In Defence of Autonomy in Psychiatric Health Care

PSİKİYATRİK BAKIMDA ÖZERKLİĞİN SAVUNMASI

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Summary

Over the last thirty years there has been a transition, in medical care, from a paternalistic model toward a model based on respect for the individual's autonomy. The application of such a model in psychiatry is controversial, as it is believed that mental illness may subvert people's autonomy. Consequently, in some countries, the diagnosis of mental illness represents one of the criteria for coercive detention and treatment of the mental disorder. I shall demonstrate that non-consensual intervention cannot be justified (even partly) on the grounds that the individual has been diagnosed as having mental disorder. It cannot be justified on the grounds that the individual does not meet some philosophical standards of personhood or moral agency, either. Autonomy should be given the same value in psychiatry that is given in other medical areas. All people's autonomous actions and choices, ranging from complex medical decisions to the simplest tasks of daily life, ought to be respected, unless, for some reasons, we want to adopt a prejudicial and discriminatory attitude toward those who receive a psychiatric diagnosis.

Key Words: Autonomy, Psychiatry, Health care

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Özet

Son otuz yıl içinde tıbbi bakımda paternalistik (babaca) modelden bireyin özerkliğine saygıya dayalı bir modele geçiş olmuştur. Psikiyatride böyle bir modeli uygulamak, mental hastalıkların bireylerin özerkliğini bozabileceğine inanıldığından, biraz tartışmalıdır. Bu nedenle bazı ülkelerde, ruhsal bozukluk tanısı, zorla alıkoyma ve mental hastalık tedavisinin kriterlerinden birisi olarak kabul edilir. Ben bireyde ruhsal bozukluk teşhisinin koyulmasının istem dışı müdahaleyi (kısmen bile olsa) meşrulaştıramayacağını ortaya koyacağım. Bireyin bazı felsefi standartlara göre birey olma kriterlerini yerine getirmiyor olması da böyle bir müdahaleyi meşrulaştıramaz. Diğer tıp alanlarında özerkliğe verilen değerin aynısı psikiyatride de verilmelidir. Muhtelif sebeplerden dolayı, psikiyatrik tedavi alanlara ayrımcı ve ön yargılı yaklaşma isteği dışında bütün bireylerin kompleks tıbbi kararlarından günlük hayattaki en basit işlerine kadar her türlü özerk tercih ve eylemlerine saygı gösterilmelidir.

Anahtar Kelimeler: Özerklik, Psikiyatri, Sağlık bakımı

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1. The Value of Autonomy and the Psychiatric Context

Over the last thirty years, there has been a transition, in medical care, from a paternalistic model toward a model based on respect for the individual's autonomy.

The implementation of a model based on respect for individual autonomy raises a number of problems, virtually in all areas of medicine, and psychiatry is one of the areas in which the most acute problems arise.

The value of autonomy is universally recognised (1) and normally protected by law in medical care as well as in other contexts. However, it is sometimes believed that we cannot demand respect for autonomy in psychiatric health care, due to the peculiar nature of psychopathology.

It is in fact believed that people with mental illness behave in certain ways, and have some disorders because of their mental illness. They are driven to act in certain ways by their mental condition. Their mental illness is seen as the cause, the reason, or the explanation of their behaviour, or of their dis-

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orders. For example, it is often claimed that people "hear voices" because they suffer from paranoid schizophrenia; or that they lose interest in life because they suffer from depression; or that they gamble because they suffer from pathologic gambling; or that they fear open spaces because they are agoraphobic, and so on.

From these kinds of beliefs it is concluded that people with mental illness do not genuinely want to do what they do, and therefore that they lack autonomy. For example, they gamble not because they genuinely want to gamble, but because they suffer from pathological gambling. It is their pathology that drives them to gamble. Therefore they are unable to make autonomous decisions about their gambling. Probably on such grounds, in some countries the diagnosis of mental illness or mental disorder represents one of the criteria for the legitimate coercive detention and treatment of the mental disorder (2).

In what follows, I shall argue that autonomy can and should be ascribed the same value in psychiatry that is ascribed in other medical areas. In fact the argument that mental illness compromises people's autonomy is logically fallacious, and therefore indefensible. This does not imply that paternalism is always unethical. I shall explain when paternalism may be a morally legitimate option (3).

2. The Argument that "Mental Illness" Compromises Individual Autonomy is Fallacious

Let us consider this case history. It is a brief conversation between myself (S.), and B., an institutionalised woman who has been diagnosed as paranoid schizophrenic.

B.: "This afternoon I had to wash my hair 10 times"

S.: "Why?"

B.: "Because some voices commanded me to do so"

If I say that B. has washed her hair 10 times because compelling voices commanded her to do so, I am probably saying something meaningful. One may wonder why B. is unable to resist these voices, but there is nothing tautological in the statement that B. has washed her hair 10 times because compelling voices ordered her to do so. There is only a missing premise. If we add that premise, the whole argument sounds as follows:

1. Some voices commanded B. to wash her hair 10 times;
2. B. could not resist these commands (for some reasons) (missing premise)
3. Therefore B. has washed her hair 10 times.

1, 2 and 3 properly answer the question: "Why has B. washed her hair 10 times this afternoon?".

1, 2 and 3 explain why B. has washed her hair 10 times this afternoon.

If I ask, however: "Why does B. hear voices?", what answer can I have? Many people would say: because she has schizophrenia.

This is not a meaningful answer, but rather an empty sentence. This sentence amounts to say: B. hears voices because she hears voices. We should understand why this is so.

Schizophrenia is a clinical term denoting a wide spectrum of disorders (4). B. has been diagnosed as having paranoid schizophrenia because she has some of these disorders (for example delusions, intrusive thoughts, and others). When I say that B. is a paranoid schizophrenic, all I mean is that B. suffers from these disorders. I do not know why she suffers from these disorders. I only know that she suffers from these disorders. I say that she is schizophrenic because I can see that she has these disorders, not because I can explain them. I say that she is schizophrenic (=that she suffers from delusions, intrusive thoughts, ideas of reference, etc.), but I can give no explanation of why she is schizophrenic (=why she suffers from delusions, intrusive thoughts, ideas of reference, etc.).

In other words, the term schizophrenia summarises, in a single word, a number of disorders, and says nothing about the cause of these disorders. Thus the diagnosis has descriptive value, not explicative value.

Of course the psychiatric diagnosis also has an important predictive value (5). If I am told that B. has paranoid schizophrenia, I shall not be surprised when she tells me that "voices" commanded her to wash her hair, and I will probably be able to predict, at least approximately, what is going to happen to

her at some point. However good I may be in predicting her behaviour, though (what may be mistaken for the ability to explain it) I am still unable to provide the reasons for her disorders. I will have to say that B. is (classified as) "schizophrenic" because she has a certain pattern of disorders. I do not know why she has these disorders, and that is the only truth.

We may outline the argument as follows:

Paranoid schizophrenia=(a term that) refers to/summarises a number of disorders (delusions, intrusive thoughts, etc.)

Proper definiton

Question (1): Why has B. been diagnosed with schizophrenia?

(or: "Why is B. - called - schizophrenic?")

Answer (1): Because B. has the following disorders: delusions, etc.

Proper answer, logically correct

Question (2): Why B. has the following disorders?

(or: Why does B. hear voices?")

Answer (2): I do not know

Proper and true answer

Answer (3): Because B. suffers from schizophrenia

Tautological answer

=to say:

B. has the following disorders, delusions etc., because B. has the following disorders, delusions etc. (schizophrenia in fact means having the following disorders, delusions etc.)

Answer (3) is clearly an improper, tautological statement (6).

This kind of logical error is often made in psychiatry. Here, there is the tendency to believe that, once we give a name to a phenomenon, then (miraculously), this name provides an explanation of such a phenomenon.

Let us make some other examples, to make sure that the argument is fully understandable.

It is often argued that people fear open spaces because they are agoraphobic. However, being agoraphobic means fearing open space. Then, if I say: "I fear open space because I am agoraphobic" (=I fear open space)? my statement is empty.

The same thing holds or gambling: suffering from pathological gambling means being unable to control one's desire to gamble. Is it not a tautology to say: "I cannot control my gambling because I suffer from pathological gambling" (=uncontrollable gambling)?

However often these arguments occur in psychiatry, they are still logically fallacious. The number of times in which they are used does not modify their tautological nature.

Acknowledging that in the majority of cases the diagnosis of mental illness merely has descriptive character has important consequences. It implies that the fact that someone has (been diagnosed as having) mental disorder does not necessarily say something conclusive, and often says nothing about the individual's capability to make their own decisions, even relating to their own mental health. It follows that non-consensual interventions cannot be justified (even partly) on the grounds that the individual has been diagnosed as having mental illness or mental disorder. Therefore, we should accord to people with mental disorders the same respect we accord to everybody else.

This of course does not mean that we should be indifferent to the individuals' destiny. Some forms of paternalism may be ethical, and I will explain when paternalism may be justifiable.

3. When is Paternalism Ethical? Some Theories

If we demand respect for the autonomy of people with mental disorders (as we demand for the autonomy of all other people), does it follow that paternalism is always unethical? This claim would be highly counter-intuitive. However, how can we justify non-consensual interventions, once we have committed ourselves to the principle of respect for individual autonomy?

Philosophers who ascribe a primary normative value to autonomy often produce an argument in justification of paternalism, which, as we shall shortly see, is hardly defensible, especially if applied in the psychiatric context. The argument is

that we ought to respect the autonomy only of those individuals who possess it, that is, persons, or moral agents (7). The principle of autonomy, so it is argued, only stands for some creatures, and only for some human beings, those, in John Stuart Mill's words, "in the maturity of their faculties" (8). Mill excluded children, those who are in need of care by others, and barbarians from the principle of autonomy. We do not have a moral duty to respect the autonomy of those who are not moral agents or even persons. We may rather have a duty to protect them. In these cases, non-consensual interventions, in the individuals' best interests, are not a violation of their autonomy (something they do not possess), and no moral blame can be attached to it.

Those who believe that we should only respect the autonomy of some creatures, namely "persons" or "moral agents", have an additional theoretical problem to solve: which creatures may be considered as "persons" or "moral agents"?

4. The Principle of Autonomy, and Individuals' "Moral Status"

It is generally agreed that not all creatures are persons, and a number of influential philosophers also argue that not all human beings are persons. In An Essay of Human Understanding, John Locke described a person as a "thinking intelligent Being, that has reason and reflection, and can consider it self as it self, the same thinking thing in different times and places" (9). On this line, philosophers such as, for example, H. Tristram Engelhardt Jr., John Harris (10) and Peter Singer (11) have developed their own views. Engelhardt defines persons as "entities who are self-conscious, rational, free to choose and in possession of a sense of moral concern" (12). He argues that not "humans", but "persons" are special. Adult competent human beings have an intrinsic moral status that is much higher than that of human foetuses or of adult frogs. A high moral status is not a strict domain of human beings. Persons, in fact, are not necessarily humans. Whilst there are non-human entities that are persons, there are human entities that cannot be considered as persons: these are foetures, infants, seriously mentally impaired people, and comatose individuals with no hope of recovering. According to Engelhardt, we ought to respect the creatures that possess a high moral status because of their moral status. We might instead be required to protect those who possess a low moral status, according to the principle of Beneficence (13).

He writes:

The morality of autonomy is the morality of persons. For this reason it is nonsensical in general secular terms to speak of respecting the autonomy of foetuses, infants, or profoundly retarded adults, who have never been rational. There is no autonomy to affront (14).

Gerald Dworkin develops a similar argument. According to Dworkin, to be considered as persons, human beings should be able to define themselves, and to give shape and significance to their own life. Only those individuals are able to define themselves and to give shape and significance to their own life are entitled to our respcet. The case of "incompetents", he writes, is "relatively unproblematic" (15), because incompetents do not reach the minimal threshold above which creatures are moral beings.

In a similar way, John Rawls states that only human beings who participate in the deliberation are a part of the moral community. In order to participate in the deliberation, and therefore, to be considered as a part of the moral community, they should manifest peculiar characteristics and preferences, for example, they must be rational and able to manage their own affairs (16).

The idea that we only ought to respect "persons" or "moral agents", and that we should at most protect those who do not fall in the "high-moral-status" group, meets with several difficulties, particularly when it is applied in the psychiatric context.

5. Who Belongs to the "High-Moral-Status" Group?

The main difficulty involved in the idea that we only ought to respect those who possess a high moral status is, of course, that we do not have a clear idea of who possesses it. Many of us would agree that, for example, an embryo is not a moral agent "whose actual decisions should be respected" (although the status of "person" of the embryo is more controversial). I am also sure that both you and I assume we possess it, and would vigorously complain if someone claimed otherwise.

However, there are situations in which it is unclear whether we should (or even whether we reasonably could) ascribe to an individual one "moral status" or the other. This problem is particularly acute in the psychiatric context (17). Of course there are severely isolated individuals, with whom any relationship is often extremely basic. However, not all people with psychiatric illnesses are severely isolated. On the contrary, most people with mental disorders are sometimes able to make their own decisions, even relating to their own mental health (18). A person may in fact be unable to control his aggressive impulses in a socially acceptable way, but nonetheless he may be able to make decisions about medical or psychiatric treatment (19). Those who have episodic illnesses may be able, during the phases of remission, to decide how they want to be treated when in the acute phases of their illness (20). Which moral status should we ascribe to these individuals? The "high" or the "low"?

It is perhaps interesting to report here a case history as an example of how problematic it can be to include someone in one category or in the other.

5.1. L.'s case

L. is a 35 year-old woman, who lives in a psychiatric institute, in Italy, with a diagnosis of chronic paranoid schizophrenia. She became pregnant as a result of a one off sexual intercourse with a man who was hospitalised in the same institute on a temporary basis. When the man was told that L. was pregnant, he suggested that she should end the pregnancy. L. already had two children from a previous marriage. Because of her mental condition, her children were placed for adoption. Later on, she became pregnant again, and, despite the fact that she is Catholic, she interrupted the pregnancy. This time, when she became pregnant for the fourth time, she knew that she would be denied custody of the baby. This idea understandably terrorised her. However, she believed that, for the child, being born and living in a family was better than not coming into existence at all. During a conversation, she told me: the law requires a careful selection of adoptive families. This means that these people will probably be good, and probably they really want to have a baby. I feel I'm making three people happy. Probably my baby will receive much love and will have a happy life; he will be able to go to the university, to have a good job. I don't want to deny my baby all these opportunities. Everybody is suggesting that I have an abortion, because they think that I will not be able to stand the moment when my baby will taken away. I know I'll be miserable at that time, but I won't be much better otherwise. I would live with the regret that, had I made a different choice, my baby would be alive, and have had a happy life.

At the time we had this conversation, L. had persecution manias. She was convinced that everybody hated her and wanted to kill her. She did not trust anyone, including doctors, who tried to convince her to interrupt the pregnancy. The psychologist suggested that she was projecting on others her feeling shameful for having had occasional sex (a sin, in her religion). Whether or not the psychologist was right, L.'s complex way of coping with the whole situation made it extremely difficult for doctors to approach her and give her proper medical advice. Besides being convinced that everybody thought she deserved to die, she was also afraid that doctors might give her something to induce an abortion. We tried to expalin to her that "doctors would go to prison", if they did something like that (in Italy, coercive abortion is illegal), but, simply, she did not believe us. Despite her inability to take medical advice, however, L. indisputably manifested the capacity to decide about her pregnancy. Some people may believe that she made the wrong choice, but nobody can sensibly claim that her decision was lacking autonomy.

Cases like this, (which are frequent in psychiatry) show that it is often impossible to determine whether particular individuals meet the stated standards of personhood or of moral agency. Mental illness is a general label, but there are remarkable differences among individuals, even among those with the same diagnosis. Individuals may be able to make decisions on a subject but not on another, or to make decisions on a subject at one time but not at another (21). Moreover, those who care for people with mental disorders will have noticed that even the most isolated individuals sometimes show interest in something, can manifest preferences and make choices, however basic these may appear.

It should also be noticed that the attempt to separate moral agents (who deserve respect) and

moral patients (who deserve protection) has implications that seem to be ethically unacceptable.

5.2. Other implications

On the one hand, including someone in the category of "those who possess a high moral status" may lead us to overlook their need to be protected, at particular times, and in some particular circumstances. It is unclear why this lack of protection should be regarded as morally unproblematic only because the individual does not belong to the "vulnerable group".

On the other hand, including someone in the category of "those who possess a low moral status" may lead us to violate the individuals' autonomous decisions, ranging from medical or psychiatric decisions to the simplest tasks of daily life. Again, it is unclear why these violations of autonomy should be regarded as morally unproblematic only because the individual does not meet stated standards of personhood or of moral agency.

One may argue that, at the end of the day, many psychiatric patients can at most choose their T-shirt or the colour of their fingernails. These are "non-important" matters, for which it would be inappropriate to disturb the "principle of respect for individual autonomy". However, it should be acknowledged that autonomy is always valuable, independently on the "importance" of its object. How would we feel if we were denied, for example, the freedom to decide what to wear? Probably we would do much more than disturbing the principle of respect for individual autonomy, in order to defend our freedom to decide on the simple matters of daily life. The freedom to decide autonomously on "non-important" matters is as valuable as the freedom to decide autonomously on "more complex" matters. We should therefore respect the individuals' autonomy, even if this amount to respecting their decision to wear a T-shirt rather than another.

From the arguments developed in sections 5, 5.1 and 5.2 it follows that a theory of personhood, or of moral agency, does not help in deciding when paternalism may be ethical, particularly in psychiatric health care.

Thus far, we have seen that:

1. Paternalism cannot be justified (even partly) on the grounds that the individual has been diagnosed as having mental illness or mental disorder (section 2).
2. Paternalism cannot be justified on the grounds that the individual does not belong to the "high-moral-status" group (sections 5, 5.1, 5.2).

So: on which grounds may paternalism be justifiable?

6. Weak Paternalism

The only form of paternalism that is coherent with respect for individual autonomy is what Joel Feinberg has called "Weak Paternalism" (22). According to Feinberg, a person has the right to prevent harmful conduct of another only when this other is acting non-autonomously, or when a temporary intervention is necessary to assess whether that person is acting autonomously or not.

Whether or not I am justified in preventing you from behaving in a certain way (except the case of harm to others) depends on whether or not your conduct is autonomous (23). As Mill argued, if I saw you attempting to cross a bridge which had been ascertained to be unsafe being unaware of the danger, but I had no time to warn you, I may seize you and turn you back without any real infringement of your autonomy (24).

Moreover, as has been explained in the previous section, what matters is not whether an individual is an autonomous agent, but rather whether that particular conduct is significantly autonomous. Autonomoy does not characterise the condition of individuals. It refers rather to actions and choices (25).

Therefore, we should not assess the individuals' general autonomy (or their mental state). We should rather assess whether specific actions and decisions are autonomous (26). Whether or not the individual has (been diagnosed as having) mental illness, and whether or not he belongs to the "high-moral-status" group, his autonomous decisions should be respected, unless, for some other reason, we want to adopt a prejudicial and discriminatory attitude.

7. Conclusions

We all value autonomy, and cannot sensibly assume that those who have mental disorders value autonomy less than others do. Therefore, we ought to respect the widest spectrum of autonomous actions and choices that people may be able to do or

make, ranging from the most complex to the simplest tasks of daily life, and, before restricting people's freedom of action in their own best interest (even if they have a mental illness), we should assess whether the conduct we want to prevent, lacks autonomy in some significant way.

An objection may be that it may be difficult to determine whether one's conduct is significantly autonomous or not. This is true. However, it should be recognised that this difficulty is inevitably part of the broader difficulty to understand other people's experience, and to relate to people who do actions and make decisions that are substantially different from the ones we would expect them to do. The morality of paternalism will probably always be controversial, and most times will conclude with a moral doubt. Fortunately, however, there are many different kinds of interventions. Coercion is not the only inescapable alternative to "absolute respect". We can discuss with people, listen to their reasons and explain ours, and prudence and good sense are always available options.

Finally, it should be acknowledged that the value of autonomy should not only be understood and respected, but also protected and promoted. For this reason, it is morally important that paternalistic interventions be not only based on the careful study of the conduct at stake, but also aimed at improving the individuals' capacity to act and choose autonomously (27). The appeal to autonomy should not be understood as a superficial appeal to a widely shared value. Stressing the importance of autonomoy means rather insisting upon the moral need for a task that requires effort, responsibility and commitment to all the parties involved.

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NOTES AND REFERENCES

1. General Assembly of the United Nations, Universal Declaration of Human Rights, 10 December 1948; Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms, Rome 4 November 1950; Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, 4 April 1997; see also the Charter of Fundamental Rights of the European Union, Bruxelles, September 2000, art. 3.
2. See, for example, the Mental Health Act 1983, in force in England and Wales, s.2, and s.3.
3. I shall refer indifferently to "paternalism" and "non-consensual interventions". Paternalism here refers to all interventions aimed at restricting someone else's freedom of action in his best interests. Some of these interventions are justifiable, some are not. I shall explain which may be justifiable. It should be noticed that the issue of restriction aimed at the prevention of harm to others is not examined in this paper. The focus is on restrictions of freedom of action imposed for the good or the well-being of the person whose freedom is restricted.
4. Eugen Bleuler used the term "schizophrenia" for the first time. He called dementia praecox "schizophrenia" "because the 'splitting' of the different psychic functions is one of the most important characteristics" of the disorder. In fact, in its etymological meaning, "schizophrenia" means "split-mind" (from the Greek σχιζο = schizo = split, and φρενια = phrenia = mind). See E. Bleuler, Dementia Praecox, International University Press, New York, 1966, p.8.
5. I owe this observation to Dr. Alan Cribb.
6. I am not underestimating the importance of diagnostic categories. I am trying to clarify a logical error that may justify moral wrongs.
7. It should be noticed that "person" and "moral agent" are not equivalent notions. It may be argued that a "person" may not be a moral agent, although a moral agent must be a person. For example, according to John Harris, a person is a creature which is able to value his life. Within this perspective, a person may not be a moral agent. Moral agency, in this case, seems to require something more than the mere capacity to value life. I shall not make any distinction between personhood and moral agency, because here I am concerned with those creatures who are believed to possess a high moral status. Some authors call them "persons"; some others call them "moral agents".
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13. ivi, 1.baskı, 66.
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16. Rawls J. A Theory of Justice. Oxford University Press, Oxford, 1972: 249.

17. It seems that many people with mental illness would not meet the standards stated by Locke, Engelhardt, Dworkin, and Rawls. Consider, for example, Rawls's statement that individuals must be able to manage their own affairs. Probably, Rawls would find that many institutionalised patients would be unable to manage their own affairs. However, the ability to manage their own affairs is situation-relative. If managing their own affairs means looking after themselves and after their finances with some sort of, for example, prudential insight, then many institutionalised patients would be found unable to manage their own affairs. However, in the situation in which institutionalised patients live, they may be able to manage their own affairs, where, for example, their own affairs may amount to practising particular skills, participating to the organisation of social activities or understanding their mates' problems, helping and supporting them when they are in need, and so on.
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21. Brazier M. Medicine, Patients and the Law. Penguin, London, 1992, chs. 2, 4, and 5; see also Harris J. op. cit., ch.10.
22. Feinberg J. "Legal Paternalism". Canadian Journal of Philosophy, 1, 1971:105-24.
23. We should also adopt a procedural conception of autonomy. According to this conception, autonomy should be evaluated on the basis of the process of reasoning and deliberation leading to a particular choice, rather than on the basis of the content of that choice (for example, on the basis of the fact that it is harmful). This position, which is apparently shared also by Engelhardt, has been accepted by the U.S. President's Commission for the study of Ethical Problems in Medicine and Biomedical and Behavioral Research. The English approach to decision-making capacity is similar. In common law, this is known as the "functional approach". As I have explained elsewhere, this is the only conception of autonomy that is coherent with a genuine respect for individual autonomy. See Simona Giordano, "Il principio di autonomia nel trattamento e nella cura dei malati di mente, una prospettiva deontologica", Bioetica, rivista interdisciplinare, 3, 1999:482-91.
24. Mill JS. op. cit., pp.106-7.
25. A similar approach is adopted in common law. When people are not "sectioned" under the Mental Health Act, or when people who are sectioned under the Act should be provided with medical treatment not directed to the mental illness, non-consensual interventions may be justified on the ground of their incompetence to make that particular decision. Incompetence is a decision-relative concept, therefore individuals may be found incompetent to make a particular decision at a one time, but competent to make other decisions or the same decision at a different time; see for example Estate of Park [1959], All ER P.12. Differently, in Italy incompetence is a broad legal concept refering to the whole person. See the Civil Code, articles 414-9.
26. This should be so, despite the predictive value of the psychiatric diagnosis, and despite the fact that we may be strongly incline to believe that people with mental illness somewhat lack autonomy. Our inclinations, however strong, however difficult to dismiss, and however widely shared, say nothing about real state of affair.
27. This is also clinically important. In fact, it is widely documented that participating actively in the therapeutic process is essential to the betterment of people with psychiatric conditions, and that improving their decision-making capacity is often propaedeutic to the remission of their disorders. See M. Selvini Palazzoli, et al. Ragazze anoressiche e bulimiche, la terapia familiare, Cortina, Milano, 1998:96-7.