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Contributory injustice in psychiatry

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ABSTRACT

I explain the notion of contributory injustice, a kind of epistemic injustice, and argue that it occurs within psychiatric services, affecting (at least) those who hear voices. I argue that individual effort on the part of clinicians to avoid perpetrating this injustice is an insufficient response to the problem; mitigating the injustice will require open and meaningful dialogue between clinicians and service user organisations, as well as individuals. I suggest that clinicians must become familiar with and take seriously concepts and frameworks for understanding mental distress developed in service user communities, such as Hearing Voices Network, and by individual service users. This is especially necessary when these concepts and frameworks explicitly conflict with medical or technical understandings of users' experiences. I defend this proposal against three objections.

INTRODUCTION

Service user involvement in mental health service provision is increasingly considered best practice for healthcare providers across the UK and mainland Europe.^{1,2} Yet, as Campbell³ points out,

[a]ction by service users has not touched the clinical authority of mental health workers—an authority, the Green Paper (Secretary of State for Health, 1999) suggests, that will be reinforced in a new Mental Health Act (p. 88).

In practice, service users still face barriers to getting their opinions on care heard, whether in primary care contexts or through programmes supposedly designed with the intent of enabling their participation.² Several negative consequences of this exclusion are well documented, including impoverished clinical knowledge regarding patient well-being and worse health outcomes for service users.⁴ The structure of these practices of exclusion themselves has been less analysed. My aim in this paper is to take a step towards plugging that gap.

I adopt Dotson's terminology,⁵ referring to ways in which people have their views persistently and unjustly ignored or invalidated as *epistemic oppression*. Recent work on epistemic oppression in mental health services has focused on Fricker's⁶ notions of *testimonial* and *hermeneutical injustice*.^{7,8i}

These authors argue that mental health service users are particularly vulnerable to these forms of injustice, as perpetrated by both caregivers⁷ and wider society.⁸ This leaves these individuals even

more vulnerable to epistemic oppression than people with somatic illnesses, who are themselves more vulnerable than the general population.⁹

There is much more to say on psychiatric service users' vulnerability to epistemic oppression. In particular, mitigating for epistemic oppression in Psychiatry will also involve clinicians being familiar with, and taking seriously, those epistemic resources (ie, concepts, terminology, standards of evaluation and so on¹⁰) that service users have collectively or individually developed to understand their experiences. Arguing for this is the aim of this paper.

In section 2, I explain the notion of *contributory injustice*. In section 3, I identify a case of contributory injustice in Psychiatry affecting service users who hear voices. In section 4, I outline the central requirement of contributory justice in Psychiatry. In section 5, I defend this suggestion against three objections.

CONTRIBUTORY INJUSTICE

Dotson argues that marginalised groups often develop epistemic resources required to make sense of their experiences, which socially dominant groups will not share.⁵ The marginalised thus understand and describe some experience of theirs relatively effortlessly, but are unable to communicate this understanding to others. Dotson terms this *contributory injustice*.¹¹

The term 'contributory' marks out a typical feature of the injustice where the marginalised are unable to *contribute* equally to collective understanding of their experiences. This is not due to their having no contribution to make, but because their contributions are systematically dismissed by those outside of the relevant marginalised community. This is closely related to Fricker's concept of *hermeneutical injustice*, but contrasts with it in one central respect. While hermeneutical injustice refers to cases where *both* the marginalised and dominant groups share a lack of epistemic resources needed to express or understand the former's experiences,^{5,6} contributory injustice picks out cases where relevant resources have been developed and used by the marginalised group, but not taken up by the dominant group.⁵

To illustrate, imagine a rape survivor speaking with the police about her assault (example due to Maitra¹¹). She is agitated, finds it difficult to form sentences and struggles to maintain eye contact with interviewers. She and other survivors understand

¹¹Kurs and Grinshpoon⁸ mentions another closely related concept—*willful hermeneutical ignorance*, described by Gaile Pohlhaus¹⁰ in reference to individuals with mental disorders. It does not, however, return to this notion in any detail when analysing service user experiences.

ⁱSee the cited papers for characterisations of these concepts. The details are not important here.



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this behaviour; it is a result of trauma. But to the police officers, the behaviour may be inexplicable. They may conclude that the behaviour indicates that she is lying, or deeply confused or mistaken. In such a case, the survivor experiences contributory injustice because her experiences and behaviours are misunderstood by her interlocutors, but not by herself or others in the relevant community, due to an asymmetry in the deployment of certain epistemic resources, caused by the officers' lack of engagement with the perspectives of survivors as a group (ie, survivors' *epistemic marginalisation*).

I shall say that a social group *g* suffers contributory injustice iff,

- There is a significant gap in the epistemic resources used by a social group *h* with whom *g* regularly interacts,
- This gap prevents members of *h* (but not *g*) from understanding some aspect of *g*'s members' experience,
- This lack of understanding significantly disadvantages or harms members of *g*, and
- This gap occurs and persists due to the epistemic marginalisation of *g*.

CONTRIBUTORY INJUSTICE IN PSYCHIATRY

Next, I will consider a plausible case of contributory injustice affecting psychiatric service users. This is found in the reports of service users who hear voices.^{12 13}

Caregivers' understanding of mental distress is often felt by service users to be rigid, uncompromising and unable to accommodate users' experiences. For example, a participant in one study stated that,¹²

When I talk to my psychiatrist it's just purely a medical model... but there is so much more to psychosis than just chemicals (p. 125).

A similarly illustrative remark is made by a participant in another study,¹³

I talked to the doctors, and they say things like 'Do you hear voices' and 'Do you think people can take thoughts in and out of your mind' and the sort of standard questions—and they are very rigid about it and they try to fit you in the framework of questions, the standard structure and they won't listen to anything outside of that—they are more interested in trying to diagnose you... (p. 147)

Participants were frustrated at a perceived rigidity in their clinicians' perspectives on voice-hearing, which emphasised neurological explanations and interventions, as well as diagnostic categorisation, that was judged to be inflexible and unsuited to understanding service users' experiences of voice-hearing in any depth.^{12 13}

This is not due to a lack of alternative ways of conceptualising psychosis developed by those who experience it. For instance, the Hearing Voices Network (HVN) is a loosely affiliated collection of support groups that aim to be,¹²

...accepting (of) all explanations of voice-hearing... (and to) encourage people to share coping strategies... to increase a sense of control over the experience of hearing voices (p. 119).

HVN advocates an explanatory pluralism regarding voice-hearing. They note that a very wide range of explanations may be offered for such phenomena, encourage dialogue and discussion between service users (and sometimes service providers) who advocate different positions, and are accepting of *any* such explanation, provided its advocate remains respectful in any

disagreement. Explanations offered in HVN groups may be spiritual, biochemical, paranormal or cognitive/affective in nature, and may also make reference to notions of dissociation, trauma or physical health problems.¹⁴ The overarching goal is to enhance the well-being of those who live with voices and visions.¹²

Oakland and Berry¹² report that service users who participate in the activities of HVN report an acceptance of in-depth, non-medicalised explorations of voice-hearing (p. 124) and "[i]ncreased empowerment, activity and control" as a consequence of, in part, "[t]he ability to share personal theories of voice-hearing..." (p. 127). For many service users, participating in the group represented,

...the first time their experiences had been believed after significant periods of isolation... including dismissal of experiences by healthcare workers (p. 126).

The novelty of the experiences within the support group, as well as the significant improvements in participating individuals' states of mind, suggests that the acceptance of service user perspectives, as well as the concomitant benefits, are not reliably present within formal psychiatric services. This is to service users' *significant disadvantage*.

The difference here does not necessarily seem attributable to service users' being *believed*. After all, the range of views expressed in HVN groups may be mutually incompatible. But the medical lens of formal psychiatric services is objectionable to many participants because it does not accommodate their experiences and summarily dismisses resources they feel are necessary to do so. This is a case where service users have collaboratively overcome gaps in understanding present within the dominant medical model of voice-hearing, but these insights are not reflected in institutional Psychiatry. The significant feature of HVN groups is that individuals' views are *not summarily dismissed* for failing to accord with some pre-existing theory. Participants are treated as equal participants in a discussion that encompasses the nature of voice-hearing, as well as strategies for managing the experiences and associated distress.

Thus, when certain service users come into contact with mental health services, clinicians lack understanding of their experiences without the service user sharing this lack of understanding. Since clinicians frequently dismiss alternative perspectives (ie, service users are epistemically marginalised), such cases amount to contributory injustice.

This is neither to condemn nor absolve clinicians for the injustice done. While the majority of medical professionals who actually propagate this injusticeⁱⁱⁱ are almost certainly ignorant of the alternative frameworks available (or their value), this ignorance is often *wilful* in the sense that it reflects a failure to engage with voice-hearers as equal epistemic agents.¹⁰ While they treat various peers within the medical establishment as reliable sources of information and insight, service user experiences of health services suggest that many clinicians do not make an effort to engage with service users in the same fashion.^{12 13} That is, clinicians are unwilling, in Pohlhaus' terms,¹⁰ to enter an 'interdependent epistemic relationship' with service users (pp. 720–723). Instead, as Crichton *et al* posit,⁷ they

...regard their patients as objects of their epistemic enquiry rather than participants in an epistemic search for the correct diagnosis and best treatment (p. 67).

ⁱⁱⁱNot all do. Many participate in, contribute to and use the resources of HVN and similar service user-led organisations. Naturally, this is to be encouraged.

ENSURING CONTRIBUTORY JUSTICE IN PSYCHIATRY

Correcting for this injustice necessitates clinicians developing the propensity to ‘give uptake’¹⁵ to service users’ communications of their perspectives on their illness and goals for recovery, regardless of how initially alien such perspectives seem. As described by Potter,¹⁵ giving uptake involves making “an earnest attempt to understand things from the communicator’s point of view” (p. 140). This does not just involve considering conventional interpretations of what the speaker is offering. Such conventional interpretations of the perspectives of people who hear voices are tainted by stereotypes regarding their irrationality or unintelligibility.^{15 16} Thus, giving uptake in these sorts of cases involves sincerely trying to understand things from the perspectives of people whose perspectives are often regarded as unintelligible.

That said, giving uptake is also not a matter of agreeing with the perspective being presented, or even thinking that the perspective is helpful.¹⁵ What it requires is “tak(ing) seriously the reasons that person gives for her actions and beliefs” (p. 141). In short, the requirements of contributory justice in Psychiatry are that clinicians are *familiar with* and *take seriously* the many different interpretive frameworks through which service users make sense of their experiences.

In this context, to take an interpretive framework seriously may involve several different attitudes. One way is to be open to the possibility that a framework provides genuine insight into the nature of a service users’ condition, even where medicalised understandings of the condition suggest that this is *prima facie* unlikely. Another is to be open to the possibility that the framework provides some kind of significant benefit for managing or recovering from distress. The unifying feature of these and other acceptable attitudes is that they treat the service user as an equal participant in a joint inquiry that aims at maximising their well-being.

Ensuring contributory justice will require clinicians’ familiarity with perspectives that diverge enormously from the technical¹⁷ or medical¹² perspective that psychiatrists are under pressure to adopt. Minimally, they must exhibit genuine openness to the thought that this perspective may miss important dimensions of some peoples’ experiences that are relevant to understanding and managing their distress.¹⁸

Taking seriously the reasons given by an individual for beliefs and actions that a clinician is trained to consider pathological will require sustained engagement and interaction with the service user communities from which alternative perspectives arise.^{iv} There are two central reasons for this.

First, as Anderson points out,¹⁹ sincere engagement with these communities will help to reduce a clinician’s sense of service users being an ‘out-group’ to their professional ‘in-group’, thus diminishing ethnocentric biases (pp. 169–170) that will otherwise tend to exclude non-medical viewpoints. Second, such engagement provides opportunities for clinicians to be exposed to the reasons and justifications for many non-medical perspectives on mental distress, in contrast to the restricted view they are typically exposed to in training and throughout their professional lives. Some HVN groups already invite participation by clinicians, on the condition that they respect service users’ diverse views.²⁰ This model could be generalised to promote clinical engagement with other service user communities, though great care would need to be taken, as many such communities

are deeply (and justifiably) suspicious of professional Psychiatry, because of experiences of violence, abuse and malpractice.

OBJECTIONS AND RESPONSES

Some may worry that the requirements of contributory justice could lead to tension with clinicians’ other ethical obligations. Suppose, as a highly simplified example, that a service user comes to interpret the voices they hear as the voices of guardian angels. Further suppose that the service user reports that this understanding of the voices’ origin significantly decreases their day-to-day distress.

If the previous section is correct, then it is a requirement of contributory justice that the clinician gives uptake to the service user’s perspective. While this does not involve believing the interpretation to be accurate, nor necessarily promoting it, giving uptake is plausibly incompatible with insisting that the view is false. This is because forceful insistence by a medical professional that a view is false has the potential to shut down *any* discussion of the view’s value. And if the view’s presumed falsity counts as medically pertinent information, then failing to offer this information in a timely fashion might violate the requirements of informed consent to treatment.²¹ So we have a *prima facie* incompatibility (in certain situations) between the requirements of contributory justice and those of informed consent.

I have two replies. First, giving uptake to an idea is *not* incompatible with insisting that the idea does not reflect reality. It seems perfectly possible for a clinician to sincerely engage with a service user’s perspective, and to observe and reflect on the benefits this perspective provides to the service user, all the while making it clear that they believe it to be false. What is important here is that the clinician retains an open mind regarding the perspective’s value for the service user and its potential role in the implementation of a recovery plan. Giving an interlocutor uptake does not require holding one’s tongue on points of disagreement, as long as it is done respectfully.

Second, it is not obvious that a clinician failing to inform a service user about their beliefs regarding angels counts as withholding *pertinent* information. If the standard for pertinence primarily relates to protecting a service user from potential harms or negative effects of proposed interventions²² (§2.1), then, unless holding a most likely false belief intrinsically counts as a harm, the information in this case is not obviously pertinent.

Nor does such information seem necessary to protect service users’ autonomy or prevent abuse. These are among the most common rationales for promoting informed consent.^{22 23} The promotion of users’ own views is a *route* to greater autonomy, and ensuring the impact of service users’ perspectives in the formulation and implementation of care plans is a sensible corrective to the risk of abuse. It stands to reason that the standard for pertinence in these sorts of cases should bear some relation to the information’s potential to enhance these outcomes (or its omission’s potential to detract from them). On such a standard, if it were the case that such information was irrelevant, or actively deleterious, to promoting such outcomes, it would not count as pertinent.

Another worry is that a clinician may not be able to *take seriously* the suggestion that the service user is putting forward to understand their experiences, not in any way due to the status of the service user, but because of the content of the suggestion itself. The existence of guardian angels is presumably incompatible with the broadly physicalist worldview of many physicians. And, just as it is not possible to choose to believe things that one thinks are false, it is plausibly impossible to choose to take

^{iv}All sorts of structural difficulties may militate against this, including clinicians’ workloads and the hectic nature of primary care. Thus, responsibility for ensuring contributory justice will not fall solely on frontline care providers.

seriously things that one thinks are patently absurd. If so, then a large number of physicians are unable to meet the requirements of contributory justice as I have described them, in a significant class of cases. This might be thought to weaken the obligation to seek out contributory justice in the first place.^v

I have two replies. First, it is not clear to me that this in any way lessens the general obligation to seek out contributory justice. I agree that nobody can be obliged to do the genuinely impossible. But much of the insight that service users have into their own condition *is* compatible with a broadly physicalist worldview, as we saw in the discussion of the range of views put forward in HVN groups. The existence of fringe cases where physicians are incapable of taking a suggestion seriously says nothing about the *general* obligation to seek contributory justice.

Second, to take a service user's perspective seriously need not involve being open to the possibility that it accurately captures the nature of some phenomenon. One could be closed off to *this* possibility, and yet open to the possibility that the perspective in question significantly supports the service user in avoiding or managing distress. One need not even *entertain* the possibility that guardian angels exist to think that the most effective therapeutic strategy *might* involve the service user maintaining such a belief. The *prima facie* absurdity of the belief from the clinician's perspective must not infect their evaluation of its potential therapeutic value.

One final worry is that even if it is *possible* for a clinician to take a service user seriously in the sense relevant to ensuring contributory justice, it may not always be ethical for them to do so. I stipulated in the above example that the service user reports that their understanding helps them to manage distress. Implicit was the assumption that their perspective was not incompatible with effective recovery. But what if a service user interprets their experiences in a way that significantly interferes with recovery? Some examples may include a service user who hears voices that tell them not to trust their psychiatrist/therapist or not to take an otherwise effective medication.^{vii}

Certainly, if a service user's perspective fails to offer genuine insight into the nature of voice-hearing, *and* impedes their well-being, a responsible clinician should not act so as to reinforce it. But this concession does not undermine my argument.

Many perspectives that service users have on their conditions that clinicians are currently dismissive of are *not* of this sort at all. Moreover, ascertaining that a service user's perspective is of this sort *necessitates* engaging with them as an equal participant in a discussion about their recovery, and thus taking the perspective seriously (at least at first). This is because contributory injustice impedes the clinician from fully understanding the role a service user's perspective plays in their understanding and management of their condition. Contributory justice does not require of a clinician that they reinforce *genuinely* harmful views a service user may have regarding their own condition. Rather, a clinician must combat contributory injustice in order to know that a service user's understanding of their condition is genuinely harmful.

CONCLUSION

I have made the case that contributory injustice is present in Psychiatry. I have also given some indication of how it is best combated.

^vI thank an anonymous reviewer for this objection.

^{vi}I say 'otherwise effective' to exclude cases where a service user is prescribed ineffective or harmful medication. Having motivations to come off such medication does not interfere with recovery.

^{vii}I thank another anonymous reviewer for this objection.

There are other frameworks for understanding epistemic oppression that have been helpful in the proper identification and analysis of racial and gender injustices that should now be investigated for their applicability to Psychiatry (see, eg, Dotson²⁴). Understanding the varied ways in which injustice may present is crucial for improving the ethical status and perception of mental health services.

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