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The impact of a psychiatric diagnosis on the self-narrative of the recipient

Abstract

A psychiatric diagnosis can have a range of effects on the person receiving it. Some welcome the diagnosis, seeing it as an explanation for their distress, while others perceive it as an unwelcome medicalized label impinging negatively on their sense of themselves as rational agents. I focus on how the diagnosis affects the latter group, and in particular how it may impact on their self-narratives. I therefore outline some key themes in narrative theory which have been explored in various ways by philosophers, though to a lesser extent by psychologists. These theorists emphasise the importance of self-narratives in human psychology. I argue that those receiving a psychiatric diagnosis may be vulnerable to experiences of epistemic injustice, as described by Miranda Fricker. This includes what Fricker describes as hermeneutical injustice, where individuals lack the ability to understand their experiences or difficulties in ways that make sense to them. The medicalization implicit in psychiatric diagnoses conveys a particular kind of narrative which may conflict with the recipient's previous self-narratives. When such effects occur, they may reduce the recipient's sense of agency and induce feelings of hopelessness about recovery, which may then limit the prospect of a positive outcome for the person concerned. A greater use of formulation could mitigate those effects.

Introduction

There has been little systematic empirical investigation of the effects of receiving a psychiatric diagnosis on its recipients. In contrast, there are many anecdotal reports in various publications. Drawing general conclusions from these is difficult, but they seem to fall roughly into two broad categories. Firstly, there are those who seem to welcome their diagnosis as providing an apparent explanation for their difficulties. Secondly, there are others who find their diagnosis diminishing or oppressive in some way. These differing reactions are exemplified in a short video posted on the BBC website (BBC, 2018) in which users of mental health services describe their reaction to their diagnosis. One talks positively about a diagnosis of bipolar disorder: ‘people suddenly realised I wasn’t doing things for attention... It was because I have a brain disorder’. In contrast, another says: ‘I hate my diagnosis. The main one I have is borderline personality disorder and I hate it with a passion. People start seeing you differently’.

This paper focusses on the second group, those who find their diagnosis oppressive, with the aim of arguing that in many cases their experiences can be understood as instances of epistemic injustice. A central aim is to argue that this can be understood in terms of narrative theory – i.e. the impact that a diagnosis has on the individual’s self-narrative. The narrative often associated with a psychiatric diagnosis is that the condition is “a disease like any other” (e.g. Malla, Joober, & Garcia, 2015). However, most psychiatric diagnoses, being broadly descriptive labels, do not have the same explanatory value as other diagnoses, though they may appear to. Nevertheless, the disease narrative that can be conveyed by the diagnosis may be taken to imply that the individual’s psychological reactions and experiences of distress are attributable to some kind of brain disease. Narrative theory is therefore a suitable framework for understanding how this implication might affect the self-narratives of the individuals concerned, particularly by changing the meanings they have previously created through their own self-narratives. I argue that this change can be seen as an example of epistemic injustice, and specifically of hermeneutical injustice.

Narrative theory

Narrativity is concerned with the idea that we live and order our lives according to implicit or explicit narratives of some kind. We experience our lives in time – narratives have a temporal or linear structure – and the stories we construct about our lives in some way shape who we are. Narratives and stories are omnipresent in our culture, such as in myths, literature, drama, films, television soap-operas, biography, and so on. The autobiographies we construct for ourselves may not have the ordered aesthetic structure of narratives in literature or drama, but they are nevertheless vehicles that carry meaning for us. However, despite being a central aspect of human psychological life, narrativity seems to have been relatively neglected by experimental psychology (although narrative therapy is a frequently used approach in psychotherapy), possibly because it does not lend itself to study in line with the dominant paradigm of quantitative methodology.

However, this is a subject which has engaged many philosophers, some of whom emphasise the importance of narratives for constructing a sense of self. For example, Daniel Dennett (1991) has described how one’s self-narrative forms an ongoing autobiography with the self at its centre. The self, as Dennett conceives it, is not a metaphysical entity, but a useful abstraction, analogous to the centre of a gravity of an object which fulfils a distinct explanatory purpose. In a similar vein, Marya Schechtman (1997) describes what she calls the ‘narrative self-constitution’ view. According to her account, a person’s self-narrative is what constitutes her identity or self – this is conceived by her as the ‘phenomenological’ self.

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, Alisdair

MacIntyre (2007) 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' (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, emphasis added). Actions only become intelligible by virtue of their place in a narrative. It is the centrality of intelligibility which, according to MacIntyre, also means that behaviourism can never be an adequate science of psychology – it cannot be anything more than a science of uninterpreted behaviours.

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. We are also actors in other people's narratives, such that their narratives may influence our own. In normal circumstances, however, we expect our self-narratives and the narratives that others have of us to be broadly consistent.

One psychologist who has emphasised the importance of narratives is Jerome Bruner (1990). Where MacIntyre talks about the role of narratives in making their subjects' actions intelligible, Bruner explains how narratives create meanings for their authors. He started his career as one of the pioneers of the cognitive revolution breaking with behaviourism. However, this revolution, which was expected 'to bring "mind" back into the human sciences after a long cold winter of objectivism' (1990, p.1), became diverted away from its original impulse and into technical issues based on the computation metaphor. He observes that:

‘Very soon, computing became the model of the mind, and in place of the concept of meaning there emerged the concept of computability’ (ibid, p.6).

Bruner subsequently moved into the study of early language development in children and then progressed into studying how children become inducted into their culture by means of their language. He maintains that an essential process in their enculturation is their adoption of the prevailing narratives of their immediate social environment, which are provided initially by their parents and later by other social contacts. Bruner describes such a process of narrative creation as reflecting the ‘cultural shaping of meaning-making, and the central place it plays in human action’ (ibid, p.xii). Through the process of receiving culturally appropriate narratives and adopting them as their own, children gain a sense of their own identity. This gives continuing meaning to their lives and their actions, and it forms the basis of their own narratives. Bruner also emphasizes 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 (ibid, p.121, emphasis in original).

This aspect of narrativity may become particularly salient for individuals who experience difficulty in justifying their existing self-narratives when confronted with a radically different narrative conflicting strongly with it.

As noted, there are always constraints on our narratives. At certain times in our lives these constraints may assume a great deal of power over us, to the extent of forcing changes in the narratives we construct for ourselves. This can particularly be the case when an individual receives a psychiatric diagnosis which they neither seek nor understand.

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 some exceptions) to convey explanatory information (e.g. Maung, 2017; Stegenga, 2018). Typically, diagnosis in medicine is linked with the notion of disease specificity – i.e. that a diagnosis names a disease entity of some kind. In psychiatry, the idea that psychiatric diagnoses represent disease entities is often reinforced, partly by the frequent prescribing of psychoactive drugs (Rosenberg, 2006). This is likely to promote a biomedical narrative about the patient's condition, with the accompanying implication that the condition can be thought of as similar to any other disease, such as diabetes or asthma.

The manner in which a psychiatric diagnosis can impact on an individual's self-narrative is discussed by Şerife Tekin (2011). She reiterates the features of narrativity discussed by other philosophers, and in addition 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. To receive a diagnosis is to be told something important about oneself. For many illnesses this may be of little enduring consequence, but for chronic or life-threatening diseases the individual's self-narrative is bound to be altered to some degree, possibly to the extent of requiring the sufferer to re-conceive the meaning of their life in the most severe cases.

In the case of psychiatric diagnoses, this can have additional significance. Tekin argues that a DSM diagnosis can itself function as a source of narrative for the person concerned. She suggests that, in some cases, the patient may find it easy to understand their experience in terms of an established medical diagnostic category. In other cases, however, patients may find that a diagnosis is imposed upon them that prevents them framing their experience in any way other than as a kind of neurochemical imbalance, which then becomes the dominant narrative. The biomedical determinism which this implies can limit their hopes for recovery and the disempowering self-narrative generated can become self-reinforcing (e.g. Yanos et al., 2010). In the case of those people who find their diagnoses oppressive, such experiences can be seen as instances of epistemic injustice, and in particular of hermeneutical injustice.

Epistemic injustice

The concept of epistemic injustice was introduced by Miranda Fricker (2007). It concerns the ethical dimension of the epistemic activities in which we are habitually involved – i.e. the activities of reasoning, believing and knowing, giving testimony, and interpreting our experience. Inasmuch as we do these, we are epistemic agents. Epistemic injustice, therefore, is a harm 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 disadvantage with regard to the context that allows the injustice to occur. She identifies two forms of epistemic injustice: **testimonial** and **hermeneutical**. Testimonial injustice occurs when the credibility given to an individual is deflated due to negative identity prejudice and their credibility in giving testimony is thereby undermined. Hermeneutic injustice refers to the marginalization of an individual’s social experience due to a structural identity prejudice of some kind. It arises where the individual’s psychological resources for understanding or interpreting their experiences are impaired or missing in some respect.

Instances of epistemic injustice can occur in medical contexts. Havi Carel and Ian Kidd (Carel & Kidd, 2014; Kidd & Carel, 2017) explain how such experiences can occur in these contexts. A principle reason for this is the vulnerability felt by patients because of their illness. This is accentuated by the power imbalance between them and the healthcare system. In particular, doctors and other clinicians occupy a position of authority due to the epistemic privilege obtained through their training and qualifications. The authority this confers on them gives them the power to define concepts of disease, determine the nature of the disease the patient may have, and authorise access to treatment. The biomedical approach to illness and the third-person stance as the basis of the medical perspective, which predominates over a more phenomenological perspective, can lead to a marginalization of the patient's 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 substantial resource limitations and time pressures lead to increased stress among healthcare staff.

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 the diagnosis assigned to the individual. The assignment of a diagnosis, such as schizophrenia, can render the individual vulnerable to having their experiences marginalized. They may experience testimonial injustice when what they say is disregarded, because it is assumed their condition causes them to confabulate or be unreliable reporters of facts. There are several examples of testimonial injustice in such circumstances reported in the literature (e.g. Crichton, Carel & Kidd, 2017; Sanati & Kyratsous, 2015). Where this happens, the influence of the diagnosis on the perceptions of healthcare staff towards the patient is evident. More generally, patients can fall victim to 'epistemic silencing' (Hookway, 2010, p.157) when their views are minimised or not even sought, because they are not judged to be useful participants in their assessment and plans for their treatment.

Such circumstances of epistemic silencing can allow individuals to become victims of hermeneutical injustice. Anastasia Scrutton (2017) 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. Psychiatric 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. Marginalization in this way can reduce their sense of confidence in the value of their own perspectives (Kurs & Grinshpoon, 2018). It can be further reinforced by the typical style of psychiatric interviews which are 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 Stanghellini observes that the use of standardised psychiatric interviews, intended to increase the reliability of diagnoses, 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...* (2004, 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 the experience of hermeneutical injustice, which can be a long-lasting effect.

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 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, emphasis in original, pp.144-5).

Another former mental health service user, Patricia Deegan, is now a clinical psychologist and disability rights advocate in the USA. She talks about some of her experiences as follows:

> *My psychiatrist told me I had chronic schizophrenia… He said I would be sick for the* rest of my life and the best I could do was avoid stress and cope. Something in me fought back against his prognosis of doom. As I stood outside his office, I remember rejecting the chronic mental patient life-*plan and thinking ‘I will become Dr. Deegan,* and then I will change the mental health system... *’* (from Deegan, 2004, www.patdeegan.com/pat-deegan/lectures/silence; quoted in Phillips, 2013, p.16).

Both these accounts can be seen as descriptions of hermeneutical injustice, mediated by the biomedical narrative with which the diagnosis is associated. They are given by individuals who have been able to draw upon sufficient psychological resources to reject the disease label that had been attached to them. In so doing they were able to overcome this kind of injustice.

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 (Yanos, et al, 2010).[1] Conversely, those with an internalised sense of stigma and a weaker sense of empowerment tend to have much poorer outcomes (Warner, 2010). The biomedical narrative, therefore, seems to 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.

Conclusion

Psychiatric diagnoses have been widely recognised as lacking validity and explanatory value, but they continue to be used, because they are still judged by many psychiatrists to have utility (e.g. Jablensky, 2016). So long as they appear to offer some sort of explanation for psychological disorders, they will add to the risk that their recipients will be victims of epistemic injustice in mental healthcare settings. Alternative approaches that can mitigate or avoid such a consequence make greater use of formulation, without the imposition of superfluous diagnoses conveying a biomedical narrative (Johnstone & Dallos, 2013).

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[1] The concepts of internal locus of control and sense of empowerment may suggest the idea of resilience in the person concerned. Resilience seems to be a broad notion encompassing a range of psychological and social resources available to the individual. Thus, there seems to be some relationship between this and locus of control. A separate paper would be needed to explore this question in depth.

Reinforcing the individual's psychological resources to help them develop their own self-narrative, such that they feel more empowered to overcome their difficulties, is a key aim of formulation in psychological therapy. Narrative therapy is one approach to formulation that can be effective in achieving this (e.g. Harper & Spellman, 2016). What helps to make formulation into a meaningful exercise is the central role of narrativity in human psychological life.

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