Abstract

The exercise of personal freedom involves decision-making capacity and behavior-actualization ability, both of which are subject to “inner” restrictions due to mental illness. In addition to changes in experience which may result, i.e., in preference reversal and hence unauthentic behavior, mental illnesses can also change one’s habituality, putting certain habits out of play or trigger acquisition of new habits.

Furthermore, the exercise of personal freedom involves negative freedom, since “outer” restrictions can further impair one’s decision-making capacity and behavior-actualization ability (i.e., inadequate information, stereotyping by relevant others, or non-barrier-free facilities). It is important to note that “outer” restrictions can become (the basis of) “inner” restrictions, especially by inducing certain habitualities or worldviews. On the other hand, “inner” restrictions caused by mental illness can be rendered less relevant for authenticity and personal freedom if counterbalanced by adequate support and/or circumstances. Therefore,
“outer” restrictions can double the infringement of personal freedom already caused by “inner” restrictions due to mental illness. This calls for the empowerment of mentally ill persons and refers to the core of personal freedom, implying that no person can lose personal freedom completely simply because she is the active agent in her lifeworld.

Introduction

Personal freedom is taken as a precondition of a good life in the modern era. Mental disorders are considered to disrupt one’s freedom, because they can impair a person’s ability to make rational decisions and can lead to behavior which seems deeply out of character for that person. While in the early modern era this inability was deemed to be a rather general and lasting quality of insane (mentally ill) persons, it emerged that such impairments are rather specific and usually correlate with episodes of acute illness.

During the last two decades, the debate surrounding autonomy and mental disorder attracted new interest in the wake of receding paternalism and an emerging recognition of the importance of informed consent in mental health care. Dehospitalization and development of outpatient and community mental health services (i.e., assisted housing, assisted employment) in the psychiatric field enhanced the negative liberty of persons with mental disorders in many (western) countries and fueled the necessity to improve insights into the connections between impaired autonomy and mental disorder. Nonetheless, future research needs to determine the specific, social-, and symptom-related impairments of individual freedom in persons with mental illnesses even further.

This debate draws on an understanding of autonomy which is informed by the decision-making capacity approach. Many authors argue for an enlargement of this understanding due to the role of values in human life. Some authors promote an understanding of a good life which is related to concepts of authenticity, while others argue for an operationalization of sub-capacities in order to achieve reliable and valid tests for easy clinical application (i.e., appreciation of information ability in depressed persons, Hindmarch et al. 2013). Other authors promote a concept of decision capacity detached from any conception of freedom of the will.

Most authors agree that the capacity for personal autonomy is independent of external restrictions on autonomy, such as inadequate information, stereotyping, or non-barrier-free facilities (i.e., the term “capacity” refers to an “ability of subjects,” Charland 2011). However, in a given situation, such conditions (adequate information, absence of stereotyping, barrier-free facilities) must be fulfilled in order to adequately bring one’s capacities into play. Nonetheless, inner restrictions are the focus of the debate on impairments of personal freedom in mental disorders such as addiction, depression, or psychosis. Hence, the entry will have the following structure:
• Concepts of autonomy in the recent debate on impaired freedom
  1. Impairments of personal freedom in addictive disorders
  2. Impairments of personal freedom in depressive disorders
  3. Impairments of personal freedom in psychotic disorders
  4. Outlook

Concepts of Autonomy in the Recent Debate on Impaired Freedom

Despite its importance, autonomy is not an unambiguous concept, yet most philosophers would agree that we should consider ourselves as autonomous if capable of giving good reasons for our behavior. In doing so, we manifest our values and (moral) guidelines into action and behave according to our fundamental moral principles. This concept of autonomy undergirds the ideal of an informed consent, in which the medical doctor follows four moral principles in his day-to-day practice, namely, respect for autonomy, non-maleficence, beneficence, and justice (Beauchamp and Childress 2011). These four moral principles are supposed to be applicable in any given situation regardless of the worldview (Weltanschauung) of the persons involved (so-called principlism). Hence, moral conflicts are understood as conflicts regarding the ranking of these four principles.

Critical debates point out the importance of understanding why a certain person selects a certain ranking of these principles – or other values – in a situation in which she is called upon to decide (Charland 2002; Wiggins and Allen 2011). One cannot simply infer that she ranked them autonomously or was not influenced in her ranking by her mental illness. Nonetheless, the principlist approach is considered to be the gold standard in applied ethics such as medical or clinical ethics (Appelbaum and Grisso 1995; Appelbaum 2007). This has influenced the understanding of autonomy which is drawn upon in recent debates regarding impairments of personal autonomy in mental disorders.

In these debates, personal autonomy is conceptualized as a capacity of a self-reflecting agent who is a moral agent. But no matter how the foundations of what it is to be a morally responsible agent are conceptualized, it has to be admitted that the reasons for an agent’s behavior must be grounded in the mental structure this agent had in the moment right before he initiated his behavior and/or decided upon a specific behavior. This groundedness of decisions and actions in a person’s mental life is the basis for the influence of mental disorders on one’s personal autonomy. In extremely debilitating conditions, such as severe dementia, this influence can also impair a person’s autonomy in an existential sense, disabling the person to explicitly say “yes” or “no” to his or her own existence as a living being in its own lifeworld.

This does not necessarily imply that one’s ability to kill oneself is the highest expression of freedom, as existentialist positions often claim (Camus 1942), but basically supports arguments highlighting the role of values in decision-making and of authenticity in personal autonomy.
From a philosophical point of view, the influence of our deepest desires, such as those for other people or things we love or long-term life goals, is of special interest. If we cannot help but care for someone, this caring prescribes all our other implicit and explicit valuations, judgments, and decisions (Frankfurt 1999). From a phenomenological point of view, such passive qualities of moral agency can even refer to the manner in which our lifeworld is disclosed to us, calling upon us not only to take up responsibility for our deepest desires but also for the manner in which we disclose our lifeworld to us (Drummond 2010). However, positions which describe certain behavior as heteronomous due to its merely being “immoral” are contradicting the consensus within the relevant discourse. In other words, autonomy entails freedom to undertake immoral behavior.

According to the informed consent movement in (mental) health care – mirroring the necessity for persons to consent to their treatment on the basis of extended information which is in line with most contemporary approaches to moral agency – personal autonomy is related to the capacity of rational decision-making. Extended (empirical) studies regarding competence to make treatment decisions distinguished four sub-capacities, or abilities/skills, considered necessary for (autonomous) decision-making:

1. To express a choice
2. To understand relevant information
3. To appreciate one’s situation and its consequences
4. To reason about treatment options/rationally manipulate information (Appelbaum and Grisso 1995)

These four cognitive skills have been used to develop a widely applied assessment tool, the MacCAT (MacArthur Competence Assessment Tool), offering at least some consensus on how to view and assess a patient’s competence in clinical day-to-day practice (Appelbaum and Grisso 1995; Charland 2011; Meynen 2011; Owen et al. 2009; Vollmann 2008). Mental competence in this sense is, however, necessarily only valid with respect to a concrete decision in this very space and time (Buchanan and Brock 1989, pp. 18–20). It is furthermore unclear whether a person can only be deemed to make autonomous decisions if she can display all four sub-capacities in a given situation, even if the decision at hand is a very simple one, such as buying a cup of coffee. This so-called threshold quality of the capacity concept (Buchanan and Brock 1989) challenges concepts of the freedom of the will, since the latter cannot be given in “degrees.” There is an open debate on whether or not a decision-making capacity can be conceptualized without referring to the concept of a freedom of the will (Meynen 2011).

On the one hand, decision-making capacity is claimed to substitute the concept of freedom of the will; on the other hand, it is argued that a meaningful understanding of personal autonomy requires acceptance of the “givenness” of freedom of the will, at least in the sense that it serves as a regulative idea. Furthermore, the role of values and valuing – both prima facie pre-reflective and reflective value apprehensions – remains unaddressed in this approach (Charland 2011; Schlimme 2012; Tan
et al. 2007). This point is of special relevance for psychiatry due to the importance of values in mental life (Fulford 2004). In combination with the problematic (or absent) role of values in the capacity concept, these debates call “the empirical validity of the concept of capacity embodied in a given test” into question (“dual nature of competence,” Charland 2011). Nonetheless, the capacity concept, which originally started within a specific area of ethically complex treatment decisions, has thus developed into a model for autonomous daily life.

To summarize, the capacity approach depicts the moral agent as deciding rationally and meaningfully for itself in a first step. According to this idea of a moral agent, they afterward actualize their decisions in their life in a second step. According to this conceptualization, restrictions of personal autonomy might therefore arise:

(a) On the level of one’s decision-making capacity
(b) On the level of one’s behavior-actualization ability

Both capacities could be conceptualized as independent from certain qualities of the relevant person’s environment in the sense of possible outer restrictions such as inadequate information, attribution of stereotypes by relevant others, or non-barrier-free facilities. However, in a given situation, such conditions (adequate information, social recognition, barrier-free facilities) must be fulfilled in order to adequately bring these capacities into play.

Nonetheless, with respect to mental disorders such as addiction, depression, or psychosis, inner restrictions are impairments which disable the person to use the granted (negative) freedom autonomously – that is, to display both her decision and behavior-actualization ability. Furthermore, debates on personal autonomy in mental disorders with a philosophical approach primarily focus on decision-making capacity, that is, on those conditions of mental disorders which specifically impair a person’s decision-making capacity. Behavior-actualization abilities and outer restrictions might be of equal importance for the relevant person in the situation in which she is called upon to act but are usually addressed in a different discourse (i.e., psychiatric or therapeutic discourses on recovery, social psychiatry, or empowerment). Positions connecting both discourses often focus on the role of values and authenticity in personal freedom (Flanagan 2011; Schlimme 2012).

Impairments of Personal Freedom in Addictive Disorders

“The addict” is a classical example of a person with impaired personal freedom. She may intend, and voluntarily consent, to abstain from her drug of choice, articulating excellent reasons to do so, yet suffer relapse an hour later in a stressful or tempting situation. From a commonsense point of view, “the addict” displays a weakness of the will. In other words, her impaired behavior-actualization ability (“guidance control,” self-control) corresponds with an impaired decision-making capacity.
“Addicts” typically display an impairment to actualize the behavior they have decided to perform (abstaining from taking drugs) in seducing situations. To put it differently, they encounter difficulties in adequately taking into account the strength of their compulsive habit and the momentary change of their goals and values toward a short-sighted and drug-oriented set when determining their choice.

The latter points out specific impairments regarding both her skill to appreciate her situation and its consequences and the ability to reason about behavioral options and rationally manipulate (relevant) information. From this point of view, the addict is indeed addicted to her drug of (involuntary) “choice” and impaired regarding all decisions (and behaviors) related to that drug. This addiction correlates with a specific impairment in her decision-making capacity (skills 3 + 4) and implies a specific impairment in her behavior-actualization ability (resembling a weakness of the will or impaired guidance control), leading to further drug consumption and so forth. All in all, this displays a specific, drug-related impairment of individual freedom.

This rather broad description is usually agreed upon both from medical and psychological as well as philosophical, ethical, and legal points of view. It is furthermore agreed that these impairments fluctuate in relation to the addictive cycle of intoxication and withdrawal. Persons with addictive disorders are hence, at least in those cultures that accept the concept of addiction as a disorder, usually deemed to display, or suffer, specific drug-related impairments of personal freedom. There is an ongoing debate on how to understand and conceptualize these impairments and regarding what kind of responsibility (legal, moral, clinical) is altered (i.e., whether they might even expel addicts from responsibility regarding drug-related behavior whatsoever) (Yaffe 2001; Poland and Graham 2011). There are three favored, not mutually exclusive, lines of argumentation on why persons with addictive disorders are specifically and fluctuatingly impaired in their decision-making capacity skills 3 and 4, resulting in an impaired actualization ability for these persons:

1. Directly drug-related impairments of attention, memory, or executive functions (i.e., intoxication, withdrawal)
2. An altered style of reasoning, developed and acquired during the process of developing and acquiring the drug habit (i.e., hyperbolic discounting to prefer short-term and neglect long-term effects of one’s behavior, resulting in a preference reversal of goals: short-term goals, not corresponding with one’s long-term interests, are preferred compared to long-term goals, corresponding with one’s long-term interests; Elster 2000)
3. An altered set of values, developed and acquired together with the drug habit (i.e., overestimation of drug-related benefits or one’s self-control, sometimes conceptualized as a specific manner of self-deception/irrational beliefs/irrational self-image; Charland 2002; Schlimme 2010)

Even a former drug addict who abstains from drugs for longer periods of time is often unable to use the drug of choice in a controlled and non-compulsive manner,
which correlates to his acquired and developed **addictive habituality** and extensive and lasting neurophysiological alterations acquired during his ongoing addictive behavior (Schlimme 2010; Schlimme and Voss 2017).

From a psychiatric point of view, underlying disorders (i.e., posttraumatic, personality, affective, or psychotic) might further fuel the addiction beside the acquired **habituality** due to positive effects of the drug of choice (so-called self-medication hypothesis; Khantzian 1985) as well as a “depraving” and demotivating environment (so-called rat park hypothesis; Alexander et al. 1978), which also minimizes negative freedom due to **outer restrictions**. Consequently, a person with an **addictive disorder** might not even try to discard the habit, if she successfully manages to maintain her social life. This is especially the case if her social life furthermore covers – or at least accepts – her habit, implying that she integrates her drug consumption as a meaningful and sustaining behavior into her life (“sober drunkard”; Schlimme 2010; Pickard 2012). This typically results in extensive “phases” or “moments of clarity,” often also given if persons with (illegal) drug addiction are integrated in substitution settings, minimize consumption of other drugs, and develop and maintain an empowering social surrounding. From a philosophical point of view, it is debatable whether a manner of drug use allowing for such “phases of clarity” could be called responsible, at least responsible in the short term or within a specific context (i.e., a special setting or regarding one’s coping with otherwise more severe symptoms/self-medication hypothesis).

This argument could be taken a little further, ending up in a **right to be addicted** claim opposing the **war on drugs** claim. The “right to be addicted” argument basically states that a person’s addiction is her or his own problem as long as that person is sober enough to get along in life and not cause problems for others. The **war on drugs** argument claims that the addict is unable to decide against the drug he is addicted to, because he is addicted to it, and therefore, the drug as a disastrous agent should be banned (obsta principiis). Both arguments aim at the heart of the concept of **addictive disorders**.

If the birth of this concept around 1800 is reconsidered, one encounters an important distinction for developing this concept as well as all other modern concepts of **mental disorders**. This distinction separates well-being from the first-person perspective and having a disease from the medical perspective. It was Thomas Trotter (1760–1832) who demonstrated the often Janus-faced coexistence of personal well-being and constant alcohol consumption in the ideal type of a **sober drunkard**, a seemingly quite frequent manner of existence for British sailors and dock workers in Trotter’s times (Trotter 1804).

Today this argument is mostly debated regarding the use of substitute drugs for illegal drug users. Some authors argue that substituted addicts might be unable to competently consent to substitution treatment because they are addicted (and hence intensively drawn) to the substituting agent (Charland 2002). Others argue that substituted addicts are typically highly competent and able to live their life **authentically** because they are substituted (Schlimme 2010).

Nevertheless, concrete impairments of **decision-making capacity** and **behavior-actualization ability** are not directly dependent on the addictive disorder but on the...
effects of the acquired drug habit, on the level of drug intoxication or withdrawal, and on the stance and worldview the addict takes toward these. From this point of view, sobriety is more important than the simple fact of continuously using certain drugs (whether for self-medication, ritual, or recreational motives).

It seems to be relevant for philosophical (and ethical) judgment how addictive behavior is conceptualized, even if it is agreed that persons with addictive behavior have diminished responsibility at least some of the time. It is furthermore generally agreed that impairments of personal autonomy in addictive behavior cannot be conceptualized in a general manner. They can only be depicted and determined individually for which decision a person with addictive behavior (i.e., abstention or continuation of further drug use or the setting in which she uses her drug) can be held responsible. In this specific determination of responsibility, the actual stage of her addictive cycle (i.e., intoxication, clarity, withdrawal) has to be taken into account.

**Impairments of Personal Freedom in Depressive Disorders**

Depressive moods are experienced as being imposed. They are hence passively experienced phenomena, typically rendering the afflicted person unable to feel happy as well as diminishing the person’s drive to pursue her own interests and thusly the person’s interest to pursue her own happiness and autonomy. Prima facie “the depressed person” seems to be impaired in her personal freedom due to impaired behavior-actualization ability (“no drive”) while seemingly having “normal” decision-making capacity. Yet this displays a rather poor understanding both of decision-making capacity and depressed moods.

A broader picture shows that “in depressed mental life everything is somehow at a devaluing loss (‘The glass is half empty.’)” (Schlimme 2013b). This negative or depressive manner of selecting and affectively responding to experienced non-axiological properties (oneself, circumstances and objects in one’s lifeworld, one’s life history, and future prospects) typically implies a devaluing, or negativistic, experience of oneself (low self-esteem) and one’s (sensible) needs (hence serving primarily the needs of others), one’s deeds in the past (feeling guilty, “If only I had...”), and one’s behavioral options in the given situation and the future (anhedonia, helplessness, hopelessness) (Hindmarch et al. 2013; Meynen 2011; Rudnick 2002; Schlimme 2013b; Sullivan and Younger 1994).

Hence, depressed moods can correlate with specific impairments in decision-making capacity, namely, to appreciate one’s situation and its consequences (skill 3), entailing possible preference reversal due to both a negativistic selection and devaluing of behavioral options or personal needs and aims.

This rather broad description accepts an intricate connection between mood and personal freedom in the sense of a “preintentional quality” of moods (see for this argument Rudnick 2002; Slaby and Stephan 2008; Ratcliffe 2010). Basically, this intricate connection argues that one’s mental life is pre-reflectively prescribed by one’s depressed mood and that the complete structure of lived experience is altered by the depression. This is a classical argument already given in the Corpus
Hippocraticum, a collection of medical papers from the fourth century B.C. in Alexandria. Here melancholia is deemed responsible for inducing delusions and a “certain desire to long for death as if it would be something good” (Hippokrates 1933–1940, V, XXIII/136ff).

It is furthermore a standard argument in the (clinically driven) psychiatric discourse, drawing on Karl Jaspers’ distinction between mood (Stimmung) and affect/feeling (Affekt/Gefühl) in his influential General Psychopathology. Jaspers redefined the term “mood” as a complex state of feelings providing the background and color (Färbung) of actual mental life (Jaspers 1913, 62f). Importantly, impairments of personal freedom can be connected with depressive moods in two ways. On the one hand, the perceived or experienced (behavioral) options can be reduced in scope; on the other hand, the experienced options can be valued in a different (“negativistic,” “devaluing”) style (Schlimme 2013b).

The first connection impairs one’s personal freedom via a reduced network of possibilities (Meynen 2011), which could be termed “inner restrictions of negative freedom” (correlating to skill 2 + 3). The second connection seems to result in impairments via a minimized concern for one’s own welfare (Elliott 1997; Rudnick 2002), which could be termed “inner restrictions of positive freedom” (correlating to skill 3 + 4). Moreover, severe depression often implies lack of drive resulting in an impaired behavior-actualization ability.

Obviously, personal freedom can be impaired in depressive moods both in scope and style, resulting in the ambiguous intersubjective experience of persons with depressive moods mentioned above. Surveys on competence to consent to medical/psychiatric treatment demonstrate that moderately depressed persons are usually still capable of giving informed consent, even while already being impaired in personal freedom due to being depressed. On the other hand, severely depressed persons often lack the capability to give informed consent to treatment (Hindmarch et al. 2013; Lee and Gazini 1994).

This complex picture can also be found in persons with ongoing depressive disorders (dysthymia, double depression), who might achieve helpful and meaningful coping styles for their ongoing or recurring depressive symptoms. The latter typically entails a more complete personal freedom, while still being impaired in some ways, possibly resulting in a unique and mostly recovered way of living (Schlimme 2012). This does not, however, merely require a mental process in which one modifies one’s demands and thereby achieves an altered worldview (i.e., fueled by psychotherapy). It also requires more negative freedom to arrange one’s everyday life on a lesser activity level, including the social and economical dimension.

The extreme side of this connection might be found in modern societies, typically pursuing high aspirations for their members (i.e., regarding autonomy and authenticity). Postmodern societies even publicly support the claim of an “anything is possible” and thus the possibility of an authentic life. Naturally, this claim is just an illusion, since a person’s negative and positive freedom is highly dependent on her social environment, individual life history, and resources. Similarly, authenticity cannot permanently be achieved or even owned like an object but is a demand in
itself. If persons identify themselves with and try to live up to their social environments’ high demands, they are more easily overtaxed with simply trying to be themselves authentically (Ehrenberg 1998).

This might result in a fatigued self (Ehrenberg) with which comes a higher risk for depressive disorders. This argument claims that negative freedom might be impaired due to inner restrictions, since social demands are habitualized and adopted during socialization (whether during childhood or later on). From this perspective, depressive moods appear to mirror a missing internal negative freedom in the face of one’s own demands.

This complexity fuels philosophical debates on suicide as well, since behavioral options are also typically altered in scope and style in suicidal mental states due to an “affective narrowing” (Einengung, hopelessness). This “affective narrowing” (Einengung, hopelessness) is usually given before committing or attempting suicide (being one of three crucial features of the so-called pre-suicidal syndrome, Ringel 1954; Beck 1987). In acute suicidal conditions, the behavioral options can indeed be effectively narrowed down to two choices: “staying alive” or “killing oneself,” while one’s prima facie valuing oscillates between valuing the given situation and mental life as “unbearable” or “just bearable” and the option of killing oneself as “last and only rescue/exit/escape” or “no exit at all,” with the tendency to overestimate negative outcomes (see Schlimme 2013a).

Basically, these different concepts developed with respect to depressive moods and disorders can be transposed to manic moods and disorders, at least to a certain extent. In manic moods, an altered scope of one’s experienced (behavioral) options and possibilities as well as an altered style of positivistic prima facie - +9 result in an overvaluing of one’s abilities (inflated self-esteem) and needs (compared to the needs of others, correlating with a reckless behavior), one’s deeds in the past, and one’s behavioral abilities and options in the given situation and the future (euphoria, omnipotence).

Although, prima facie “the manic person” seems to be impaired in her personal freedom due to a massively inflated behavior-actualization ability (“too much drive”) while seemingly having “normal” decision-making capacity, a closer look reveals that, in particular, the appreciation of one’s situation and reasonable digestion of information in the light of one’s values (or moral principles) is impaired. This impairment is due to the manic person’s overly optimistic (sometimes even incorrigible/delusional) pre-reflective valuation of her individual abilities, sometimes even experiencing herself as being endowed with supernatural abilities (i.e., delusions of grandeur). In the light of her imagined abilities, a person values, reasons, and judges other things and circumstances as relevant for her decisions and behaviors than the same person would in a more sober mood (preference reversal).

Impairments of personal freedom in depressive and manic disorders draw attention to the correlation between mood and personal freedom, the intricate connection between social and personal demands and habitualization of these demands, as well as the influence of mood and demands on external as well as internal negative freedom. Internal negative freedom toward habitualized (self-)demands are of particular interest here. In order to achieve greater freedom, it might be necessary, both
during critical illness episodes and alongside ongoing depressive symptoms, to grant the depressed person a greater negative freedom from outer restrictions or social demands (i.e., as is granted in the social role of a patient or a chronically disabled person).

It is indeed relevant for understanding personal freedom to adequately conceptualize these intricate and complex connections. However, impairments of personal autonomy in depressive (and manic) disorders need to be depicted and determined specifically and individually, taking into account especially the possibility of preference reversal during the course of the mental illness (Lee and Gazini 1994; Rudnick 2002). In this regard, possible impairments of personal freedom in persons with a depressed (or manic) state of mind are, besides possible impairments of one’s behavior-actualization ability (i.e., lack of drive, depressive stupor), usually conceptualized as an impaired decision-making capacity mediated via one’s automatic (pre-reflective, subliminal) preintentional (implicit) and biased choice as well as explicit over- or underestimation of prospects and outcomes of behavioral options or personal needs and preferences.

Impairments of Personal Freedom in Psychotic Disorders

“The psychotic person” is the classical example of a person with impaired personal freedom: she is supposedly unable to develop a meaningful and reasonable intention and at the same time unable to coherently pursue her perhaps perceivedly peculiar and weird interests in the given situation. This picture of the unreasonable and unpredictable “lunatic” still fuels the stigma persons with psychotic disorders face in their communities. It is, however, outdated if taking a closer look at the discourse on impairments of personal freedom in persons with psychotic disorders.

Nonetheless, in florid psychotic states, the affected person may indeed act on delusions (i.e., delusional mood, delusional hallucinations, delusional convictions) possibly entailing threatening behavior or may be unable to adequately appreciate and digest information (skills 3 + 4). This might even lead to the inability to understand relevant information (skill 2).

Surveys with psychiatric inpatients demonstrate that poor appreciation as well as poor reasoning explain apparently poor decision-making capacity (skills 3 + 4) (i.e., due to magical thinking, formal thought disorders, delusions; Vollmann 2008, 114 F; Owen et al. 2009). In non-acute phases, decision-making capacity might be impaired to a lesser degree or fully given, and behavior-actualization abilities (i.e., lack of drive, lack of emotional engagement) might be more important regarding impairments of personal freedom.

This rather broad description claims the possibility of a clear distinction between inner and outer restrictions regarding personal autonomy in persons with psychotic disorders. It stresses the passive quality of psychotic experiences, which overwhelm the pertinent person to such an extent that she values herself in retrospect as “different” or “not herself” (in the sense of not authentic) (Bolton and Banner 2012, p 96; Moller and Zauszniewski 2011; Noiseux et al. 2010; Schlimme and
Brückner 2017). However, during psychotic experiences, it is usually not the person herself but the world that is experienced as changed and altered in the first place. Consequently, impairments of personal freedom often become overt in interpersonal conflicts fueled by an inability to adequately adopt a commonsensical point of view.

While the psychotic person might experience her behavior as meaningful and justified, other persons judge her behavior as unjustified and threatening. From a psychiatric point of view, such situations are often fueled by delusions, these delusions being the most important source of interpersonal conflicts in persons with psychotic disorders (Golenkov et al. 2011; especially delusions of grandeur, Ullrich et al. 2013). Delusions, occurring during most (75 %) psychotic experiences diagnosed as schizophrenic, often wax and wane during the course of the illness (Appelbaum 2007; Jorgensen 1994; Schlimme and Brückner 2015). The role of delusions regarding impairments of personal freedom is, due to the very individual nature of those delusions, very difficult to define and should be the object of further research (Schlimme 2013c).

While delusions often dominate the delusional person’s experience during acute psychosis, they are typically “parked” as actually unrequired experience and interpretation at other times. They can actually become “integrated” into that person’s lifeworld and worldview as a private, unshareable parallel reality in long-lasting psychosis (pseudo-solipsism: Sass 1994; also: Bock 1997; Schlimme 2013c; Schlimme and Brückner 2015 a. 2017). In both ways they do not – at least not in principle – restrict the person’s potential to respect the rights and worldviews of those (potentially) afflicted by her behavior, even if her behavior is driven or informed by delusional experiences or convictions (Schlimme 2013c). Delusions that manifest themselves in this manner need not result in or correlate with unreasonable and irresponsible behavior.

Responsibility for one’s behavior while having delusions seems to be easier to assume if the person:

(a) Is able to communicate her highly private (psychotic) experiences (i.e., in certain self-help groups, trialogue, psychotherapy), in spite of her ongoing psychosis
(b) Can maintain a robust amount of social integration, enabling her to adopt the commonsensical point of view more easily as a justified and (at least) parallel worldview in the given situation (islands of clarity, Podvoll 2003; Schlimme and Brückner 2017)

Furthermore, negative symptoms with a depression-like character might further impair one’s personal freedom. Nonetheless, insight into the delusional (private, unshareable, unprovable) character of one’s psychotic experiences correlates more often with better social integration but is not a necessary requirement (i.e., 40 % of persons with schizophrenia displaying full functional recovery did not show this kind of insight: Alvarez-Jimenez et al. 2012; see Bottlender and Hloucal 2010; Nixon et al. 2010). However, recovery with long-lasting psychotic experiences (and ongoing delusions) is often connected with an impaired personal autonomy
due to impaired stress tolerance, stamina, and cognitive functions, which implies impaired decision-making capacity (skills 2 + 3) and behavior-actualization ability after participating in strenuous situations for a prolonged period of time. These impairments can be further fueled by (rapidly) emerging self-disorders in such situations, overall implying the necessity to adequately “dose” these strenuous situations.

These highly diverse manners of impaired personal freedom in psychotic disorders have their common ground in a loss of “normality,” more precisely in a loss of the taken-for-grantedness of one’s “normality.” This loss might be more overt in acute phases (i.e., delusions, hallucinations) but is often also given in non-acute phases during recovery (i.e., perplexity, hyperreflectivity). The concept of a “loss of taken-for-grantedness of one’s ‘normality’” refers to the fact that we usually, that is, automatically and reliably, present our lifeworld in a more or less homelike manner to ourselves (Blankenburg 1971).

Moreover, the current “project” the person is involved in (i.e., buying a cup of coffee) automatically informs the manner of how we disclose our lifeworld to ourselves as an experiential workspace (i.e., automatically paring out irrelevant information in the given situation in which one is called upon to act) (Schlimme 2012; Schlimme and Brückner 2017; Schlimme and Voss 2017). It is this automaticity that is impaired in psychotic disorders. Hence, persons with psychotic disorders need to reflectively and actively select the relevant meanings even in the most common situations, while often being impaired in their cognitive functions as well, rapidly implying impaired decision-making capacity skills 2 + 3 (impaired ability to adequately appreciate and manipulate relevant (sic!) information).

Consequently, impairments of personal freedom in psychotic disorders call for a more intricate and complex conceptualization of “inner” and “outer” factors with regard to impairments of personal freedom. As persons with psychotic disorders and other long-lasting mental illnesses demonstrate, their personal freedom is not only dependent on personal abilities (i.e., decision-making capacity and behavior-actualization ability) but also highly dependent on the structure of the given situation (i.e., negative freedom, social support). Achieving normal goals is a paramount and demanding aim for persons with psychotic disorders. It often requires adequate assistance (i.e., assisted housing, assisted employment) (Davidson et al. 2009) and social support due to ongoing unusual behavior (Schlimme and Schwartz 2013). These insights call into question the adequacy of the abovementioned strict distinction between inner and outer restrictions of personal freedom.

Conclusion

Insights from appreciation of fine-grained understandings of mental life, as present in some specific disorders/mentally illnesses, challenge some normative qualities of autonomy concepts, especially regarding the self-image of profound independence
both from one’s situation (i.e., circumstances, social recognition, community, empowerment) and from one’s self (i.e., desires, habituality, life history). These insights highlight **authenticity** concepts and call for acknowledgment both within therapeutic discourses and discourses about diversity. They adopt Rudnick’s critique of the standard notion of competence to consent (**informed consent**): “It seems that the four abilities noted above refer to the output (expression) and process (understanding, appreciation, and reasoning), but not to the input (information and preferences), of decision making. Input information is addressed within the broader doctrine of informed consent, but input preferences, which may be characterized as ends assumed by the individual, are largely ignored in this framework” (Rudnick 2002, p. 152).

**Values** and preferences as well as life history, in which these **values** and preferences are brought into play, are deemed to be those aspects most crucially missing in the current medico-ethical debate on **personal freedom** and **mental illnesses** (Wiggins and Allen 2011). This corresponds to the redefinition of many features of persons with long-lasting **mental illnesses** as **handicaps** which implies to move the relevant background of impairment from **inner** to **outer restrictions**, namely, to expect a more diverse normality in order to allow for a greater variety of lifestyles (including **values**, preferences, **worldviews**) which might be, to a relevant extent, fueled by **mental illnesses** (c.f. Convention on the Rights of Persons with Disabilities, United Nations 2006). Last but not least, the current debate rejects points of view claiming a given behavior as not autonomous simply because it is judged (from their stance, i.e., representing the commonsensical position of their culture) as immoral (i.e., **drug** consumption, **suicide** attempts) or abnormal (i.e., unusual behavior during long-lasting psychotic disorders).

**Definitions of Key Terms**

**Authenticity** means to behave and decide in accord with one’s most cherished or cared for interests and preferences. Authenticity cannot permanently be achieved or even owned like an object but is a demand in itself for one’s conduct of life.

**Behavior-actualization ability** means the ability to behave in accord with one’s decisions. Being primarily a mental competence, in actual life it nonetheless depends on situational circumstances (i.e., social recognition, barrier-free facilities).

**Decision-making capacity** means the ability to decide in accord with one’s (moral) values and principles. Being primarily a mental competence, in
real life it nonetheless depends on situational circumstances (i.e., adequate information).

**Freedom, negative**
means the situational or socially granted space to decide and especially behave the way one decides to do. It refers primarily to the concrete social situation in the sense of an “outer negative freedom” but could also be understood in the manner of an “inner negative freedom.”

**Freedom, personal**
means the concrete freedom a person can bring into play here and now in her lifeworld, in which she is called upon to act. On the one hand, it calls on decision-making capacity and behavior-actualization ability and is therefore potentially subject to “outer” and “inner” restrictions; on the other hand, it is an immeasurable component given of every human being as active agent in its lifeworld.

**Habituality**
means the acquired, not easily unlearned or altered pre-reflective (subliminal, “passive”) activity of the mind according to which our experience and the experienced is given in a manner we are already acquainted with. Habituality implies a complex set of pre-reflective anticipations concerning the manner of experiences and the experienced.

**Lifeworld**
means the experienced situation and horizon a person is experiencing itself as being in as embodied self and in which it is called upon to act. Lifeworld is a key concept to every approach and concept drawing on the first-person perspective.

**Mental disorder**
means a disorder affecting the mind and causing mental illness. Mental disorders are conceptualized as structural change of one’s mind. The structural change can be located on the habitual (psychosocial), on somatic (neurophysiological), or on both (interacting) levels. The
exact understanding of mental disorders varies over time and culture (i.e., mental disorders as natural entities versus mental disorders as useful guides to treatment).

**Mental illness**
means to suffer from altered manners of experiences not open for intentional change (i.e., depressed mood, psychosis). These changes can be experienced as being given in the lifeworld (i.e., delusional hallucination), in oneself (i.e., loss of drive), or in one’s experience itself (i.e., anxiety). Typically, these manners of experiences are evaluated as “unusual” or “altered” from the first-person perspective, but not necessarily as “ill” or symptom of a mental disorder.

**Restrictions, inner**
mean impairments disabling the person to use the granted (negative) freedom autonomously and authentically and to display both decision-making capacity and behavior-actualization ability in the situation to act. Classical “inner” restrictions are mental alterations implying preference reversal (i.e., focus on short-term goals according to craving, different focus according to depressive (de) valuing or delusional convictions).

**Restrictions, outer**
mean social or situational barriers for deciding or behaving the way one wants to. Classical “outer” restrictions impair one’s negative freedom to behave the way one would like to do (i.e., inadequate information, givenness of stereotypes by relevant others, or non-barrier-free facilities). “Outer” restrictions can become (the basis of) “inner” restrictions especially by inducing habitualities or worldviews.

**Values**
are specific meanings of things and circumstances we find value in. The value of things and circumstances is principally distinguishable from these things and circumstances themselves.
Therefore, values can be very concrete (i.e., the delicacy of food) or highly abstract (i.e., the concept of a delicacy of passions), immediately experienced (i.e., some food looks and tastes delicious), or reflectively addressed (i.e., a theater performance is judged as delicate in retrospect).

**Worldview**

means the personal narrative concerning the given as a whole. It is a set of explicit and implicit meanings, interpretations, and values, ordering the experienced in relation to the whole. Every person has a worldview, more or less coherently corresponding to her experiences, life history, and prospects.

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**Summary Points**

Personal freedom can never be lost completely as long as the pertinent person is an active agent in her lifeworld.

Personal freedom calls on decision-making capacity and behavior-actualization ability, both open for “inner” restrictions caused by mental illness, in order to live authentically.

Personal freedom calls on negative freedom in order to live authentically, since “outer” restrictions can impair one’s decision-making capacity and behavior-actualization ability (i.e., inadequate information, givenness of stereotypes by relevant others, or non-barrier-free facilities).

“Outer” and “inner” restrictions are intricately connected: “inner” restrictions can be rendered less relevant if counterbalanced by adequate circumstances; “outer” restrictions can double the impairments caused by “inner” restrictions; and “outer” restrictions can become (the basis of) “inner” restrictions especially by inducing certain habitualities, demands, or worldviews in the long run.

Mentally ill persons need to be empowered to grasp their personal freedom and live an authentic life.

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