

Hermeneutical injustice and mental disorder

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It is a familiar outcome of some psychiatric diagnoses that a patient welcomes having new resources for understanding herself.¹ Suppose that Katie receives in early adulthood a diagnosis of bipolar disorder after several years of unsettled life, punctuated by depressive episodes and (unrecognised by Katie before diagnosis) periods of hypomania. She may receive the diagnosis positively for a number of reasons:

- It means that her clinicians can begin to provide appropriate treatment.
- It makes sense of events in her life (impulsive behaviour, poor decisions, volatility) and allows these to be reincorporated into her self-understanding and life narrative.
- It enables her to make contact with, and enter support groups with, other people with bipolar disorder, and to access disorder-specific information and resources.

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- It simply helps her to understand herself better.

Implicit in all of these, but particularly clear in the last, is the fact that Katie (along with others) is now able to *name* her mental distress, to contain it under a concept. I will assume in what follows that this is a good thing, not least for the reasons listed above.²

People with mental disorders sometimes face, or are threatened with, situations in which they do not have the capacity to possess elucidatory concepts under which their disorders fall. This paper suggests a framework for understanding this, and for recognising it as a genuine occasion of injustice, *hermeneutical injustice* in Miranda Fricker's terminology. §1 below outlines Fricker's account of hermeneutical injustice and makes a *prima facie* case for its usefulness in thinking about psychiatry. There follow two case studies. §2 argues that attempts, within anti-psychiatry and wider society, to deny the applicability of the concepts of *illness* and *disorder* in cases of mental disorder, as well tendencies to downplay the importance of diagnosing individuals with specific disorders, rob people with mental disorders of conceptual resources which could help them understand, and respond practically, to their distress. §3 looks at the removal of the Asperger's Syndrome diagnosis from DSM-5, and argues that this too could be a case of hermeneutical injustice. The conclusion lays out some implications of taking hermeneutical injustice seriously.

²There is a strand in anti-psychiatry which seems to view categorisation of itself as a wrong; Foucault is the best example [Foucault, 1989]. Katie's experience, and she is a very life-like fiction, is decisive against this. This line of thought deserves flagging at the outset, since it manifests itself in wider society and clinical practice in an aversion to 'labelling'.

1 What is hermeneutical injustice?

Miranda Fricker’s pioneering monograph *Epistemic Injustice* examined the ways in which people can be victims of injustice with respect to their capacities to know and understand both themselves and the world around them [Fricker, 2007]. Fricker’s work has generated a good deal of conversation, and her theories of epistemic injustice have undergone modification at the hands of numerous authors.³ Here I will remain faithful to Fricker’s original account, any differences between that and the accounts of sympathetic critics not being important for present purposes.

Fricker treats two distinct kinds of epistemic injustice: *testimonial injustice* and *hermeneutical injustice*. A person is a victim of testimonial injustice if ‘[they] receive... an unfair deficit of credibility from a hearer owing to prejudice on the hearer’s part’ [Fricker, 2007,]. So, for example, if one person refuses to take seriously what another person says because of their race they make that person a victim of testimonial injustice. The concept of testimonial injustice is likely to prove fertile for thinking philosophically about the social situation of people with mental disorders. The focus of the present paper, however, is on hermeneutical injustice.

Hermeneutical injustice occurs, according to Fricker when ‘someone has a significant area of their social experience obscured from understanding owing to prejudicial flaws in shared resources for social interpretation’ [Fricker, 2007,

³See the contributions to [Kidd et al., 2019]

147]. Interestingly for present purposes, one of the first examples of a ‘shared resource for social interpretation’ presented is the concept of a particular mental disorder, postpartum depression. Fricker quotes from Susan Brownmiller’s memoir of the US women’s liberation movement,

Wendy Sanford, born into an upperclass Republican family, was battling depression after the birth of her son. Her friend Esther Rome, a follower of Jewish Orthodox traditions, dragged her to the second MIT session. Wendy had kept her distance from political groups. ‘I walked into the lounge,’ she recalls, ‘and they were talking about masturbation. I didn’t say a word. I was shocked, I was fascinated. At a later session someone gave a breastfeeding demonstration. That didn’t shock me, but then we broke down into small groups. I had never ‘broken down into a small group’ in my life. In my group people started talking about postpartum depression. In that one forty-five-minute period I realized that what I’d been blaming myself for, and what my husband had blamed me for, wasn’t my personal deficiency. It was a combination of physiological things and a real societal thing, isolation. That realization was one of those moments that makes you a feminist forever. [Brownmiller, 1990, 182]

Wendy Sandford had been denied access to the concept of postpartum depression, a concept of which other members of her society had a grasp (psychiatrists, for example); because of this she suffered. There is a real injustice here, and it lies in the denial of an interpretative resource which

might reasonably have been made available, and in this case the denial is both the product of, and serves to reinforce, the subordinate social position of women. As Fricker writes of Sanford, ‘the area of hermeneutical gloom with which she had lived up until that lifechanging forty five minutes constituted a wrong done to her in her capacity as a knower, and was thus a specific sort of epistemic injustice — a hermeneutical injustice’ [Fricker, 2007, 149].

Hermeneutical injustice is intrinsically social: it consists of a certain kind of wrong done to groups, and individuals within those groups, *within society*. Parallel to this is the fact that the means by which hermeneutical injustice is overcome are often similarly social. There is a platitudinous sense in which this must be true: concepts are expressed in public languages, and in order to acquire new concepts one has to interact with at least one other language user. However, there is a more interesting sense in which the undoing of injustice with respect to interpretative resources is communal, namely that it is through membership of *interpretative communities* that those who have been victims of hermeneutical injustice often acquire and become competent with the resources required to make adequate sense of their lives and experience. This is evident in the Sanford case: it is within a group setting that Sanford acquired the concept of postpartum depression and (contrary to any suggestion that medical categorisations of mental disorders invariably block a social understanding of those disorders) came to understand the relation of her depression to her isolated social situation.

Perhaps less obviously this collective context for the overcoming of hermeneu-

tical injustice is present in the case of Katie, with which this paper began. Here Katie learns to apply the concept *bipolar disorder* to what has hitherto been a motley of episodic distress from another person, the diagnostician. Furthermore she comes to be proficient in her understanding of the concept and application of it to herself through engaging with others still, counsellors perhaps, peer-support groups or on-line communities. Initial possession of the concept and realisation that it is applicable to herself, open up membership of interpretative communities which enable Katie to deepen her understanding.

By contrast with interpretative communities of the sort that help people to escape hermeneutical injustice, the context of this kind of injustice is likewise communal. It is *societies* which fail to make interpretative resources available to certain groups or individuals, either through denying them the means to possess existing concepts (as in the Sanford case, where the concept *postpartum depression* has been withheld from affected women) or failing to develop concepts to capture sufferings or injustices amongst the affected group (an example of Fricker's is a victim of sexual harrassment in a society which has not developed the concept *sexual harrassment*). The contention of the rest of this paper is that currents of thought critical of the concept of *mental disorder*, and of concepts corresponding to particular psychiatric diagnoses, risk making present-day society a site of hermeneutical injustice for people with mental disorders.

2 Hermeneutical Injustice and Anti-Psychiatry

Sanford discovered that she had been suffering from postpartum depression, and so that ‘what I’d been blaming myself for, and what my husband had blamed me for, wasn’t my personal deficiency’. Congruently with a biopsychosocial understanding of mental disorder she goes on to say that her depression was ‘a combination of physiological things and a real societal thing, isolation’ [Brownmiller, 1990, 182]. Contrary to the sometimes made suggestion that an understanding of mental disorder as having at least some basis in pathophysiology is ethically or politically deliterious, Sanford reports her coming to possess the concept of postpartum depression as the beginning of her feminism. And it is not difficult to see why; here is a concept important for understanding women’s health, which had been denied her and in the absence of which she was blamed for her state of mind. In short, the discovery that she has been suffering from postpartum depression is, for Sanford, emancipatory, contributing positively to her self-understanding and flourishing.

The situation with Katie, as presented at the outset of this paper, is similar. Aspects of her life that had hitherto seemed incomprehensible, which perhaps attracted blame or guilt, and certainly seemed incongruous in terms of the stories she would want to tell herself – impulsivity, risky behaviour, anger, agitation – now have a name for her, ‘hypomania’, as does her more overarching condition ‘bipolar disorder’. The most obvious benefit to Katie is that she can now access appropriate treatment, but another positive out-

come is the ability to apply these concepts to herself. This permits her to tell new stories about herself, her illness explaining apparent ruptures in her life's narratives, and this in turn opens the door to Katie adopting a more compassionate attitude towards herself. The diagnosis further means that Katie can seek empathy and support from others with bipolar disorder, both through organised peer-support groups and less formally (on-line, for instance). As in the Sanford case, Katie's life is improved by her being able to apply appropriate psychiatric categories to herself (and the ability of others to do likewise).

Note that in both cases it is important that the person in question has discovered that they are suffering from an *illness* or a *disorder*.⁴ There are two reasons for this. First, the discovery that the person felt, or acted, a particular way, was a cause of guilt, and the realisation that the cause of the guilt was itself caused by an illness provided the occasion for the guilt lifting. We do not, in general, think that people are to blame for feelings, thoughts, or actions caused directly by illnesses.⁵ Second, the recognition that the person is suffering from an illness situates their condition relative to practices which promise relief: illness is, amongst other things, the kind of phenomenon which medicine (in these cases, psychiatric medicine) can alle-

⁴Whatever difference, intensionally or extensionally, there might be between the concepts *illness* and *disorder* I will ignore in what follows.

⁵There are, of course, marginal cases – witness the literature around so-called psychopathy. For present purposes, however, I don't need to defend anything as strong as the claim that no illness-caused state or behaviour is blameworthy. All I need is the claim that in some cases illness functions to mitigate blameworthiness, and that the cases of Sanford and Katie are ones of which this is true

viate, or hopes to be able to alleviate.⁶ Both sources of importance point to a liberating aspect of learning that one has an illness, to freedom from guilt and freedom from the fear that there is nobody who can help one, respectively.

What I shall term *anti-psychiatry* denies the propriety of applying the concept of disorder to a significant range of conditions which are routinely so classified.⁷ In particular, the anti-psychiatrist thinks that persons who, according to usual diagnostic criteria, are suffering from affective disorders – people like Sanford and Katie – are not unwell in virtue of that fact (which is to say they do not have *any* disorder, or at least none that is manifest in affective symptoms). Motivations for anti-psychiatry vary. Szasz, for instance, holds that the prospects for a rigorous scientific understanding of mental disorder sit unfavourably alongside those for somatic illness,

The concept of illness, whether bodily or mental, implies deviation from some clearly defined norm. In the case of physical illness, the norm is the structural and functional integrity of the human body. Thus, although the desirability of physical health, as such, is an ethical value, what health is can be stated in anatomical and physiological terms. What is the norm, deviation from

⁶It might be thought that I am suggesting here that illness is a *pragmatic kind*, where pragmatic kinds are supposed to contrast significantly with (say) natural kinds. I am sceptical of the general form of metaphysics underlying this kind of distinction. I think that all our concepts are devised to serve our practical needs, just as all our concepts are constrained by the nature of reality. But here is not the place to argue that.

⁷This rather roundabout way of putting things is to make it clear that it is a particular sense of ‘anti-psychiatry’ with which I am concerned, namely one which focuses on the concept of mental disorder. There may be others. On present debates around mental disorder, see [Radden, 2019].

which is regarded as a mental illness? [Szasz, 1973, 15]

The question, thinks Szasz, does not admit a satisfactory answer. Rather, ‘contemporary psychotherapists deal with problems in living, not with mental illnesses and their cures’ [Szasz, 1973, 19]

Ethical and political questions fed into Szasz’s position; a libertarian, he viewed the medicalisation and institutionalisation of psychiatric patients as dehumanising. Other anti-psychiatric thought sits on the left of the political spectrum.⁸ There can be a fear of ‘labelling’, or of the act of diagnosis being an exercise of power (Foucault is the salient theorist here). But once we understand the possibility of epistemic injustice, we have to be similarly appraised of the threat that in heeding the anti-psychiatrist’s suspicion of the concepts of disorder and of particular disorders we would be soliciting an hermeneutical injustice against the very people who fall under these concepts.

Nor is this simply an abstract threat: *were* anti-psychiatry to gain currency, *then* there would be hermeneutical injustice. On the contrary, ideas recognisably within its ambit already have currency and are instrumental in cases of real hermeneutical injustice. It so happened that Katie was in contact with psychiatric services at an appropriate time and received a diagnosis. But she so very nearly contacted Jim, a counsellor recommended

⁸This does not include Laing, who is often described as an anti-psychiatrist, in spite of his own rejection of the label. But in *our* sense, he clearly was not an anti-psychiatrist: ‘I have never idealized mental suffering, or romanticized despair, dissolution, torture or terror. I have never said that parents or families or society ‘cause’ mental illness, genetically or environmentally. I have never denied the existence of patterns of mind and conduct that are excruciating’ [Laing, 1985, 8].

by a friend, shortly before she was referred by her GP to psychiatry. Jim is very suspicious of labelling, and encourages his clients to not be overly attached to labels. Even if Katie had received the bipolar diagnosis whilst in a counselling relationship with Jim, he would have encouraged her to question its significance, so threatening the positive effects of diagnosis noted at the outset of this paper. No less than Katie, Jim is a realistic fiction, and in the scenario we are entertaining he is the perpetrator of a hermeneutical injustice against Katie.

There is a lot that can and should be said in reply to anti-psychiatry. That is business for elsewhere. Here my point is simply that attention to epistemic injustice enables us to see that there are reasons internal to a concern for justice to resist some anti-psychiatric proposals. This is important because it means that the ethical and political terrain around anti-psychiatry is not uncontested. Far from anti-psychiatry being a standard bearer for justice in the sphere of mental healthcare, albeit one perhaps whose philosophical foundations do not stand up to scrutiny, it stands itself accused of advocating hermeneutical injustice.

3 Hermeneutical Injustice and Asperger's Syndrome

The DSM-IV contained, and the ICD-10 still does contain a diagnosis of *Asperger's Syndrome* (AS). The DSM-5, however, does not contain the diag-

nosis, the motivation for its removal in the new edition of the manual being scepticism about the distinction between AS and (what is now termed) mild autism spectrum disorder.⁹ In response, the (UK) National Autistic Society noted,

For many people, the term Asperger syndrome is part of their day-to-day vocabulary and identity, so it is understandable that there are concerns around the removal from DMS-5 of Asperger syndrome as a distinct category. [National Autistic Society, 2016]

Talk of day to day identity ought to alert us to the risk of hermeneutical injustice, and whilst of course the change between the two editions of the DSM does not 'undo' pre-existing diagnoses of AS, it does mean that future patients who would have satisfied the DSM-IV criteria for AS will not receive that diagnosis if the DSM is the in-use manual, and will therefore be denied the distinctive interpretative resources and communal belonging associated with the diagnosis. This is significant because there are rich supportive and subcultural communities for people with AS, both in face-to-face settings and on-line.

From one perspective scepticism about the distinction between AS and high-functioning autism might seem odd: after all, the DSM-IV contained diagnostic criteria for the two conditions, and the difference between those

⁹I think that the use of the language of *disorder* of mild cases of autism is very arguably an instance of testimonial injustice – autistic people themselves often tell anyone prepared to listen that any distress or dysfunction accruing to their condition stems from societal attitudes rather than from autism *per se*. Difference, including neurological difference, need not involve disorder. Still, that is the language the DSM uses.

conditions can be viewed as constituted by the difference between those criteria. Scepticism gets its foot in the door only in the light of a certain metaphysical picture of mental conditions,¹⁰ according to which they are ‘real’ or ‘valid’ only insofar as they correspond to fundamental divisions, perhaps neurological, in nature. This picture is not compulsory, and one reason not to hold onto it is that it denies people access to conceptual resources which those in similar situations have found useful in the past, and thereby risks hermeneutical injustice.

4 Conclusions

Fricker’s work on epistemic injustice deserves to be better known in psychiatry, and is likely to find application in a number of areas. Here I have focused on hermeneutical injustice, the unjust deprivation of people of resources by means of which they can make sense of their lives. I have suggested that the anti-psychiatric opposition to the concept of mental disorder, and to particular diagnostic concepts, risks commissioning hermeneutical injustice, and I have sketched a worry that in one particular case of conceptual revision in psychiatry, the removal of the AS diagnosis from the DSM-5, such an injustice may have occurred. A greater awareness of these issues on the part of clinicians is needed if patients are to be afforded the resources to understand better themselves and their distress, and so flourish in the manner which is the aim of all responsible clinical practice.

¹⁰I’m using ‘condition’ rather than ‘disorder’ here because of my above-stated disquiet about the use of this language with respect to the autism spectrum.

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