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"Above These Badlands": Delusions, Autonomy, and Individual Beliefs in Right to Refuse Psychotropic Medication Cases

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At the time of writing this paper Lindsay J. Webb was completing her BA in Philosophy at the State University of New York at Oswego (December 2007). She is now a participant in the Online Program in Mental Disability Law at New York Law School. We look forward to seeing her future work in the area of mental health ethics. Congratulations!

As the recipient of this award Lindsay will receive $500 Canadian.

With every good wish for future success…

The Editors

Abstract

This paper reviews the claim that matters of truth can be arbitrated through general consensus or agreement. Philosopher William James proposed two methods for establishing truth: First, we may be able to directly verify the truth of ideas by checking our hypotheses against the world. Second, when verification is not possible, truth can be approached through the utilization of consensus.

There are some contexts in which a general consensus of truth will suffice. However, a mere consensus of truth is inadequate when reliance on such an agreement may result in the preservation or minimization of individual autonomy. Mental disability jurisprudence is often concerned with the preservation of individual autonomy. Yet, often, individual autonomy is cast aside in lieu of professional agreements. This is especially the case in right to refuse psychotropic medication cases.

Introduction

William James asserts that "true ideas are those that we can assimilate, validate, corroborate and verify. False ideas are those which we cannot" (James, 1981, p. 92). James admits, however, that some ideas cannot be directly verified. Sometimes, this lack of verification results in a reliance on agreement and consensus to lead us toward the direction of true ideas (James, 1981, p. 97). It seems that the direct verification of an idea entails outlining the causal relationship between claiming an idea as true, and then checking our claim against the world. When we are unable to directly verify our ideas by citing a casual relationship, we still may be able to correlate our ideas with reality. We can find an agreement between our ideas and the world (Fawcett, 1911, p. 400).

This paper will focus on delusions as a symptom of mental illness. I will argue that there are situations in which it may be difficult to verify that the beliefs of others are unjustified irrational beliefs. I will question the reliability of utilizing general consensus to assign the label of incompetence to an individual who has been adjudicated as suffering from delusions. Labeling beliefs as delusions and then implying incompetence as a result, may have negative effects on the preservation of individual autonomy in right to refuse psychotropic medication cases.

Psychiatrists are often left without a way to directly verify the irrational nature of a belief and in many cases can only surmise the relationship between a belief and the real world. A common approach to the alleviation of delusional thinking is the use of psychotropic medication. Psychotropic medication is sometimes proffered even when the subject of such delusions clearly objects to the proposed course of treatment.

Many times, the right of a psychiatric patient to refuse medication rests on the judgment of a psychiatrist. Yet there seems to be something unjustifiable in overriding individual autonomy based solely on a conjecture of truth. We should be critical in applying such a framework to situations that will likely result in the invasion of mental privacy and individual autonomy.

In New York, an individual who has been civilly committed to a psychiatric hospital has a right to refuse medication in non-emergency situations. However, if the treating psychiatrist believes that medication is warranted, she may seek to obtain a judicial order allowing for the administration of medication regardless of the patient's objection (Rivers v. Katz). Medication hearings occur in front of a judicial body and often include testimony regarding the severity of the symptoms of a patient's mental illness. Judges issue medication orders when they view a patient as being dangerous to self or others, or not competent to make the decision to refuse medication. The decision to medicate over objection occurs

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only when the medication is deemed in the patient's best interests (Rivers v. Katz). One can imagine that evidence of delusions is consistently discussed in judicial hearings. The truth or falsity of a patient's beliefs, and the supposed irrational nature of these beliefs, may support the notion that the patient is incompetent to make decisions regarding his or her medical care.

What constitutes the labeling of a belief as a delusion varies. E. E. Southard (1916) notes that James pays little attention to the concept of delusions in his work, citing merely that he believed delusions to be false opinions about matters of fact that may or may not involve perceptions of sensible things (p. 429). There are many beliefs which may be false or unverifiable but they hardly fit into our normative model of delusions. For example, the belief in God is not physically verifiable, yet we do not label religious persons as being delusional. Dreams and night terrors are a type of data that many individuals interpret and rely on for knowledge. However, we do not seek to label these persons as incompetent, nor do we medicate them over their objections because they seek to interpret their dreams.

James (1889) has discussed how dreams relate to justified beliefs. He cites the example of a dream that contains a winged horse. One can dream about a winged horse and find no trouble with doing so, so long as the horse remains in the world of dreams and the dreamer does not find himself believing that the winged horse is in the right hand stall of his barn (p. 11). Perhaps most individuals do not believe that physical objects in dreams transfer to the real world. Yet we often find ourselves applying the conditions of our dreams to reality, i.e. exhibiting fear, anxiety, or apprehension in real world contexts because something bad happened to us in a similar context during a dream we had last week.

James (1889) states that, "conceived objects must show sensible effects or else be disbelieved" (p. 17). This view suggests that a false idea may be justified, but if the outcome of such a belief is not sensible, a rational agent would abandon the belief. So the trouble with delusions is not only that they are false beliefs, but that they have no sensible effects and only become labeled as delusions when the believing agent is unable to abandon them. This view closely resembles Derek Bolton's (2001) assertion that delusions represent some failure of intentionality; that delusions fail to represent themselves as being "about something" (p. 185). Unfortunately, in many contexts it may prove difficult, if not impossible, to verify the beliefs of others as being without sensible effects. True, there may be certain beliefs that we can show to be false, but the mere falsification of a belief does not mean that we can label the belief as a delusion. We first need knowledge that the belief contains no "sensible effects", and secondly, we need to know that the agent is unable to abandon the belief (James, 1889, p. 17). The label of a belief as a delusion then rests on the beliefs of others about the belief in question. This seems to be an odd and intuitively poor approach to our method for determining beliefs as delusions. To illustrate my point, I will discuss the legal case, Charles Sell v. United States.

In Sell v. US, the Supreme Court concluded that it is not permissible for a state to forcibly administer anti-psychotic medication to a defendant solely to render him/her competent to stand trial (Charles Sell v. United States 539 U.S.166, 2003).

Charles Sell was a practicing dentist who was being tried for Medicaid fraud. He was found incompetent to stand trial and was interviewed by more than one mental health expert. There were conflicting expert opinions as to whether or not Sell suffered from a Delusional Disorder or from some type of Schizophrenia.

At first glance it appeared that Sell was quite deluded and in need of medication to decrease his delusional thinking. However, the court noted that an adjudication of incompetence to stand trial, and the presence of delusions alone, does not necessarily determine incompetence to make personal decisions about one's medical care. The court noted,

> "Why is it medically appropriate forcibly to administer antipsychotic drugs to an individual who 1) is not dangerous and 2) is competent to make up his own mind about treatment?" (Charles Sell v. United States).

The matter addressed at civil 'right to refuse treatment' hearings is not solely the presence of delusions, but whether or not these delusions somehow render one incompetent to make decisions regarding treatment (Rivers v. Katz 67 N.Y.2d 485, 504 N.Y.S.2d 74 N.Y.,1986). In this context, the presence of delusions should bare some relation to the refusal of medication. In Sell v. US, the content of the delusions cited in the record had nothing to do with Sell's refusal to take medication so it is not surprising that this evidence had little weight in the court's final assessment of the case. The issue in Sell, once again, was whether or not it is permissible to administer medication, against an individual's will, solely to render that person competent to stand trial. The issue was not whether or not Sell was competent to make decisions regarding his treatment.

However, at some point, there was a consensus reached regarding Sell's behavior and statements, and three examples were noted by the court as being related to delusional thinking.

1) "The gold he used for fillings was contaminated by communists".

2) "God told me for every [Federal Bureau of Investigation] person I kill, a soul will be saved".

3) "Sell could not sleep because he expected the FBI to 'come busting through the door'"

Assuming, for the purposes of this paper, that the first two statements are in fact, delusions, I will focus on the third statement; that Sell believed the FBI would come 'busting down his door". Sell had in fact been investigated by the FBI, and was arrested by an FBI agent in the past. It seems somewhat logical that he felt the stress of FBI involvement, and that such stress might have contributed to his inability to sleep. Yet, the above statement was utilized by the court as an example of behavior that was related to delusional thinking. The court might have accepted such a statement as delusional in nature, merely because previous statements clearly seemed to be delusions.

Yet, there is little at stake if we err when asserting that Sell's inability to sleep due to his fear that the FBI will come "busting down the door" is related to delusions. After all, the belief is not related to Sell's refusal of treatment and evidence of his delusions

played little role in the court's decision. However, in civil 'right to refuse treatment' hearings, adjudicating the beliefs of another as delusional may result in the loss of liberty to make decisions regarding one's medical care.

Consider some examples of statements relating to the refusal of medication which might appear to be delusional in nature:

1) "They're putting microchips in the medication so that they can find me when I am released."

2) "I'm always trippin' and I can't think straight".

3) "The Devil told me in my dream that I should not take the blue pill".

First, although it is highly unlikely that medication will contain tracking devices, it is not an idea completely without merit. Parolees are often tracked with bracelets, dogs can be micro-chipped, and sex offenders are registered and closely monitored. Perhaps there is a slight amount of justification for the first belief. However, we can directly verify that the idea is not true by checking the medication. Second, the assertion, "I'm always trippin' and I can't think straight" may be associated with a side-effect of the medication. However, if the subject of a civil 'right to refuse treatment' hearing makes several "outlandish" declarations in court, then the statement, "I'm always trippin' and I can't think straight" might be construed as being related to delusions. Verifying whether or not such a statement is related to delusional thinking might be as simple as asking the subject of the hearing to elaborate. Last, responding to an occurrence in a dream is not all that unusual. As mentioned previously, dreams in themselves seem to fit the definition of delusion, but we do not typically view them this way. When we wake up from having a nightmare we tell ourselves it was just a dream, it was not real. However, often, we remain quite disturbed by what occurred during our dream. In some circumstances, and for several days after a nightmare, we even avoid the people or places that we came into contact with during our dream, even when we know the events were not real. We do not consider ourselves delusional when this occurs, perhaps a bit irrational, but not delusional. The subject of a 'right to refuse treatment' hearing may be in a similar situation with his or her belief. One might impose an idea from a dream onto the real world, but it is not clear that this means the idea is senseless. It seems likely that most of us would be concerned about taking a medication if some figure in a dream warned us against doing so. Faced with a similar situation, many of us may be bothered by the dream, perhaps reluctant to start a new medication, and some of us may decide not to take the medication at all. Most of us would probably not verbalize the reason for our reluctance to our clinician because we know that acting on an idea from a dream seems irrational. However, it is not at all clear that our actions should be determined to be delusions. In fact, if we closely examine the statement, "the Devil told me in my dream that I should not take the blue pill" we see that the content of the dream includes a blue pill. The assertion tells us nothing about whether or not one would be willing to take a green pill. In fact, perhaps the green pill has fewer side effects then the blue pill.

These hearings may indeed be conducted without thorough investigations into the nature of individual beliefs. As a result, judicial orders of medication may be issued regardless of the individual's desires. If there is a shred of evidence that one's arguments for not wanting to take psychiatric medication is sensible then we may not be able to label that belief as a delusion. If we are unable to label the belief as a delusion, then it does not matter if the belief is false, the belief is still justified. If the belief is justified, we cannot make the claim that the belief somehow renders one incompetent to make personal decisions regarding medical care.

If medication hearings do lack thorough investigation into the nature of beliefs, then such hearings may be invading individual autonomy and one's right to refuse medication, by utilizing mere agreements and heuristic reasoning.

Recall that James is concerned with whether or not ideas are in agreement with the world (Fawcett, 1911, p.300). James (1889) would have also sought to determine not only whether or not one's beliefs have sensible effects, but whether or not one could abandon these beliefs if they did not (p.17). It may not matter whether or not a belief is false, but it matters if an individual still believes absent any justification for doing so.

A history of delusional thinking and outlandish statements to psychiatrists may be presented in a medication hearing thereby impacting how a patient's in-court statements are perceived. Michael Perlin (2005) notes that individuals seek to justify beliefs by relating them to existing stereotypes; this is known as the illusion of validity (p. 17). The judge and psychiatrist may label reasons for refusing medication as being related to delusions since such statements seem to fit the pattern of an existing stereotype, the stereotype of previous delusions. Perlin (2005) also notes that many judges engage in ordinary common sense reasoning. For example, *it is obvious to this psychiatrist that this man is deluded, it is obvious to me just the same, so it therefore must be true* (p. 23).

I am not seeking to claim that the above examples of statements are non-delusional. However, it is important to note that if such declarations are grouped together as delusions, one stands little chance in arguing that s/he is competent to make the decision to refuse psychotropic medication. Recall earlier, I stated that judges issue orders to medicate individuals over their objection when they deem the patient as being a danger to self or others, or not competent to make such treatment decisions (Rivers v. Katz). I argue here that if a court is able to identify one statement as having sensible effects, then that sensible assertion should be evaluated in light of an individual's refusal to take medication. My argument is consistent with how courts have viewed the relationship between mental illness and incompetence in 'right to refuse treatment' cases. For example, the appeals court in Rivers v. Katz rejected the argument that the *"mere presence of a mental illness somehow negates the liberty interests involved in the refusal of antipsychotic medication"*. Since one of the purposes of such a hearing is to determine whether or not an individual is competent to refuse medication, then the above statement would suggest that the Rivers court did not believe that the symptoms of a mental illness necessarily render one incompetent. Although the court in Rivers meant to preserve individual autonomy in 'right to refuse treatment' cases, it attempted to do so while offering us little guidance as to how we should verify the relationship between the symptoms of mental illness and the type of competency in question. The court cited a clinical study concerning the competence

to refuse medication in a footnote. The footnote cautioned that evaluations of competency should investigate whether or not there is an "absence of any interfering pathological perception or belief, such as a delusion concerning the decision [to refuse medication]" (Rivers v. Katz, in Perlin, 2005, 469-470).

So while the Rivers court established the need for a judicial review in right to refuse psychotropic medication cases, the decision did little to explain the judicial methodology needed to evaluate and scrutinize clinical opinions of delusions. It seems though, that the court should have been concerned with such a methodology considering the interest the court had in the preservation of individual autonomy and liberty.

The District court in Lessard v. Schmidt utilized a statement by Philosopher John Stuart Mill in a footnote in the landmark decision that established the minimal requirements of injunctive relief procedures for persons involuntarily and civilly committed to psychiatric hospitals in Wisconsin. The court noted that individuals have a right to manage their own affairs, unless the state can provide a compelling interest to infringe on such autonomy.

> …a statement by John Stuart Mill is worth recalling: "The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest". (Lessard v. Schmidt, in Perlin, 2005, p. 76)

Conclusion

A medication hearing is prompted when a treating psychiatrist deems that medication is both necessary and in a patient's best interests, and that the patient is not competent to make the decision to refuse medication (Rivers v. Katz). A general consensus is reached, when a judicial panel reviews the evidence supplied by the hospital's psychiatrist and weighs such evidence in light of individual liberty interests and autonomy. Psychiatric evidence will include documentation of a mental illness and opinions on how the symptoms of the illness correlate with a deficiency in the patient's level of competence. In this paper, I have focused on the symptom of delusions and attempted to show the difficulty we may have in labeling the beliefs of others as delusions. I have further discussed that the verification of beliefs as delusions, and the relation of this verification to incompetence, may be compromised by the presence of ordinary common sense and similar types of heuristic reasoning. Agreements among psychiatrists and judges regarding the nature of another's beliefs may not be leading us closer to the truth of such beliefs. In fact, it may be leading us further astray. We may accept the conclusion that a belief or statement is related to delusional thinking, when in fact, this is not the case. Consensus in these hearings is reached when a patient is adjudicated as being incompetent to make decisions regarding medication due to delusions. Not only is it difficult in some contexts to label a belief as a delusion, it is likely more challenging to verify that these delusions render one incompetent to make treatment decisions

Our efforts to reconcile the direct verification of ideas with how we judge the beliefs of others will be rough terrain to travel. However, I am confident that we can rise above these badlands by strengthening the framework for investigating both the nature of beliefs, and delusions, so that we do not proceed recklessly into situations that pose a threat to mental privacy and individual autonomy. My hope is that mental health and legal professionals, as well as philosophers, will continue to investigate the nature of delusions and offer a thorough account of how delusions are formed and what constitutes a delusion. By critically evaluating the concept of delusions, we may be able to better pinpoint our own assumptions about the beliefs and actions of others.

Note 1: The title of this paper is taken from Bruce Springsteen's tune, "Badlands". This is a joke aimed at Professor Michael Perlin, who insists on using Bob Dylan lyrics for the titles of his publications.

Note 2: I focused on the issue of incompetence as it relates to the refusal of medication and not the concept of danger to self or others, a second criterion for the involuntary administration of medication.

Note 3: This paper does not aim to define or offer an account of delusions. Instead, delusion is plainly referred to as a belief, one that may be unjustified or irrational, that an agent may be unable to abandon.

Competing Interests: None

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