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Sense-making and hermeneutical injustice following a psychiatric diagnosis

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Abstract

When one is seriously ill, the diagnosis given can generate questions about what it means and how to make sense of it. This is particularly the case for psychiatric diagnoses which can convey a biomedical narrative of the sufferer's condition. Making sense of one's diagnosis in such cases can involve changing one's self-narrative in such a way as to incorporate the belief that one has developed a disease with an unknown cause. To demonstrate the importance of self-narratives, I outline key themes in narrative theory which have been explored in various ways by philosophers and some psychologists. These theorists emphasise the importance of self-narratives in creating meaning for their authors. The biomedical narrative associated with a psychiatric diagnosis may conflict with the recipient's previous self-narratives. This may reduce the recipient's sense of self-efficacy and induce feelings of hopelessness about recovery. I argue that those receiving a psychiatric diagnosis may consequently be vulnerable to epistemic injustice. In particular, this includes hermeneutical injustice, where individuals lack the ability to understand or articulate their experiences in ways that make sense to them, due to their hermeneutical resources being marginalised by the dominant narrative in a medicalized environment. I consider two possible objections to my claim and offer answers to these.

KEYWORDS

diagnosis, hermeneutical injustice, narratives, psychiatry, sense-making

1 | INTRODUCTION

When one receives a diagnosis for one's illness, one will likely want to make some kind of sense of it. For many common illnesses this may not be difficult. However, for chronic or life-threatening diseases, making sense of what the diagnosis means may be very challenging. This can also be the case for diagnoses of mental disorders where the psychiatric terminology can seem particularly mysterious.

One way in which patients make sense of their illnesses is by developing narratives allowing them to understand the illness in their

own terms. The psychiatrist and anthropologist Arthur Kleinman¹ describes many cases from his clinical experience of people with chronic diseases and their illness narratives. An important influence on the patient's narrative is the diagnosis given. Kleinman describes diagnosis as a semiotic activity: the patient's complaints are translated into a diagnosis by means of the signs or biomedical indicators of the disease named by the diagnosis. To a significant extent, the diagnosis shapes the meaning of the illness for the patient.

I argue in this paper that a psychiatric diagnosis can lead to the recipient becoming a victim of epistemic injustice, and specifically

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hermeneutical injustice, as described by Miranda Fricker.² I do not, however, claim this is invariably the case, and there is evidence that some patients welcome their diagnosis (e.g., ref. 3). My argument here only concerns those who find the diagnosis stigmatising or disempowering in some way.

I argue that such instances of hermeneutical injustice can be understood in terms of narrative theory. The narrative often associated with a psychiatric diagnosis is that the condition is “an illness like any other”.⁴ However, psychiatric diagnostic categories based on the DSM⁵ are broadly descriptive labels and do not represent discrete disorders.⁶ Unlike most medical diagnoses, they generally lack explanatory value. Nevertheless, the disease narrative that can be conveyed by the diagnosis may suggest that the recipient’s psychological difficulties are attributable to some kind of biomedical disorder. Such an attribution might change the previous understanding about themselves that individuals have developed through their self-narratives.

In Section 2, I begin by discussing theories of narrativity and how narratives play an important role in our lives in making the sequence of our experiences meaningful. Then in Section 3, I discuss how receiving a psychiatric diagnosis can impact on the recipient and, in particular, how it can change the individual’s self-narrative. In Section 4, I describe Fricker’s conception of epistemic injustice, with particular reference to hermeneutical injustice. I also discuss how patients can become victims of epistemic injustice in healthcare settings. In Section 5, I discuss how this can occur in mental health services. I argue that the biomedical narrative suggested by the diagnosis can change the patient’s self-narrative in such a way that she loses her sense of self-efficacy regarding her ability to influence her circumstances. This, I argue, is what can lead to hermeneutical injustice. In Section 6, I consider two objections to my claim and argue that they can be answered. I conclude by summarising these arguments in Section 7.

2 | NARRATIVE THEORY

The central idea in theories of narrativity is that we understand our lives according to implicit or explicit narratives of some kind. We experience our lives in time and the stories we construct in some way shape who we are by describing how we have developed over time. Our lives are more than just a seemingly endless sequence of days with one following another without any meaningful connection. What unites our days and years together into more than just a mechanical sequence in time is the self-narrative we have that connects them.

What is meant by ‘meaningful’ in this context is the sense in which self-narratives represent to us who we have become and how we make sense of our lives. Among the many philosophers who have written about narrativity, Charles Taylor⁷ argues that having a narrative that reflects one’s life story in certain ways serves these functions. Our narratives also contribute to our sense of identity as individuals and the self-concepts we form. One’s identity is partly shaped by the narrative one has of one’s life—where one has come from, what one has experienced, and where one envisages going in

the future. Of course, the narrative cannot incorporate future events, but it indicates what possibilities may seem realistic in the future and some of the personal difficulties one might expect to encounter in an uncertain world.

These perceived possibilities and anticipated difficulties will be influenced by the sense of *self-efficacy* that one has. This is described by the psychologist Albert Bandura^{8,9} as the appraisal by the individual of her or his ability to carry out tasks or overcome obstacles to achieving desired goals. He defines self-efficacy as “one’s beliefs in one’s capabilities to organise and execute the courses of action required to produce given attainments” (1997, p. 3). He and his co-workers have demonstrated in many empirical studies how one’s sense of self-efficacy affects one performance in a large range of activities including exam performance, parenting behaviour, and many others. It also affects the manner in which people cope with the consequences of psychological disorders. Self-efficacy is a belief state and, as such, is influenced by one’s self-narrative, which includes experiences of both success and failure in varying degrees. Believing one can succeed in a range of tasks encourages the belief that one can succeed in new ones in the future. Conversely, repeated experiences of failure can lead to a narrative that one is ill-equipped to deal with many challenges, particularly unpredictable ones that may arise in the future.

As well as the influence of narratives in generating feelings of optimism or pessimism about an unknown future, a central theme in accounts of narrativity is the emphasis of the role of self-narratives in generating *intelligibility* or *meaning* for how people understand their lives. Thus, Alasdair MacIntyre¹⁰ emphasises the importance of the concept of intelligibility for understanding human actions, both of ourselves and of others. He says: “... the concept of an intelligible action is a more fundamental concept than that of an action as such” (2007, p. 209). Narratives represent the vehicle by which this is attained. For MacIntyre, this is an important thesis: “...man is in his actions and practice, as well as in his fictions, *essentially* a story-telling animal” (ibid, p. 216, italics added). Actions only become intelligible by virtue of their place in a narrative.

Importantly however, we are far from being in full control of our narratives. As MacIntyre notes, we enter society as young children with a set of stories given to us. We have to learn what these are and what roles they confer on us. As we do so, we gradually develop our own self-narratives. Nevertheless, we are always constrained in the narratives we construct by the personal and social circumstances in which we are living and by the narratives which others have of us.

One psychologist who has emphasised the importance of narratives for creating meanings for their authors is Jerome Bruner.¹¹ Like MacIntyre, he also explains how narrative formation starts in childhood. Through the process of receiving culturally appropriate narratives and adopting them as their own, children gain a sense of their own identity. These narratives give continuing meaning to their lives as they grow into adulthood. Bruner also emphasises the moral dimension to the stories we tell about ourselves. He says:

... the larger story reveals a strong rhetorical strand, as if justifying why it was necessary (*not* causally, but



morally, socially, psychologically) that the life had gone a particular way. The Self as narrator not only recounts but justifies (1990, p.121, italics in original).

This aspect of narrativity may become particularly salient for individuals who experience difficulty in maintaining or justifying their existing self-narratives when confronted with a different narrative conflicting with it. There are always constraints on our narratives. At certain times in our lives these constraints may assume a great deal of power over us, such that they force changes in the narratives we have constructed for ourselves. I claim that this can particularly be the case when an individual receives a psychiatric diagnosis which they neither seek nor understand.

It might be argued that self-narratives are not an essential feature of human psychology in the way that theorists like Taylor, MacIntyre and Bruner imply. For example, Galen Strawson¹² has argued that not everyone understands their life in the form of a narrative. In particular, he says *he* does not, and if he doesn't, then it cannot be an essential feature. He does, however, concede that he has knowledge of his past, as does everyone with normal cognitive functioning, but he regards this as a "trivial" claim. Nevertheless, it is not clear why this should be trivial and he offers little by way of argument to substantiate this view. Being aware of one's past and its significance for understanding one's present situation is a key element in narrative theories, even if individuals differ in the emotional weight attached to their narratives.* Moreover, people suffering from mental disorders are likely to ruminate over those aspects of their life history which they feel have led to their current emotional distress. People with serious illnesses typically develop a narrative to make sense of their condition¹ and it is plausible that this is also the case for those with mental disorders.

3 | THE IMPACT OF A PSYCHIATRIC DIAGNOSIS

Whilst psychiatric diagnoses may convey different meanings to different people, they are given in a medicalized environment by people with medical qualifications. In somatic medicine, diagnoses are generally understood (with a few exceptions) to convey explanatory information (e.g., ref. 13, 14). Diagnosis is closely linked with the notion of disease specificity—that is, that a diagnosis names a disease entity of some kind.^{14,15}

Biomedical conceptualisations of psychopathology in neurological or genetic terms are predominant in contemporary psychiatry.¹⁶ Moreover, the idea that psychiatric diagnoses represent disease entities is often reinforced by the prescribing of psychoactive drugs.¹⁷ This can promote a biomedical narrative about the patient's condition, with the accompanying implication that the condition can

be thought of as comparable to other diseases, such as diabetes or asthma. Thus, it can seem reasonable for the patient to assume that a psychiatric diagnosis suggests the presence of some kind of neurological abnormality underlying their difficulties.

To receive a diagnosis is to be told something important about oneself. For chronic or life-threatening diseases the individual's self-narrative may be correspondingly altered, possibly leading to the sufferer re-conceiving the meaning of their life. The manner in which a psychiatric diagnosis may impact on an individual's self-narrative is discussed by Şerife Tekin.¹⁸ She reiterates the features of narrativity discussed by other philosophers, and also emphasises the distinction between the narrative authored by the individual and that received from their social environment. This distinction can assume particular salience when an individual receives a diagnosis, whether medical or psychiatric.

In the case of psychiatric diagnoses, Tekin argues that a DSM-based diagnosis can function as a source of narrative for the person concerned. She suggests that, in some cases, the patient may be comfortable in understanding their experience as a kind of illness in terms of an established medical diagnostic category. In other cases, however, patients may find that the diagnosis imposed upon them prevents them framing their experience in any other way than as some kind of neurochemical imbalance. This kind of narrative may impede the individual from developing sufficient cognitive and affective resources of her own that could help her recovery in future. To the extent she is encouraged to think of her psychological states as merely a function of unbalanced brain chemistry distinct from the environmental and social contexts that may have precipitated her condition, she may question the reality of her own experiences, with a consequent loss of self-respect and feelings of agency. The belief that her psychological states are outside her control may undermine her sense of autonomy and self-efficacy. This may particularly be the case when patients believe their condition is a chronic one. The biomedical determinism which such a narrative implies can limit the hopes for recovery, and the disempowering self-narrative generated can become self-reinforcing.¹⁹ If patients come to believe that their condition is entirely, or even partially, caused by an underlying medical condition which they cannot understand, they may feel there is little they can do to counteract its effects.

It can be pointed out correctly that the causes of mental disorders are very variable and often mysterious. However, the issue here is about the *belief* that patients might have about the cause of their condition, not about any actual cause. Given that the brain is the locus of all mental activity, the belief by patients that they have a brain disorder of some kind is understandable. Thus, for example, Elyn Saks²⁰ writing about her experience of her diagnosis of schizophrenia says: "I was being told that whatever had gone wrong inside my head was permanent, and... unfixable" (2007, p. 168). Similarly, in a short video interview about service-users' reactions to their diagnosis, a respondent states: "people suddenly realised I wasn't doing things for attention... It was because I have a brain disorder".²¹ Whilst there is no quantitative data about how

*There are further responses that can be made to Strawson's criticisms, which I cannot discuss here due to space limitations. However, it is enough for my purpose to argue that the narrativity thesis is not trivial in the way he claims.

widespread such beliefs are, it seems clear that this is a common conception for many patients.

4 | EPISTEMIC INJUSTICE

The concept of epistemic injustice was introduced by Fricker² to describe an important aspect of the ethical dimension of the epistemic activities in which we, as epistemic agents, are habitually involved—that is, activities of reasoning, believing and knowing, giving testimony, and interpreting our experience. Epistemic injustice, therefore, is an injustice done to someone in their capacity as an epistemic agent. It is generated by some kind of negative identity prejudice towards the victim, and in some cases the victim may have internalised the negative identity, whether consciously or unconsciously. Fricker emphasises that it occurs in contexts of a power imbalance, in which the victim is situated at a power disadvantage to relevant agents in their environment.

She identifies two forms of epistemic injustice: *testimonial* and *hermeneutical*. Testimonial injustice occurs when the credibility given to an individual is deflated due to a negative identity prejudice. Hermeneutical injustice refers to the marginalisation of an individual's social experience due to a structural identity prejudice in the dominant hermeneutical resources in her environment. It arises where the individual's conceptual or hermeneutical resources for understanding or interpreting their experiences are impaired or missing in some respect. This can occur when the victim of the injustice lacks the necessary conceptual repertoire to adequately understand the nature of her experiences. Fricker gives as an example the experience of women subjected to unwanted sexual advances by men and who lacked the concept of sexual harassment before this had become a recognised concept in public discourse. However, it can also occur when the victim has adequate hermeneutical resources with which to make sense of her experiences, but these resources are not acknowledged by the dominant culture in which she is situated.^{22,23} Instead, the victim may lose trust in her own hermeneutical resources in favour of those prevalent in the dominant culture.

A key element in defining hermeneutical injustice is the experience of the individual in the situation concerned. As Fricker²⁴ notes, hermeneutical injustice occurs either when the victim is unable to make sense of their situation (what she calls the 'maximal' case), or when the victim can make good sense of it but is unable to communicate their understanding to the dominant culture in which they are situated (what she calls the 'minimal' case). Therefore, the nature of the experience is typically central to identifying whether hermeneutical injustice has occurred, and the reports the individual makes constitute evidence for its occurrence.

Both testimonial and hermeneutical injustice can occur in medical contexts. Havi Carel and Ian Kidd^{25,26} explain how such experiences can occur in these contexts. A principle reason for this is the vulnerability felt by patients because of their illness. Doctors and other clinicians occupy a position of power due to the epistemic

authority deriving from their training and qualifications. The authority this confers on them gives them the power to determine the nature of the disease the patient may have and to authorise treatment. The biomedical approach to illness, which predominates over a more phenomenological perspective, can lead to a marginalisation of the patient's subjective experience. Patients may often find their experiences being overlooked or negated as a consequence of the structures and contingencies of rigid healthcare systems. This may be particularly apparent when serious resource limitations and time pressures lead to increased stress among healthcare staff.²⁶

Kidd and Carel²⁷ also discuss the 'epistemic predicament' that patients can find themselves in. This encompasses the various epistemic challenges often confronting patients in the healthcare system. These can be complex and ongoing over time, rather than confined to single instances of epistemic injustice in an otherwise straightforward episode of healthcare. There can be continual attempts, however unintended, by healthcare staff to undermine the testimonial credibility of the patient. The resulting confusion in the patient generated by the experience of not having his testimonies taken seriously can also lead to him questioning his own understanding of his experiences. His own hermeneutical resources can come to feel marginalised in consequence, such that he may fall victim to hermeneutical injustice in his diminishing ability to make sense of his predicament.

5 | EPISTEMIC INJUSTICE IN MENTAL HEALTH SERVICE CONTEXTS

Epistemic injustice can be experienced by mental health service users for similar reasons to those above, but also specifically as a result of their status as psychiatric patients and the diagnosis assigned to them. Receiving a diagnosis, such as schizophrenia, can render the individual vulnerable to having their experiences marginalised. They may experience testimonial injustice when what they say is disregarded, because it is assumed their condition causes them to either confabulate or be unreliable reporters of facts. There are several examples of testimonial injustice in such circumstances reported in the literature (e.g., ref. 28, 29). More generally, patients can fall victim to "epistemic silencing" (ref. 30, p. 157) when their views are minimised or not even sought, because they are not judged to be useful participants in their assessment and the plans for their treatment.

In particular, such circumstances of epistemic silencing can lead to individuals becoming victims of hermeneutical injustice. Anastasia Scrutton³¹ describes two ways in which this can be experienced by people receiving psychiatric care. Firstly, individuals are liable to be treated simply as sources of data rather than participants in the diagnostic process. Secondly, the experiences they report can be interpreted primarily as symptoms of a diagnostic category, with other aspects of their experience being discounted. Their subjective experiences can be marginalised because of the dominant



hermeneutical resources associated with the diagnostic system. Patients may be particularly vulnerable to this kind of injustice when the clinician treats them merely as providers of mundane information, rather than as meaningful contributors to their assessment or treatment plan. Marginalisation in this way can reduce their sense of confidence in the value of their own perspectives.³² It can be further reinforced by the typical style of psychiatric interviews aimed at establishing whether the patient's symptoms conform to a diagnostic category, thus neglecting the personal meanings the symptoms may have for the patient. For example, Giovanni Stanghellini³³ observes that the use of standardised psychiatric interviews, which are intended to increase the reliability of diagnoses obtained, are likely to contribute to this tendency:

The 'meaning' of a symptom is reduced to the properties that correspond to one category... There is little space for personal meanings and personal narratives... (p. 184).

Stanghellini also emphasises how narratives play a central role in creating coherent meaning for people in their lives. If the manner in which the psychiatric interview is conducted ignores this at a time when the person concerned is experiencing severe distress, their confidence in their own psychological resources for making sense of their experiences are likely to be diminished. This is what can lead to hermeneutical injustice, the effect of which can be long-lasting.

Part of the reason for this is the frequent tendency for people to be encouraged to think of their condition as "an illness like any other". This is evident from the many personal reports of people who have been mental health service users and who have spoken or written about their experiences. For example, Jacqui Dillon,³⁴ a campaigner in the UK on behalf of service-users, talks about her experience in the following terms:

The clear message I received... was that I was ill. *Everything* that I said and did was caused by my illness. The abuse never happened—even thinking it did was part of my illness.... The fact that I didn't want to take medication was because I was ill. If I wanted to get better, I must accept my diagnosis and take medication... I would always have this illness. I wouldn't be able to work. I didn't know what was best for me. I lacked insight (2011, italics in original, pp. 144–5).

Similarly, Elyn Saks,²⁰ now a law professor in the USA, has written about her experiences of psychological disturbance and her involvement with mental health services. She writes about her diagnosis as follows:

The Diagnosis. What did it mean? Schizophrenia is a brain disease which entails a profound loss of connection to reality.... The prognosis: I would largely lose the capacity to take care of myself. I wasn't expected to have a career, or even a job that might bring in a pay check. I wouldn't be able to form

attachments, or keep friendships, or find someone to love me, or have a family of my own (2007, p. 168).

These accounts can be seen as demonstrating that the writers have been victims of hermeneutical injustice, because of the biomedical narrative with which the diagnosis is associated and the pressure they felt to accept that narrative. They are given by individuals who have been able to draw upon sufficient psychological resources to question the disease label that had been attached to them. In so doing they were eventually able to overcome its harmful effects.

Many other people, however, will find overcoming such experiences much more difficult. This is important because it affects the likelihood of their recovering from the conditions which have brought them into contact with mental health services. There is evidence that those with a more internal locus of control and a greater sense of empowerment are more likely to have a good outcome after an episode of psychosis.¹⁹ Conversely, those with an internalised sense of stigma and a weaker sense of empowerment tend to have much poorer outcomes.³⁵ The biomedical narrative, therefore, can have the effect of reducing the person's locus of control and sense of empowerment with its message that the disease is responsible for their experiences. To the extent that it distorts one's self-narrative and diminishes one's psychological resources, one can thereby become a victim of hermeneutical injustice.

Another theme that emerges from the accounts given above is that both individuals were given the message that schizophrenia is a chronic condition from which full recovery was an unrealistic prospect. However, much recent research has challenged this view and revealed that there are widely varying outcomes, with studies reporting anything from 13% to 72% recovery rates, depending upon definition as well as many psycho-social factors including geographical location.³⁶ Thus, the diagnosis does not predict longer term prognosis with any precision; for those diagnosed with schizophrenia it seems there is no common prognosis. The course of the condition is an open-ended process that can be modified in many ways.^{6,36,37} The outcome for people given this diagnosis is therefore very variable.

6 | POSSIBLE OBJECTIONS

It could be objected that the receipt of a psychiatric diagnosis might actually *add* something to the patient's hermeneutical resources, rather than impairing them. Similarly, the *failure* to assign a diagnosis might contribute to hermeneutical injustice by depriving the patient of an important concept to help her understand her experiences. In response to this, it does not follow from my argument that diagnoses should always be avoided. Rather, a diagnosis can be given if the patient requests it. There are other possible ways of assessing the patient's difficulties which neither rely on assigning a diagnosis, nor preclude one. These can enable a clarification that the diagnosis is descriptive, rather than explanatory, when one is given. These include a case-formulation approach,³⁸ in which the therapist works collaboratively with the affected individual to co-construct a narrative that helps her to understand her predicament and to feel

more empowered to overcome her difficulties. Since case-formulation has a different focus than the symptom-oriented approach of a traditional diagnostic assessment,³³ the patient will be encouraged to articulate her own feelings which can be incorporated into the formulation in a way that often does not happen when the assessment is focussed on diagnosis.

Another approach involves taking a more explicitly phenomenological stance in the psychiatric encounter,³⁹ to avoid instances of hermeneutical injustice occurring. This entails a more systematic attempt to engage in a complex dialogue and interpretative process with the patient, who may be struggling to clearly articulate her experiences. The focus is on encouraging the creation of a more coherent and empowering narrative, rather than placing primary emphasis on diagnosis. This has some similarities to a case-formulation approach. Therefore, there are approaches that can be used in which the main focus is not on reaching a diagnosis, but which do not preclude giving one in response to a patient's request.

Another possible objection is that the recipient of the diagnosis may just be a victim of epistemic bad luck, rather than of hermeneutical injustice as well, because of the uncertainty and limited knowledge typically associated with psychiatric diagnoses. In response to this, the first point to note is that I am not claiming that recipients of these diagnoses are invariably victims of hermeneutical injustice—I only argue that some can be. Secondly, I argue that this depends on the manner in which the diagnosis is given and what kind of explanation, if any, accompanies it. As the two quotes given above indicate, patients are sometimes led to believe that their condition is inevitably a long-term one, although such a belief is not supported by current evidence. To the extent that this happens and the patient frames his understanding accordingly, I argue that this can constitute hermeneutical injustice, rather than just epistemic bad luck, precisely because such an understanding could be avoided. Even if patients are not explicitly given this message, they may come to believe it because of the associations that frequently accompany these diagnoses in the public mind. Therefore, the experience of the patient is what underpins hermeneutical injustice in this situation. Consequently, it should be possible to give someone a diagnosis if they request it, while making clear that it does not signify a long-term illness and that a full recovery is possible. To be told one's condition is a long-term one, or even to gain this belief less explicitly from one's social environment, is likely to be harmful to the patient. It may damage their belief in their sense of agency and hopes for recovery. Therefore, this is more than just epistemic bad luck. It is also an epistemic injustice which stems from the predominantly biomedical understanding of psychopathology in psychiatric services. Fricker argues that hermeneutical injustice is a "purely structural notion" (2007, p. 159) and is not perpetrated primarily by individual agents, although they may reinforce it. As such, hermeneutical injustice, when it occurs, arises from the structures and diagnostic practice of many contemporary mental health services.

Moreover, clinicians under stress and time pressures may also find themselves in an epistemic predicament when they need to make a quicker assessment than they would wish. They may feel pressured to assign a diagnosis hastily before assessing the next

patient. Such situations create epistemic uncertainty for both patients and clinicians, without any fault attributable to the clinicians. As Fricker notes elsewhere (2016), a distinctive feature of hermeneutical injustice is that it can happen without epistemic fault on the part of individuals. However, it is particularly in circumstances of under-resourced health services, where clinicians are having to cope with excessive caseloads and patients with complex difficulties, that epistemic injustice in healthcare is more likely to occur.²⁶ Such circumstances are common in mental health services at present. Thus, patients may be particularly vulnerable to becoming victims of hermeneutical injustice in these situations.

7 | CONCLUSION

People with serious illnesses can find themselves in an epistemic predicament; one of trying to make sense of what has befallen them. An important part of sense-making is developing a self-narrative which provides meaning for the individual. Typically, for people with serious physical illnesses, receiving a diagnosis is an important element in the person's self-narrative and helps to explain how the illness came about. However, in the case of psychiatric diagnoses, the diagnosis does not generally explain the patient's condition, although the recipient may be led to think it does. The diagnosis can have a disempowering effect on the patient, in addition to the mental distress he may be experiencing. To the extent that he uses it to make sense of his condition without understanding its limitations, he may be misled about its implications for his future recovery. He may incorrectly believe that he has little power to change his circumstances and his emotional reactions, because the problem lies in some sort of biomedical disorder which he feels powerless to change. Similarly, his own psychological and epistemic resources, which could contribute to his recovery, may be marginalised. Insofar as this happens, I argue that he can become a victim of hermeneutical injustice. However, this can be avoided by making clear that diagnosis is not an explanation of his condition and does not imply that the patient cannot make a full recovery in time.

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CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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