbaum also defends compulsory education for children “as a necessary prelude to adult capability."²⁵³ Thus, it seems that when it comes to the rights of people with psychotic disorder, in some cases functioning may be the urgent goal instead of capability. For example, if a patient with psychosis wants to live in a closed religious community, one might question whether that person should be prevented from doing so if it seems that his or her capabilities to make choice would be seriously weakened by living in such a community. However, from the viewpoint of capabilities it seems to be unclear how far the capabilities of psychotic people can be protected compulsorily.

It seems that principalistic approaches give more “either or” answers in these kinds of situations. The justification of decisions concerning a psychotic person depends crucially on which side of the border between sufficient and insufficient competence or authenticity the psychotic person is. If the person is sufficiently competent, paternalistic intervention is not justified even though it is, if the person is not sufficiently competent. In the same way, a sufficiently authentic person is left without intervention, but the person who is determined to be unauthentic may be object of such intervention.²⁵⁴ When freedom of belief and opinion is understood in terms of capability, there does not seem to be a clearly defined border or point beyond which intervention would be justified. One reason for this might be that freedom of belief and opinion in terms of capability is such an idealistic goal that large numbers of people might be seen as needing support in order to be capable. Therefore, psychotic individuals are not special cases beyond a certain point.

When I considered freedom of belief and opinion in the negative sense and in terms of authenticity I noted that there was a “special application” about these rights for individuals with psychosis. On the one hand, this also seems to be so when freedom of belief and opinion is understood in terms of capability: When the psychotic individual’s rights are being discussed, the goal is not necessarily capability like it is in general, it may also be functioning. On the other hand, even if there is this kind of “special application” in the capabilities approach, it does not seem to be rooted in as deep background suppositions about being exceptional as the

²⁵⁴ For example, Radoińska (2012b, 275) seems to suggest that autonomy could be understood “in terms of authorship and ownership of one's motives and actions” and when these types of self-determination no longer hold firm, the views of autonomy, which she calls value-laden and relational, should be applied. However, if freedom of belief and opinion is understood in terms of capability, there is no need for such a clear, special application for psychotic people. It is not that, in general, freedom of belief and opinion is understood as negative liberty, but for people who are not sufficiently competent, we adopt a view of freedom of belief and opinion in terms of capability. Instead, rights should be understood in the sense that they are the same for everyone.
special applications presented in the context of negative liberty and authenticity are. Functionings are goals only as far as protecting capabilities requires. In this sense capabilities are defined as goals for everyone. Moreover, the list of central capabilities is the same for everyone, everyone is defined as citizens, and in this sense there are no “special applications” for different people in the capabilities approach. Nussbaum states:

The capabilities approach operates with a list that is the same for all citizens, and it uses the notion of a threshold level of each of the capabilities, which is taken to be a minimum beneath which a decently dignified life for citizens is not available.

This seems to mean that individuals with psychotic disorder are not exceptions as fundamentally in the capabilities approach as they are when freedom is understood in the negative sense or in terms of authenticity.

5.4.4. The view of humanity in the capabilities approach

In spite of the challenges linked to capability when it is discussed in the context of human rights, its significant potential seems to be rooted in the way humanity is seen in this approach. First, it seems that when freedom of belief and opinion is understood in terms of capability the problems that we faced when discussing authenticity seem to disappear. When we discuss capabilities, we are not interested in who the individual “really is” in some metaphysical and idealistic sense. The capabilities approach is more focused on humanity in general. Even though individualized care and the meaning of the individual’s values are emphasized, at the same time it is argued that the psychotic person, as a human being, has the same kind of needs as everyone else. Everyone has the same human capabilities and it is these capabilities that are being promoted.

Second, when freedom of belief and opinion is understood in the negative sense, the problem is that only competent citizens are defined as full members of society. For example, John Rawls describes citizens as “fully cooperating members of society over a complete life”. According to Rawls, any problems that arise concerning people who do not fit these requirements can be solved after the basic political principles have already been chosen. In

Nussbaum 2006, 98, 179, 190. See also Nussbaum (2006, 184-186), who states that there should be one list of central capabilities for everyone even though some people would not use some of the capabilities for functioning in a certain way (for example, people who never vote should have the right to vote). If there were different lists for different people, there would be, according to Nussbaum, hierarchy instead of full equality. Nussbaum also notes that people who dislike religion often still prefer that people may choose their religion. Thus, there is single list of capabilities even though people have different views about what it is to flourish.

Nussbaum 2006, 179.
this context Rawls also mentions that some have mental disorders “so severe as to prevent people from being cooperating members of society in the usual sense”.

The Kantian view about person also seems to exclude many people with psychotic disorder. According to Kantian view, reason is the central factor which distinguishes human persons from animals and animality. Humanity is grounded, according to Kant, in the capacity to engage in moral rationality. Even though, Kant claims that each person should be treated as an end itself and never as a mere instrument, this is not applied to those who do not fulfil the requirement of person. These people have no dignity as such, but only in relation to persons. Nussbaum claims that the Kantian view suggests that the core of humanity and personality is self-sufficient rather than needy, and active instead of passive. Diseases, old age and accident are not included in personality. Moreover, the core of humanity is defined as atemporal, since it does not seem to grow, mature, and decline. Dependency is excluded from the core.

These kinds of presuppositions seem to be one of the main problems in human rights theory when it comes to freedom of belief and opinion. Since theory is created by assuming that people are competent and persons in a Kantian sense, people who deviate from these criteria, are excluded from the humanity whose rights are being discussed. After the theory of freedom of belief and opinion is created with assumptions of competence and Kantian persons, some special applications are created for those who do not fulfil these criteria, but these applications do not seem to fit very well into the original theory. For example, the problematic definition given for the forum internum is a sign of this kind of exclusive thinking in human rights theory. The question is whether we choose this way of seeing human rights or whether we try to develop human rights theory and even redefine rights so that human rights theory recognizes psychotic people.

According to Nussbaum, there is a need to change the basic structure of society and view of humanity and to create a new form of liberalism which rejects hierarchies, for example, between “normal” and atypically disabled citizens. Even though Nussbaum recognizes that people

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257 Rawls writes that parties in the Original position know that their “various native endowments such as strength and intelligence” lie “all within the normal range”. Even though citizens do not have equal capacities, Rawls assumes that they have “at least to the essential minimum degree, the moral, intellectual, and physical capacities that enable them to be fully cooperating members of society over a complete life”. According to Rawls, the fundamental question of political philosophy is “how to specify the fair terms of cooperation among persons so conceived”. Rawls 1993, 20-21, 25, 183. See also Nussbaum 2006, 109.

258 This is how Nussbaum (2006, 130-133) describes Kant’s view of persons.

259 Nussbaum 2006, 139, 221.
have a deep interest in choice,\textsuperscript{260} she states that a human being’s rationality and sociability grow and mature and, if time permits, decline. It is part of human life to be dependent and vulnerable:\textsuperscript{261}

Humans begin as needy babies, grow up slowly, and require lots of care as they grow. In the prime of life they have the “normal” needs that the social contract model typically incorporates, but they may also have other needs, stemming from accidents or illnesses that put them in position of asymmetrical dependency for a shorter or longer time. If they live to old age, they typically need a great deal of care again and are likely to encounter disabilities, either physical or mental or both.\textsuperscript{262}

According to Nussbaum, the capabilities approach stresses the animal and material underpinnings of human freedom. For this reason it also recognizes “a wider range of types of beings who can be free”.\textsuperscript{263} It seems that this kind of view also includes people with psychosis in humanity and citizenship.

Since people with psychotic disorder are included in humanity and are considered as citizens with human dignity, the state is challenged to promote their capabilities. Individuals with psychosis have a right to life, which is worthy of dignity as human beings and citizens. Even though Nussbaum emphasizes the vulnerability and dependency of people and also sees dignity in relations of dependency, she also thinks that “citizens enjoy full equality only when they are capable of exercising the whole range of capabilities”. The goal is always that people could “enjoy the sort of liberty and independence their condition allows”. Even though nobody is self-sufficient and even though our independence is always temporal and partial, we also need “liberty and opportunity, the chance to form a plan of life, the chance to learn and imagine on one’s own, the chance to form friendships and other political relationships that are chosen and not merely given”. Thus, a decent society does not settle for a situation where a person is dependent on another person because of the lack of some capabilities. A decent society is, instead, challenged to organize public space, public education, and other relevant areas of public policy in order to give people as many capabilities as possible.\textsuperscript{264} Nussbaum also points out that people who are dependent on others

\textsuperscript{260} According to Nussbaum, this is one of the ways in which the capabilities approach is part of the liberal tradition.

\textsuperscript{261} Nussbaum 2006, 88, 160.

\textsuperscript{262} Nussbaum 2006, 88.

\textsuperscript{263} Nussbaum 2006, 88. In social contract tradition it has been suggested that people who cannot make a social contract with others could be taken into justice through guardianship. However, Nussbaum (2006, 137-138) criticizes this solution: “The whole idea is to choose a way in which “we” will live together in political society. The proposal we are considering would add, “we gather and take care of our dependents.” But that makes the dependents not full parts of the “we” and the “our,” not fully equal subjects of political justice. They are taken into account because some member of the “we” happens to care about their interests, not because they are citizens with rights, equal ends in themselves.”

\textsuperscript{264} Nussbaum 2006, 218-219, 222. When it comes to people with mental impairments, who can never
and need support in order to flourish, have something to give in social relationships. They are not just objects of care, but able to reciprocate.\textsuperscript{265}

If I compare different views of freedom of belief and opinion to the aspects of a psychotic view of reality (irrationality, being unwell and alienation) it seems that the view of freedom in terms of capability is actually closest to the model of psychosis that I presented in chapter 2.1. While in negative liberty alienation is a crucial aspect of psychotic disorder and while in authenticity well-being seems to have a crucial role, the way of emphasizing these aspects is different with capability. It seems impossible to say that some of the aspects are more important than others. The reason for this seems to be that in the capabilities approach human dignity is connected to rationality, wellbeing and sharedness. Nussbaum just discusses rationality, sociability and bodily needs.

The specifically human kind is indeed characterized, usually, by a kind of rationality, but rationality is not idealized and set in opposition to animality; it is just garden-variety practical reasoning, which is one way animals have of functioning. Sociability, moreover, is equally fundamental and equally pervasive. And bodily need, including the need for care, is a feature of our rationality and our sociability; it is one aspect of our dignity, then, rather than something to be contrasted with it.\textsuperscript{266}

\begin{itemize}
\item \textbf{achieve all the capabilities which are on the list, there are two options. First, their life is not considered a human life at all. Or second, the person is not able to live a flourishing human life however hard other people might help that person. According to Nussbaum (2006, 187), the first option is relevant in some extreme cases when all possibility of conscious awareness and communication with others is absent: “Some types of mental deprivation are so acute that it seems sensible to say that the life there is simply not a human life at all, but a different form of life. Only sentiments leads us to call the person in a persistent vegetative condition, or an anencephalic child, human.” However, when at least some central capabilities are present, the person belongs to a human community (and here the fact that he or she is a child of human parents is significant, which reminds us of the idea of human dignity presented in intuitionist phenomenology, see chapter 2.2.2.). It should be admitted then, that it is unfortunate that not all capabilities are attainable. In these cases the list of capabilities is, however, the same as for others, even though the person would probably never achieve all the listed capabilities. Nussbaum points out that it would be very dangerous to “give up” and make a different list for these people since it would lead to the assumption that some goals are too difficult and too expensive for some people to meet. Because of this, people would not be supported toward achieving capabilities which are not on their special list. In this case it would be even more difficult for them to “surprise” and develop capabilities in these areas. In this context, Nussbaum clearly states that it is the duty of society to promote capabilities (even though it might be expensive) and develop ways to prevent a lack of capabilities from emerging. Nussbaum 2006, 188-190, 192-193.  

\item See Nussbaum (2006, 133-134), who states that people with mental impairments have reciprocity with those who are with them. She gives as an example somebody called Arthur, who “whenever he is not frightened, and is able to trust, his capacity for affectionate exchange flourishes”. According to Nussbaum, education helps to expand one's capacity to engage in reciprocity. 

\item According to Nussbaum, human dignity is understood in the context of capabilities in an Aristotelian way, which means that rationality is only one feature of what it means to be a human being. According to Nussbaum, for Kant (and Rawls), rationality is considered more fundamental when it comes to defining human dignity. Nussbaum 2006, 159-160. Because mental well-being or the lack of mental suffering is not mentioned here explicitly, it might be that the aspect of well-
\end{itemize}
The view of humanity in the capabilities approach is also quite positive since it is assumed that people seek and love justice itself and have compassion for people who need help. Thus, rights are not based on mere mutual advantage, as they are, for example, in the theory of justice presented by John Rawls. People, instead share complex ends with others at many levels, and by promoting what is good for others a person is also pursuing his or her own good.267

If this background supposition is realistic, as it might be at least to a certain extent in many cases, it would follow that people would actually like to be more virtuous in relation to people with psychotic disorder. Thus, many people might welcome state support for their development and they would not consider it as an undesirable interference with their negative liberty – especially if they are raised and educated to see the dignity of other people. Even though I am afraid that this image is quite idealistic, I would also like to see some potential in this view, which does not lean on mere mutual advantage as the foundation of rights. It might be that most people are happy if other people’s human rights are realized and if they are able to promote them somehow, even though they would not get any direct advantage from doing so. However, I suppose that people in general are less willing to promote other people’s rights if they feel that they will be harmed in the process. This is why we need legislation to define how far the state can interfere with people’s negative liberty in order to promote the capabilities of others. The goal could be, however, that people given adequate education eventually become “happy tax payers” and are happy to give some of their time to engage in civil service, even though it is their legal duty to do such things. Attitudes can be influenced by education and by creating structures in society which people really can value. For example, if people see that psychiatric treatment is well organized and people with psychosis really get help through it, they may be more willing to make good treatment possible by paying taxes and giving their time.

267 Nussbaum 2006, 156-158. Nussbaum (2006, 158) writes: “the capabilities approach feels free to use an account of cooperation that treats justice and inclusiveness as ends of intrinsic value from the beginning, and that views human beings as held together by many altruistic ties as well as by ties of mutual advantage. Together with this, it uses a political conception of the person that views the person, with Aristotle, as a political and social animal, who seeks a good that is social through and through, and who shares complex ends with others at many levels. The good of others is not just a constraint on this person's pursuit of her own good; it is part of her good. Thus, instead of being a matter left to individual conceptions of the good, as in Rawl's theory, a strong commitment to the good of others is part of the shared public conception of the person from the start.” Nussbaum (2006, 162-163) also states that the capabilities approach does not separate right and good as Kantian approaches do, but it “operates with a richer and moralized account of the good”. 

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5.4.5. Values-based practice meets the capabilities approach

As I see it, the capabilities approach is conceptually far too unclear to be adopted by human rights theory when discussing freedom of belief and opinion. First, it is unclear when we discuss legal rights and when we describe what is ethically desirable. Second, I noted that it is unclear what the forum internum could signify in the context of the capabilities approach. Third, the relationship between capabilities and functionings seems to be unclear, which makes it difficult to define how people with psychosis should be treated in such situations where they seem to harm themselves. How far can the capabilities of psychotic people be protected compulsorily by interfering with their negative liberty? In spite of these challenges I, however, see that the capabilities approach has potential when we want to create a view about freedom of belief and opinion which is also relevant when discussing psychotic patients’ rights. The crucial question is, how human rights theory could be developed further. As I see it, some of the ideas in the values-based practice presented by Bill Fulford and Fulford et al, could be applied here, especially because these ideas seem to fit quite well with the views presented in the capabilities approach.

First, in values-based practice it is emphasized that the meaning and diversity of values should be recognized. According to Fulford et al, abuse in psychiatric treatment is not prevented and patients are not protected by developing better diagnostic criteria or strengthening the role of law, rules and regulations in psychiatry, as some have suggested.268 When it comes to diagnostics, Fulford et al claim instead, that a so-called hard-line scientific approach to psychiatric diagnoses increases the risk of abuse because it “excludes what is essential to an understanding of the abuse of psychiatric diagnosis, the evaluative element in the meaning of the medical concepts”.269 When it comes to the role of law, rules and regulation, which is emphasized in traditional bioethics, Fulford et al see a similar threat. They note that in other medical fields than psychiatry, values are widely shared and the regulations express those shared values. However, traditional bioethics does not work so well in psychiatry where values differ more. Instead, it may increase the risk of abuse:

In psychiatry, values, far from being shared are characteristically diverse. Hence in psychiatry, the more tightly the rules are drawn, the more encompassing the regulations are made, the more abusive they will come. For in psychiatry, a rule or regulation

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268 For example, Reich, who demands more objective criteria for diagnosing psychiatric disorders (better science), also demands, that the role of law should be strengthened in psychiatry (better ethics). Fulford, Thorton & Graham 2006, 565, 594.

269 Fulford, Thorton & Graham 2006, 594.
expressing a given value, will necessarily be at variance with the very different values of many of those to whom the rule or regulation is intended to apply.  

Thus, according to Fulford et al, the risk of abuse in psychiatry does not stem from the supposed scientific weakness of psychiatry or from the supposed ethical weakness of its practitioners. Instead, risk stems from the failure to recognize and take seriously the diversity of values “in the areas of human experience and behaviour with which psychiatry, as a medical discipline, is concerned”.

Fulford argues that values-based practice helps to work with complex and conflicting values in psychiatry:

The distinctive contribution of values-based practice is the extent to which it emphasizes and builds on the diversity of human values. There are no preconceived ‘right outcomes’ in values-based practice; it relies instead on ‘good process’ as a basis for balanced decision-making where values conflict.

According to Fulford, there is tendency to notice values only when values diverge or when they conflict. However, this does not mean that values are absent in other situations. Fulford suggests that awareness of the values present in a given situation can be increased by paying attention to the language which is used and by using clear ethical reasoning in order to explore the values which are present in decision making.

The way in which meaning and diversity of values is emphasized in values-based practice seems to be relevant when we discuss freedom of belief and opinion in psychiatry. Namely, the need of freedom of belief and opinion is based on the fact that values diverge. If we fail to recognize that they do so, we will probably not understand that there is a need for freedom of belief and opinion, since we think that our decisions depends only on facts. For example, if we considered psychotic disorder solely as something which makes a person unfree, discussing such a person’s freedom of belief and opinion turns out to be in vain. If it is considered to be in vain, the risk of abuse in psychiatry increases.

It seems that in the capabilities approach the meaning of values are recognized from the start. The background suppositions concerning what is good are declared and unlike when freedom is understood in the negative sense, more is said about humanity and what it is to live a life worthy of human dignity. However, I wonder whether the role of values could be even better acknowledged in the capabilities approach. Nussbaum states that capabilities are free from any specific metaphysical grounding, which means

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270 Fulford, Thorton & Graham 2006, 595.
271 Fulford, Thorton & Graham 2006, 594.
272 Fulford 2009, 72.
273 Fulford 2009, 73. See also Fulford, Thorton & Graham 2006, 520.
that they can be accepted by people whose views of “the good” differ.\textsuperscript{274} The question arises whether Nussbaum actually thinks that capabilities are grounded only in metaphysical presuppositions that are widely shared. More questions arise: how widely are these presuppositions, actually shared. Is it really the case that the idea of each human being’s dignity is already widely shared all over the world? Or is it the case that we are ready to defend the argument that this idea should be widely shared and encourage people to adopt this view domestically and internationally? Second, even though the idea of human dignity might be widely shared all over the world, it might be good to acknowledge that question involves metaphysical presupposition. Stating this clearly might make it easier to discuss this issue with people who do not share this presupposition or with those who share it but consider it a metaphysical issue.

Second, the developers of values-based practice demand co-work and communication between different disciplines and between the service users and providers of psychiatric care. Both values and facts which are relevant for a given situation should be acknowledged, and both philosophical and empirical methods should be used when values-based practice is put into action. There also needs to be a partnership with ethicists and lawyers. Fulford and Fulford et al note that scientific progress creates new opportunities and options in health care, which should be discussed. Different perspectives should be balanced in decision making by a multi-disciplinary team which ensures that all significant values are taken into account.\textsuperscript{275} When it comes to

\textsuperscript{274} Nussbaum 2006, 70, 79.

\textsuperscript{275} Fulford 2009, 73; Fulford, Thorton & Graham 2006, 520, 597. Heal's (2012, 22) notion reminds from values-based practice and the capabilities approach when she states that in reality there is not one such a thing which is autonomy. Instead of trying to capture what autonomy means philosophically, Heal suggests, first, that “we should bring a general orientation of respect and care to our deliberations” and second, that “we will find various complex and distressing details in each particular case”. However, it seems that Heal's (2012, 22-23) way of presenting this juxtaposition is not what values-based practice and the capabilities approach encourage: “But philosophical thought, in its current state, has no agreed insight to deliver on what real autonomy is, an insight on which we can call and in the light of which we can make decisions. It is more likely that thinking about what is humane, respectful, and decent in dealing with the mentally disordered will help us to see the complexities of 'autonomy' than that theorizing about autonomy is going to show us how to treat the mentally disordered.” As I see it, in values-based practice and in the capabilities approach, this kind of juxtaposition between theory and practice and philosophy and nursing is not meaningful. Instead, the challenge is to encourage to collaboration between these fields. In values-based practice, philosophical work is clearly valued. See Fulford 2009, 73; Fulford, Thorton & Graham 2006, 520, 597. Nussbaum (2006, 306) defends the meaningful role of philosophy, but argues that interdisciplinary work and cooperation between theory and practice is crucially important in order to secure people's capabilities. Practice can challenge ideas and show that they should be developed. The problem with multi-disciplinary work is that responsibility is divided amongst many actors and the risk that the patient is ignored and nobody really has a clue about wholeness of the patient's life situation increases. Peele & Chodoff (2009, 214) note this risk in the context of community-based treatment: “when psychiatric patients
freedom of belief and opinion, discussion is needed with experts in neuro-biological psychiatry in order to understand better how medication and different sorts of surgery on the brain influence the patient’s internal capabilities and what kinds of risks are included in different treatments.

In values-based practice the role of service users as active partners in decision making is emphasized which seems to fit well with the ideas about participation discussed in chapter 5.3.3. and with the consumer model and individualized care considered in chapter 5.3.4. Even though multi-disciplinary team work is important, Fulford et al demand that decision making be put “back where it belongs, with users and providers at the clinical coal-face”. According to Fulford and Fulford et al, the perspective of the service user should be taken as the first source of information when taking different values into account: it is important to identify and take seriously the values of each individual patient. Fulford et al acknowledge that it is difficult to ask people directly about their values. They suggest the following questions as examples: Are there any good or positive aspects to your experiences (as well as bad or negative aspects)? Do you find that your experiences stop you doing things you want to do, or are they sometimes helpful to you? Is the experience comforting or supportive in some ways? Do you have any ideas about where the experience comes from? It seems that answers to these kinds of questions might reveal something crucial about how the service user experiences his or her capabilities and to what kind of help he or she needs.

Even though some of the ideas linked to values-based practice and the capabilities approach seem to be similar, there is also one significant difference. Namely, in values-based practice there are no preconceived “right outcomes”. Instead, values-based practice relies on “good process” in decision making. However, the capabilities approach, as described by Nussbaum, is oriented to the right outcome, not to the process.

The capabilities approach is like the criminal trial. That is, it starts from the outcome: with an intuitive grasp of particular content, as having a necessary connection to life worthy of human dignity. It then seeks political procedures (a constitution, various allocations of powers, a certain type of economic system) that will achieve that result as nearly as possible, although it seems likely that such procedures will change over time and may also vary with the circumstances and history of different nations. Justice is the outcome, and the procedure is a good one to the extent that it promotes this outcome.

moved from hospital to community, responsibility, at best, moved from one agency to many, for example housing, welfare, vocational and rehabilitation, all looking after their own portfolios with unfortunate results for patients, many of whom have fallen between the cracks.” This kind of risk should be acknowledged in values-based practice as well as in the capabilities approach. It is a challenge to create structures where common responsibility does not lead to a situation where nobody is actually responsible for treatment.

276 Fulford 2009, 73; Fulford, Thorton & Graham 2006, 520, 597.
277 Fulford 2009, 72.
278 Nussbaum 2006, 82.
However, even though values-based practice emphasizes the right process and the capabilities approach focuses on the right outcome, they are not necessarily in conflict with each other. It seems that even in values-based practice outcomes are valued to some extent. Namely, Fulford et al also argue that in values-based practice a good decision is defined as much by how the decision is arrived at, and how it is implemented, as by what decision is taken and what is actually done.\textsuperscript{279} Thus, it might even be that Fulford’s statement that there are no preconceived “right outcomes” in values-based practice may be too imprecise. For example, Fulford might consider that the use of brainsurgery which destroys the patient’s abilities to think and believe, is a preconceived wrong outcome. When it comes to the capabilities approach, Nussbaum attempts to show that her list of capabilities, in spite of its universal nature, still respects pluralism.\textsuperscript{280} Thus, it is open for discussion, at least to some extent, what the so-called right outcomes actually are in the capabilities approach.

I also wonder whether a very strict distinction can be made between process and outcome. This kind of distinction may be misleading. Namely, a so-called right process is also a right outcome of something. Right process also indicates some principles, namely, principles about how things should be done. Moreover, a right process also seems to require some principles. For example, it has often been stated that protecting freedom of belief and opinion is a requirement for a democracy and an open society. This is particularly important notion, given that Fulford et al compare values-based practice with political democracy. According to them, a good process in values-based practice depends on an “open society in mental health”, which they describe as “a defence against the repeated collapse of psychiatric services into abusive practices”.\textsuperscript{281}

Thus, it could be claimed that freedom of belief and opinion is the core element which makes values-based practice possible, and some parts of this core could and should be expressed as rules. Would it be possible to develop values-based practice in such a way that it would be possible to declare what a person’s legal rights are, and if there are absolute rights, what might they be? After all, even though values differ, it might be possible to find shared values in the area of freedom of belief and opinion that could be defined as absolute rights. Especially when the \textit{forum internum} as the core area of freedom of belief and opinion is discussed, I would defend the need for better principles and a redefinition. I think that it is misleading to say that the \textit{forum internum} protects thinking and believing processes and the holding of thoughts and opinions. Rather it should be seen that the right to the \textit{forum

\textsuperscript{279} Fulford, Thorton & Graham 2006, 528.
\textsuperscript{280} Nussbaum 2006, 78-80.
\textsuperscript{281} Fulford, Thorton & Graham 2006, 523.
*internum* protects the abilities needed for believing and thinking. Further discussion is, however, needed in order to understand better, whether the absolute right to the *forum internum* signifies a negative right to mental competence or should we understand it in a wider sense so that also abilities to have emotions, imagination and affiliation are protected in a negative sense. However, arguing that there is an absolute right to the *forum internum* does not mean “blind absolutism”\(^{282}\), where it is suspected that statements are value-free. Instead, defining that there is an absolute right to the *forum internum* and redefining what this right means is deeply value-laden. When this kind of absolute right is defined, something absolutely important is being recognized in humanity. Moreover, when the *forum internum* is redefined, people with psychotic disorder are included in humanity. This is also a value-laden statement, since it declares who belongs to humanity and who has absolute rights.

\(^{282}\) Fulford et al (2006, 596) recognize that the fear of relativism usually makes people express some kind of absolute values. However, they consider that blind absolutism is a more serious threat than the threat of the relativistic “anything goes” approach: “But the lesson of history, in medicine and psychiatry as in politics and religion, is that it is from absolutism, nor relativism, that we have most to fear.”
6. Conclusions

The purpose of this study was to seek a definition for freedom of belief and opinion which would allow this freedom to be seen as a human right for a person with psychosis. There were four research questions, namely: 1) How can the freedom of belief and opinion be understood as a human right? 2) In what kinds of discourses, concepts and presuppositions are the different views of freedom of belief and opinion based? 3) What aspects are relevant when the realization of and interferences with freedom of belief and opinion are considered in the case of an individual with psychosis? 4) How are views about freedom of belief and opinion challenged in the case of an individual with psychosis?

Materials from different fields were analysed by philosophical conceptual analysis in order to realize interdisciplinary two-way interaction in human rights theory. The analysed material included: (1) legislation and ethical principles which guide psychiatric care, (2) human rights theory, legislation and conventions concerning freedom of belief and opinion, (3) textbooks considering psychiatric diagnosis, (4) discussions concerning philosophy and the ethics of psychiatry, (5) (political) philosophical discussions concerning freedom and human rights and (6) studies and reports which concentrate on the views and experiences of patients with psychotic disorder.

In chapter 2.1. I created a hypothetical model of psychosis with the help of psychiatric diagnostics and discussions concerning the philosophy of psychiatry in order to clarify what distinguishes psychotic and other exceptional views of reality. I suggested that psychosis occurs as serious irrationality (with loss of insight), as serious “being unwell” and as serious alienation, while other exceptional views of reality are restricted to not more than one or two of those aspects.

In this model irrationality has three characteristics, namely non-correspondence to reality (which signifies that psychotic beliefs are not in accordance with reality), incomprehensibility (which includes the idea that psychotic views of reality are not understandable for others) and agential irrationality (which refers to the psychotic person’s inability to endorse beliefs by offering good reasons in support of their content, and by acting in a way which is consistent with and explicable by their content). A view of reality can be defined as irrational if at least one of the characteristics is realized. In addition, irrationality has to occur with a loss of insight, which means that the person with an irrational view of reality does not think that there is something wrong with them. The aspect of being unwell has three characteristics as well, namely, unsound mind (which refers to the idea that the person’s mind is disintegrated), incapacity (which includes different kinds of impairments and
disabilities), and distress (which refers to the person’s own negative experience and suffering). Criterion of being unwell fulfils when at least one of these characteristics is connected to person’s view of reality. The third necessary criterion of a psychotic view of reality is alienation, which refers to the fact that other people do not share or accept the beliefs and opinions expressed by the person. I argued that this kind of conceptual distinction is relevant in order to understand the nature of psychosis better, though I also noted that the different aspects overlap with each other. With this model I endorsed the continuum model of psychosis. I also noted that the model is value-laden but did not see that as a problem since value-laden models are the only models we may expect to have for defining psychosis. With this notion I also endorsed the approach of values-based practice.

In chapter 2.2, I presented the debate in the philosophy of psychiatry concerning the question of whether delusions are beliefs. I noted that some debaters deny delusions a belief status because they have been considered as irrational on the grounds of their content or the way in which they are formed. However, I argued that in human rights discussion beliefs need not be rational in order to be defined as something worth protecting. Instead, I found out that the concepts of thought and opinion are defined so that they also seem to include delusions. Moreover, since it is also declared in human rights theory and conventions that there is an absolute right to hold thoughts and opinions in one’s mind (forum internum), it seemed to follow that a person had a right to hold a delusion (if these formulations are interpreted literally). I noted that this conclusion challenges the formulations presented in human rights theory and reveals that there is a tension in relation to views and practice of psychiatry.

In order to seek a relevant definition for freedom of belief and opinion I then proceeded to elaborate three different interdisciplinary views concerning freedom of belief and opinion and analysed whether they are applicable to the case of an individual with psychosis. I also clarified what kinds of challenges there are in each view.

In chapter 3, I discussed freedom of belief and opinion in the negative sense, which means that other people do not interfere technically or physically with an individual holding and manifesting his or her beliefs and opinions. It seems that freedom of belief and opinion understood in the negative sense focuses on the contents of beliefs and opinions. Generally it has been thought to be justified to restrict the freedom of belief and opinion in the negative sense in order to protect other people’s rights, including public order and morals. This is one of the reasons why in- or nonvoluntary treatment of individuals with psychotic disorder, which is seen as an interference with negative liberty, is justified. Freedom of belief and opinion in the negative
sense can also be interfered with in order to protect the psychotic individual’s health and safety, and it seems that right to treatment is prioritized over right to negative liberty in cases where the patient is determined to be incompetent. Sufficient mental competence is defined as a requirement of liberty. Since a psychotic disorder is thought to have consequences for the mental abilities needed in decision making and coming to evaluations, the psychotic individual is usually considered incompetent in some sense and at some level. Thus, paternalistic interventions are understood to be justified, which means that those people who have a legal right to make decisions for the patient may make them providing they take into account the patient’s best interest. Even though the concept of competence refers to rationality, I noted that if the competent person has a right to make irrational choices, an aspect of sharedness seems to be even more important when it comes to evaluating who is sufficiently competent and who is not. Moreover, I noticed that best interest can be described, on the one hand, as something that the person would have decided if he or she had been competent and, on the other hand, as something more objective to be considered alongside the patient’s own wishes. I noted that the latter view seems problematic from the viewpoint of negative liberty.

When it comes to freedom of belief and opinion in the negative sense, it also seems ethically problematic that the use of involuntary antipsychotic medication can be defined as interference with the forum internum and thus as a violation of absolute human rights. The other option to solve the tension between the right to negative liberty and the use of involuntary antipsychotic medication is to say that an incompetent person does not have an absolute right to the forum internum. In this case the person with psychosis is excluded from the group of human beings who have a right to freedom of belief and opinion, and this kind of ignorance is ethically problematic, as well. In the context of negative liberty, the forum internum could also refer to a negative right to competence in which case there would be an absolute prohibition on reducing the other person’s competence in technically and physically concrete ways. If this is the case, a redefinition of the forum internum is needed in human rights theory. I also noted that the view of negative liberty does not take into account that the person with psychosis may need help in order to develop and manifest his or her beliefs and opinions and in order to live a life which is sufficiently in accordance with his or her values.

In the chapter 4, I sought to establish whether freedom of belief and opinion could be understood in terms of authenticity on the grounds of views presented in philosophical and ethical discussions. In this case freedom of belief and opinion means the right to hold beliefs and opinions which are really one’s own and the right to such manifestations of those beliefs and
opinions which are in harmonious relationship with them. It seems that freedom of belief and opinion understood in terms of authenticity focuses on the process of believing and thinking. If freedom of belief and opinion is understood in terms of authenticity, manipulation can be defined as one form of interference with this right. Moreover, a psychotic disorder which also distorts the person’s beliefs and opinions can be defined as a violator of authenticity. Psychiatric treatment and the use of involuntary antipsychotic medication can be defined as a way to return a psychotic patient’s *forum internum*.

One problem with this viewpoint is that there are different views about how authenticity should be evaluated. It has been suggested that authenticity is recognized by the stability of the beliefs and a person’s recalcitrance. Some have stressed that an ability for reflective self evaluation is crucial while others have emphasized that authentic people are able to create a coherent narrative about their lives. These criteria presented for evaluation seem to be, on the one hand, too demanding in order to understand freedom of belief and opinion as a human right in general. On the other hand, some people with delusions still fulfill these criteria, and should be defined, because of that, as authentic people and left without treatment. I also noted that the idea of psychotic disorder as a violator of absolute human rights is problematic from a legal point of view. Psychosis cannot be defined as being juridically responsible for violating someone’s *forum internum*, and, vice versa, there cannot be an absolute positive duty of other people to liberate people from the alien force of psychosis. Moreover, the view of freedom of belief and opinion in terms of authenticity seems be based on quite an idealized view of humanity since it does not take into account that it may be part of authentic humanity to be irrational, to do evil things and to suffer. As a philosophical view it is also difficult to apply in legal contexts. I also noted that the view of freedom of belief and opinion in terms of authenticity seems to emphasize most the aspect of being unwell as a criterion of psychosis. However, irrationality also seems to play a crucial role, at least when the authenticity of psychotic views are evaluated, since it seems that in an evaluation of authenticity more rationality is required from psychotic people than from others.

In chapter 5, I presented a view of freedom of belief and opinion in terms of capability. From this viewpoint, freedom of belief and opinion signifies that the individual is capable of choosing a way of life which he or she considers valuable and which is worthy of human dignity. When freedom of belief and opinion is understood in this sense, the interest is in both the external opportunities and internal capabilities, which influence each other, and the individual’s capability to believe, think and choose his or her way of
action. I noted that, for example, stigmatization and the undesirable effects of both psychotic disorder and antipsychotic medication can be seen as impediments to capability. On the other hand, the capabilities approach encourages the patient to be active in treatment and to find his or her place in society, and encourages carers to listen to the patient’s voice including his or her existential considerations. This view also demands the development of better treatments for psychotic disorders in order to avoid undesirable effects. Moreover, internal capabilities connected to psychosis, such as the ability to experience meaning in life can also be considered in some cases valuable for people with psychotic disorder.

Because of its background suppositions, the view of freedom of belief and opinion in terms of capability also seems to be relevant to people with psychosis. Even though in some cases functionings are promoted instead of capabilities, the tendency in the capabilities approach is to include people with psychosis in humanity instead of making a distinction between people who are sufficiently competent or authentic and people who are not. It also seems that the view of capability coheres best with the model of psychosis which I presented in chapter 2.1. However, one problem with the view of freedom of belief and opinion in terms of capability is that the relationships between legal rights and ethical goods are undefined. Moreover, when prioritizing some capabilities over others is avoided, the difficult situations where prioritizing should be done are left unresolved. For example, it seems unclear whether there can be an absolute right to the forum internum, and if there is, what it might mean. It seems that many decisions are left to be considered individually in each case. This is why the capabilities approach is difficult to apply in a juridical context where more general principals are necessary. However, the view of freedom of belief and opinion in terms of capability could be developed in interdisciplinary discussion and cooperation so that juridical challenges concerning the freedom of belief and opinion might be discussed and resolved in more detail. In psychiatry, ideas presented in the values-based practice could help to do that.

The following table presents different aspects and challenges of views of freedom of belief and opinion:
<table>
<thead>
<tr>
<th>Freedom of belief and opinion</th>
<th>Definition of freedom</th>
<th>Definition of freedom</th>
<th>Definition of freedom</th>
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<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>The right to be free from other people's technical or physical interference with the individual holding and manifesting his or her beliefs and opinions.</td>
<td>The right to hold beliefs and opinions which are really one's own and the right to such manifestations which are in harmonious relationship with them.</td>
<td>The right to be capable of choosing a way of life which a person considers valuable and which is worthy of human dignity.</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>Content of the beliefs and opinions.</td>
<td>Process of believing and thinking.</td>
<td>Capability to believe and think.</td>
</tr>
<tr>
<td><strong>Problematic forum internum</strong></td>
<td>Involuntary antipsychotic medication violates absolute right OR absolute right is not applied if the person is incompetent OR prohibition to reduce another person's competence in technically and physically concrete ways (redefinition of the forum internum was needed in human rights theory).</td>
<td>Psychotic disorder cannot be legally responsible for violating absolute right. Other people had an absolute positive duty to liberate the person from psychosis. If a psychotic view is evaluated to be authentic, a person is left without treatment.</td>
<td>Unclear whether there are absolute rights OR unclear what the forum internum means. Could it signify that it is prohibited to destroy the neuro-biological preconditions of another person that are needed in thinking and believing, which are the internal capabilities to engage in practical reasoning, experience emotions, exercise one's imagination and have relationships with others?</td>
</tr>
<tr>
<td><strong>Special application for people with psychosis</strong></td>
<td>Because of incompetence a psychotic person's right to health and safety are prioritized over freedom of belief and opinion. In general, for competent people, it is vice versa.</td>
<td>More rationality is demanded from a psychotic person than is required from others in order to be defined as sufficiently authentic.</td>
<td>Generally capabilities are promoted but in the case of a person with psychosis, certain functionings can also be defined as a goal.</td>
</tr>
<tr>
<td><strong>Challenges when understood as a human right</strong></td>
<td>Ethically unacceptable consequences: abandonment, ignoring the individual with psychosis as a right holder, ignoring the need for help.</td>
<td>Too idealistic and philosophical, demands too much if applied in general.</td>
<td>Too unclear for juridical purposes. Has to be developed.</td>
</tr>
</tbody>
</table>

During my analysis I found several grey areas where conceptual distinctions, which have to be made in order to see things clearly, overlap with and influence each other. There is conceptually a grey area between psychotic
and other exceptional views of reality, as well as between different aspects of psychosis, which I called irrationality, being unwell and alienation.

There is also a grey area between the internal and external dimension of a person and of his or her freedom. Even though it seems that the internal and external dimensions cannot be totally separated, in order to make conceptual clarifications they have been distinguished in human rights theory (the distinction between the *forum internum* and the *forum externum*) and in different views of freedom. From the viewpoint of negative liberty there is an inner dimension in a human being which should be left intact by others. When authenticity is discussed, being internally authentic and living an externally authentic life with self-fulfilment are distinguished. In the capabilities approach external opportunities and internal capabilities are distinguished though it is also emphasized that they influence each other. I have also utilized the conceptual distinction between internal and external dimensions, even though I am aware that these dimensions can be separated only conceptually and in theory. However, in practice, the internal dimension seldom has any meaning and value without the external dimension. On the other hand, meaningful and valuable external manifestations seem to depend on something which could be called internal.

It also seems that when freedom of belief and opinion is discussed in relation to mental health issues, we meet a grey area between jurisprudence and ethics. These areas cannot, of course, totally overlap. Even though we adopted a view that jurisprudence has a lot to do with ethics, we also need to admit that only some unethical actions should be defined as illegal and only some ethical duties should be legal duties. When it comes to liberty in the negative sense, the question is how far should the protection of other people’s mental health restrict other people’s freedom of belief and opinion in cases where these rights seems to be in conflict. Namely, using one’s freedom of belief and opinion in a way which could be seen by many people as unethical, should still be juridically legal. When it comes to authenticity, the same kind of grey area is found when manipulation is discussed. In the context of capability, the discussion concerns the use of power. In certain situations the use of power might be unethical, but still legal. However, it is unclear, when there is a place and need for juridical human rights discussion and when there is a need for an ethical consideration, instead. As far as I can see, there should also be important ethical questions which are not, however, legal issues.

We also face grey areas between jurisprudence and ethics when we consider the question of what it is to be sufficiently authentic and sufficiently capable, and when the individual (psychotic or not) has a juridical right to get support for being more authentic or more capable. It is also questionable whether there can be a juridical duty for a psychiatrist to be virtuous. It cannot
be stated in a mental health act that a “psychiatrist has to be kind to his or her patients”, since what it means to be kind in different cases is too open to interpretation and different kinds of experiences. On the other hand, the patient’s right to good treatment seems to require that he or she gets help from somebody who is not totally without virtue. Jurisprudence still has to leave enough room for ethics so that caregivers can concentrate on ethically good care instead of concentrating on realizing “their juridical duties”. This cannot mean, however, that the core juridical challenges should be shifted on ethics, or considering each individual case. When there are juridical challenges they should be conceptualized in general as well as possible and even some direction has to be given in order to ensure the legal protection of the patients.

Each view of freedom has its own grey areas and continuums. When we discuss liberty in the negative sense, we meet a grey area between competence and incompetence since competence is not an “all or nothing” issue. Also the border between authenticity and inauthenticity is on the continuum. Borders between different central capabilities are in a grey area as well, which is seen, for example, if we try to describe what different capabilities are connected to the freedom of belief and opinion.

The borders between different views of freedom of belief and opinion also constitute a grey area. In the grey area between negative liberty and authenticity there are questions such as how mental competence is to be distinguished from authenticity. When the evaluation of authenticity is discussed could the same notions also be applied to discussions concerning competence and how it is evaluated? Moreover, even though manipulation in the sense in which it is discussed in the context of authenticity, cannot be defined as an interference with negative liberty, giving misleading information is not only part of manipulation but also crucially affects competence. The grey area between negative liberty and authenticity is connected to the grey area between the internal and the external. Namely, it can be asked whether a very strict distinction can be made between technically and physically concrete interferences (negative liberty) and a psychological way of influencing (authenticity).

When it comes to the borders between negative liberty and capability, one can discuss when restrictive opportunities are caused by other people and when they are just “environments” which happen to be as they are. If we consider such impediments to capability as inequality, poorness and stigmatization, we can hardly claim that they are just challenges which happen to be there for some people and which other human beings have not caused in concrete ways. Moreover, the concept of competence and a wide view of the right to self-determination which includes the right both to negative liberty and the right to competence seem to come close to the view of freedom in
terms of capability, though there are some differences in the presuppositions concerning the nature of humanity.

It also seems that the view of authenticity and the view of capability meet since the way in which authenticity is evaluated brings up considerations concerning the ability to reflect and the ability to create a coherent narrative both of which might imply what it is to have a central capability for thought. Moreover, when manipulation and the use of power is discussed, we touch similar kinds of phenomena even though we might describe the problem with different kinds of words and use different kinds of arguments.

In a way there seems to be a grey area between different views of freedom of belief and opinion right at the core of the right, namely, in the ways in which the forum internum is understood. Namely, competence, as a requirement of negative liberty, sufficient authenticity and sufficient capability are not so far from each other. It is possible that the forum internum lies somewhere there in a shared grey area. If it does, the concept of the forum internum should be redefined in human rights theory so that it would better describe what is actually absolutely protected. As we saw in the table above, currently the meaning of the forum internum seems to be unclear and there are many different ways to understand it. It is worth asking whether a right which has a conflicting and unclear meaning should be absolute. We cannot protect “something like that” absolutely. Not, at least, if protecting “something like that” means acting in some way or not acting in some way. However, I suggest that the forum internum should be redefined in human rights theory and, thus, clarified. The forum internum could signify, at least, a negative right to competence (or a negative right to an ability to engage in practical reasoning, as it might be called in the capabilities approach). In this redefinition the focus is not on the contents of the beliefs and opinions held nor is it on the believing and thinking process, but rather it is on the abilities needed in believing and thinking. This way of defining the forum internum would not be in conflict with the different kinds of views of freedom, since this definition might be possible to connect with views of negative liberty, authenticity and capability. A consensus could be found. However, it should be also discussed whether the forum internum could also protect the individual’s negative right to those internal capabilities that are needed in experiencing emotions, exercising one’s imagination and having relationships with others.

So, did I find a definition of freedom of belief and opinion which would also allow it to be regarded as a human right for a person with psychosis? This was the purpose of my study, after all. I would say that I was successful in analyzing this question and I have been able to describe my search for some answers. However, the analysis presented in this study reveals
that freedom of belief and opinion is not (at least at the moment) a simple principle which we can just protect and simply inform patients about. In this sense, it has to be said that I could not find and elaborate a view which would be as such, already now, both relevant for people with psychotic disorder and suitable for juridical purposes on the grounds of my material. However, I have noted that some directions are more relevant than others for developing human rights theory further. In this sense I found something very important.

All the views of freedom of belief and opinion which I have presented in this study are somehow problematic. On the other hand, since all these views seem to bring something important to the discussion, it might not be justified to choose just one of them and leave out the others. However, it seems to me that it would be best if we were to develop the human rights theory concerning freedom of belief and opinion in terms of capability. The reason for this is that presuppositions concerning humanity seem to be more realistic in the capabilities approach than in the views of freedom of belief and opinion in the negative sense and in terms of authenticity. First, it is admitted in the capabilities approach that human beings are both needy and dependent on others. Second, in the capabilities approach people with psychosis are included in humanity. They are not exceptions but worthy of capabilities like all people are. This is a promising starting point when rights are discussed. However, considerations presented in discussions concerning negative liberty and authenticity can be utilized in order to develop the capabilities approach. First, when it comes to negative liberty, the relationships between different rights are conceptually relatively clear (when compared with the other two views) and these relationships could also be considered in the context of capability. The views presented in the context of authenticity could perhaps be utilized and elaborated in order to understand and refine what kind of different aspects there can be in a capability for senses, imagination, and thought and in a capability for practical reasoning, and what is defined as sufficient when it comes to these capabilities.

It seems that if freedom of belief and opinion is understood in the negative sense or in terms of authenticity, many relevant questions, like the undesirable effects of medication and stigmatization, are left outside the discussion, while the capabilities approach seems to present these kinds of relevant issues more widely. Moreover, it seems that there is more to debate between the views of negative liberty and authenticity, while the capabilities approach might be less provocative. It seemsunlikely that the definition of freedom of belief and opinion in terms of authenticity will be adopted in jurisprudence. However, when it comes to capabilities approach, there are already ideas in human rights theory which are very close to what the capabilities approach emphasizes. Thus, the current adequate consensus
between different disciplines and fields could be made even better if the view of freedom of belief and opinion in terms of capability was developed. Instead of debates which may lead to ignorance, there might even be helpful and fruitful consequences both for patients with psychosis and for everyone else.

I also consider whether in psychiatry the approach of values-based practice could be used in order to develop the view of freedom of belief and opinion in terms of capability. The approach of values-based practice could be useful, because we will probably live and act in situations where several views of freedom of belief and opinion live together, and partly conflict. Different values influence what view we prefer and what kind of understanding we apply in practice. Therefore, I see the need for developing practices which help us all – patients, mental health workers, researchers and other carers – to live in this confusing situation. Even though it depends on the view of freedom how a psychotic individual’s freedom of belief and opinion is understood, people with different views may well make the same kinds of decisions (of course not always, but it seems however to be possible). Practical decisions and ways of nursing might be the same despite the fact that they might be argued about in different ways and even though different views of freedom have different theoretical challenges. One reason for this is that the view of freedom and the way in which freedom is valued are separate things. Thus, those who have adopted the view of freedom in the negative sense do not necessarily value freedom as much as those who have adopted the view of freedom in terms of capability.

The possibility of finding a common practical area despite the differences in the views of freedom and their argumentation makes it possible for different views of freedom to live along side each other in peace and to utilize values-based practice in psychiatry. The main issue here is that the psychotic person has an experience that his or her rights are not being ignored and that their rights are really concerned in treatment planning (even though nobody is quite sure what should actually be protected according to the law). In this way, the mess, if acknowledged, might even increase the psychotic individual’s experience that his or her freedom of belief and opinion is really being taken into account. The challenge presented by the freedom of belief and opinion guides us to make decisions in individual situations with the psychotic individual. Thus, people with psychosis are invited to develop a theory of freedom of belief and opinion which might be empowering and increase freedom of belief and opinion in terms of capability.

In order to develop a human rights theory concerning the freedom of belief and opinion which also applies to people with psychosis, we need empirical ethics and empirical jurisprudence. Thus, developing human rights theory requires further cooperation between conceptual research and practical
psychiatry in order to clarify what we really want to protect when referring to
the freedom of belief and opinion. During my research process I have worried
about two things. First, I have been afraid whether my analysis is relevant. Do
I sufficiently understand the reality where people with psychosis live? Do I
know enough about psychiatric practices in order to realize an
interdisciplinary two-way interaction in human rights theory? Second, I have
been wondering whether my analysis, even if it is relevant, will have any kind
of influence in practice. What are, actually, the practical possibilities of a
social ethicist to help people with psychosis?

I have been thinking whether it would move psychiatry in a good
direction if philosophers and ethicists (and even jurists) working in the area of
psychiatry would spend, for example, one day per week, in the context of a
psychiatric practice, meeting patients, discussing issues with nursing staff and
so on. Would there be a need for a joint discussion about ethical concerns
where both patients and nursing staff would be present? Could researchers
help us to see and understand aspects of practical situations and considerations
which have not been recognized so far? And vice versa, how would it
influence conceptual research if researchers took more part in practice? If
researchers took more part in practical psychiatry, would it be easier for them
to realize in which areas there actually is a need for conceptual distinctions?
As far as I understand it, the approach of values-based practice with its
emphasis on the multidisciplinary approach and partnership could prompt us
to develop structures like this. Perhaps I am somewhat idealistic, but I would
like to believe that people with different kinds of talents and skills have shared
moral goals. However, they need structures in order to help others better with
their skills.
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