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Overcoming Hermeneutical Injustice in Mental Health: A Role for Critical Phenomenology

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ABSTRACT
The significance of critical phenomenology for psychiatric praxis has yet to be expounded. In this paper, I argue that the adoption of a critical phenomenological stance can remedy localised instances of hermeneutical injustice, which may arise in the encounter between clinicians and patients with psychosis. In this context, what is communicated is often deemed to lack meaning or to be difficult to understand. While a degree of *un-shareability* is inherent to subjective life, I argue that issues of unintelligibility can be addressed by shifting from individualistic conceptions of understanding to an interactionist view. This takes into account the contextual, historical and relational background within which meaning is co-constituted. I conclude by providing a corrective for hermeneutical injustice, which entails a specific *attentiveness* towards the person's subjectivity, a careful *sensitivity* to contingent meaning-generating structures, and a degree of hermeneutical *flexibility* as an attitude of openness towards alternative horizons of possibility.

1. Introduction

The onset of psychosis alters subjective life and can undermine taken-for-granted assumptions about what is real, true and meaningful. In some cases, the conditions of possibility for mutual understanding might break down, leading to irreconcilable perspectives emerging from separate "realities" (that of clinician and patient). As a consequence, the experience of psychosis can be isolating for the subject of experience, who may feel seen but not heard.

In this essay, I argue that the adoption of a critical phenomenological stance may improve conditions of hermeneutical marginalization as lived by individuals affected by psychiatric disorders (such as psychosis). The assumption is that these conditions are not unintelligible *per se;* rather, clinical-epistemic practices may suffer from a gap in shared hermeneutical resources. While I will not directly address broader structural inequalities affecting participatory research practices (as this would

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require a far more extensive analysis of systemic societal issues), I will discuss localized forms of hermeneutical marginalization—which can be more readily addressed within psychiatric care through the cultivation of virtuous epistemic habits and practices.

In particular, the focus is on the transformative potential of critical phenomenology as a *praxis of freedom* in relation to the epistemic encounters between mental health clinicians and service users.[1] Indeed, in addition to grounding the phenomenological enquiry within socio-cultural contexts and power relations, critical phenomenology puts the phenomenological programme into action as "a praxis of freedom that seeks not only to interpret the meaning of lived experience, but also to change the conditions under which horizons of possibility for meaning, action, and relationship are wrongfully limited or foreclosed" (Guenther). In the healthcare interaction, I conceive of freedom as a condition where the encounter between patients and clinicians opens up, rather than closing down new spaces of meaning which allow for "a sense of alternative possibilities" (Searle p.67).

In section 1, I introduce the notion of hermeneutical injustice (Fricker) and discuss its relevance for the encounter with patients experiencing psychotic symptoms, such as delusions.[2] In section 2, I clarify actors and stakes in healthcare interactions by addressing the central question: *who* is communicating *what* to *whom*? In section 3, I show how localized instances of hermeneutical marginalization can be addressed through the adoption of a critical phenomenological stance. Correcting for hermeneutical injustice requires that both clinicians and patients engage in a form of *hermeneutical humility* and sincere *openness* towards alternative horizons of possibility.

2. Hermeneutical Injustice and Psychosis

2.1. What is Hermeneutical Injustice?

Hermeneutical injustice occurs when someone is rendered unable to understand or express some important aspect of their own experience due to a gap in the shared tools of social interpretation (Fricker).[3] Hermeneutical injustice is a particular instance of a broader group of harms and wrongs in epistemic practices going under the

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[1] In this essay, I use the terms "patient" and "service user" or just "user" synonymously and interchangeably, while taking into account the ethically-loaded connotations that both terms carry along within psychiatric research and practice (see Priebe for a recent discussion).

[2] The term "delusions" refers to a clinical phenomenon commonly characterized as irrational beliefs. For instance, someone with delusions may believe that a devil is persecuting them and following them around, or that they have been chosen to become the next Messiah and have the ability to predict the future. The veracity of such ideas is usually affirmed and maintained by patients in the face of seemingly plausible and decisive counterargument and counterevidence (e.g., the fact no one else can see the devil or that all predictions about the future turn out to be wrong).

[3] In this initial section of the essay, for the sake of clarity, I refer to and quote Fricker's original account of hermeneutical injustice to provide a definition of this concept. However, the current discussion about hermeneutical injustice is characterized by a wide variety of different notions and conceptions, with a broader range of meanings than the initial account quoted here. For further elucidation of different versions and dimensions see contributions in *The Routledge handbook of epistemic injustice* (2017) (especially Medina, "Varieties of Hermeneutical Injustice 1"). For instance, hermeneutical injustice can involve an unfair unwillingness to try and understand someone's experience—one has the interpretive tools but lacks the will to put them to use; or it can refer to situations where hermeneutical resources are available, but they are not fit for the purpose—perhaps because they were designed to be used in different contexts such as in non-pathological cases.

general heading of "epistemic injustice"[4], which may affect epistemic subjects in different capacities (e.g. as a giver of knowledge and/or as a self-interpreting agent). For hermeneutical injustice to occur, there are three necessary conditions:

a) a subject does not have the interpretive resources to adequately understand or express some important aspect of her experience (this might occur because the subject has not been exposed to the relevant concepts or because adequate concepts do not yet exist);
b) the lack of interpretive resources is due to the fact that the subject belongs to a social group which is hermeneutically marginalized;
c) the same subject is harmed by this lack of meanings[5], that is, she is prevented from understanding an important and distinctive patch of her own experience; "a patch of experience which it is strongly in her interests to understand, for without that understanding she is left deeply troubled, confused, and isolated, not to mention vulnerable to continued harassment" (p.151).

The example of postnatal depression used by Fricker will help to clarify this notion. In the 1960s, Wendy Sanford was experiencing depressive symptoms after the birth of her first son, and she and her husband had been blaming her for these difficulties. A friend of hers convinced her to attend a consciousness-raising group:

> 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. (p.149)[6]

In this case, Wendy had been experiencing a certain set of feelings which was in her interest to better understand and communicate, for which she had been blaming herself instead of seeking help (condition c). Wendy did not have the adequate interpretive resources to fully understand her experience (condition a) because she was a member of a hermeneutically less powerful group, where the concept of post-natal depression was missing from the pool of meanings (condition b).

What sorts of harm is Wendy experiencing? From a phenomenological perspective, we can identify at least three interrelated dimensions wherein harm can occur—all leading to a failure of understanding (Romdenh-Romluc). We could further articulate

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[4] Under this general heading, we find two forms of epistemic injustice: *testimonial* and *hermeneutical*. In her book *Epistemic Injustice* (2007; p.1), Fricker defines them clearly: "Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences. An example of the first might be that the police do not believe you because you are black; an example of the second might be that you suffer sexual harassment in a culture that still lacks that critical concept." Thus, in the case of testimonial injustice, someone is wronged in their capacity as a *giver of knowledge*; in the case of hermeneutical injustice, the subject is wronged as a *self-interpreting agent* and as a *subject of social understanding*.

[5] As Fricker's points out (2007, p.151), hermeneutical injustice cognitively disables all those involved, but only actually harms the victim. This is particularly evident in the example she offers of "sexual harassment" (p.149-155) at a time when this concept was not available to women to name their experience. In this case, there is a sense in which it is advantageous for the harasser not to understand the experience suffered by the victim.

[6] The example used by Fricker is taken from Susan Brownmiller, *In Our Time: Memoir of a Revolution)* New York: Dial Press, 1990), 182.

these failures as tapping into three psychological-existential domains or functions: one concerning *meaning-making* (i.e. the possibility of fully understanding and making sense of one's own experience); another concerning the *communication* of experience to others (i.e. the possibility of such experience being properly relayed to a hearer through a linguistic action or non-linguistic representation); and a third existential dimension concerning *self-interpretation* (i.e. related to the impact that a certain understanding of experience may have on the subject's construction of her self-identity). In Wendy's case, a global failure of understanding and subsequent harm can be identified across all three domains.

Crucially, these three aspects (meaning-making, communication and self-interpretation) are all intimately related so that many of our experiences can be construed as essentially interpersonal from the beginning: as meaning-making agents, we often use communications as a means to create (self-)understanding, rather than simply passing information to others. Moreover, the very act of self-interpretation is shaped by our social nature and by our interpersonal encounters; the interpretations we make of our own commitments, beliefs, actions, and desires, are constantly prompted, guided, sustained, or questioned by other people. All of this draws special attention to the social or interpersonal character of understanding.

As I see it, psychosis makes a similar, urgent demand for self-interpretation which will be inevitably shaped by others' responses to the person's beliefs and behaviour, and by the registered dissonance between the person's current lived world and their previous basic assumptions about what the world is like. Indeed, individuals with symptoms of psychosis (especially during the initial stages if illness onset) may be confronted with feelings of perplexity, puzzlement and confusion, which it is strongly in their interest to understand. Wang describes it well (2019):

> A person experiencing psychosis can seldom describe the ongoing turmoil with any kind of eloquence, but they might be able to tell you what it was like in hindsight, when the damage is in the rear window. Before the psychosis properly begins, as I experienced during Lucy, *I experience an agitated sense of something being wrong*. The wrongness isn't limited to the grotesqueries mutating inside, but is also true of the world at large: *how did it get this way, and what am I supposed to do with it?* (p.125; my emphasis)

When coming into contact with mental health services and talking to a clinician, people may struggle to adequately express the significance of their own experience through everyday words and concepts. They may draw upon widely spread cultural or sub-cultural interpretative resources, for example those linked to conspiratorial, religious, mystical or spiritual narratives. Alternatively, depending on their health literacy, academic studies or previous experience with services, they may rely on medical concepts and language. In some situations, however, they may be harmed in their capacity as knowers and may suffer from various forms of epistemic injustice both in the clinical as well as the social domains (Kurs and Grinshpoon).

2.2. How Does Hermeneutical Injustice Affect Individuals with Psychosis?

Although the notion of "psychosis" remains vaguely defined in current diagnostic manuals, the adjective "psychotic" is widely used to characterize a variety of signs or symptoms (i.e. psychopathology) associated with what psychiatrists call "impaired reality testing" or "loss of touch" with reality, such as delusions (Henriksen and

Englander). The latter formulations seem to imply that there is something wrong with the patient's ability to distinguish objective reality from an inner, fictional, or dream world. This often carries along prejudiced assumptions about the epistemic status of the "psychotic" person, as detached from reality, irrational and incomprehensible.

As a consequence, people with unusual experiences and beliefs and/or a diagnosis of mental disorder are more vulnerable to epistemic injustice (Crichton, Carel, and Kidd). This is not only caused by stigma, negative stereotypes and lack of hermeneutical resources; vulnerability to epistemic injustice may also be a direct by-product of radical alterations in lived experience (such as the altered sense of reality), as these experiences may affect the person's sense of agency and their relationship with language thus directly disrupting the familiar patterns of meaning that bind together subject and object.

When young people use services, the risk of epistemic injustice can be even higher (Houlders, Bortolotti, and Broome). This is because their epistemic agency (i.e. the capacity to produce and share knowledge competently and authoritatively) is already under threat in multiple ways. Indeed, young people with psychosis may already have a fragile sense of agency due to psychopathological features intrinsic to their condition (e.g. an altered sense of self), or the form of epistemic agency available to them may be altered in fundamental ways due to a significant change in existential orientation and a breakdown in the sense of belonging (Ratcliffe pp.257–269).

In addition, other people may challenge or dismiss their testimony and interpretive abilities due to prejudiced assumptions of irrationality commonly associated with young age and with neurodiversity. Gender, physical appearance, sexual orientation, socioeconomical status and ethnic origin may also further bias the attribution of epistemic agency (Houlders, Bortolotti, and Broome).

Intuitively, threats to epistemic agency—if not promptly addressed—can lead to testimonial injustice (i.e. the deflation of someone's credibility for no good reason). The relevance of epistemic injustice in the assessment of mental disorders and delusions has been the subject of a growing body of work in philosophy of psychiatry (e.g. Sanati and Kyratsous; Crichton, Carel, and Kidd). But threats to epistemic agency may also render people with psychosis more vulnerable to *hermeneutical* kinds of injustice. There are two possible reasons for this: either adequate meanings are lacking from the collective resource (i.e. they do not exist for anyone), or useful meanings exist for a certain social group but are not taken up more widely (Mason). In the latter case, the wrong may be better articulated as "contributory injustice" (Dotson; Miller Tate) due to the fact that the marginalized may *not* lack the interpretive resources; rather, they have achieved valuable understanding but are unable to *contribute equally* to the shared stock of meanings because of a failure of hermeneutical uptake by the dominant knower(s).

Accordingly, there are a number of different extrinsic and intrinsic factors which may contribute to hermeneutical marginalization in people with psychosis. Extrinsic factors include but are not limited to:

1) an uneven epidemiological terrain carrying significant associations between higher rates of psychosis and ethnic, gender and sexual minorities (all of which are likely negatively affected by an unequal distribution of hermeneutical resources);
2) systemic problems associated with the unequal participation of service users in the production of shared meaning-resources (for instance, through user-led research);

3) negative stereotypes associated with psychotic experiences such as rigid binary assumptions of incomprehensibility, meaninglessness and dysfunction.

Intrinsic contributory conditions may include (but again, are not limited to):

1) a degree of un-shareability of experience (i.e. communication difficulties), which is inherent in any attempt to relay subjective experience to others but is more so in the context of ineffable transformations of self-consciousness occurring in psychosis (partly due to the limits of language itself);
2) impaired cognitive or language performance such as in the case of formal thought disorders, where a disorganized semantic structure of spoken or written sentences may render patients' utterances difficult to follow.

These may all be good places where to begin our enquiry into the mechanisms of injustice and its potential remedies. However, is seems that such an enquiry is missing something fundamental about the nature and meaning of human *understanding*. That is, the fact that *relational contexts* and *communicative dynamics* matter deeply (Medina).

The importance of the *relational context* for processes of meaning-making and self-understanding is particularly evident in clinical encounters involving diagnostic disclosure. For instance, in cases in which the interpretive resources are lacking, receiving a psychiatric diagnosis can be *lived* as a relief for many people suffering mental ill health (Perkins et al.). It can validate their suffering and allow greater self-understanding, while giving them the language resources to speak about it and access mental health care. For others, a diagnosis of mental disorder can be a deeply oppressive and unwanted "label" with harmful implications such as stigma, stereotyping, status loss, discrimination and epistemic injustice (Link and Phelan; Corcoran). While both internal (e.g. prior experiences and beliefs) and external (e.g. culture, public acceptance) factors have a significant effect on the way in which diagnosis is experienced by the person, the context and the quality of the relationship between user and practitioner play a fundamental role (Perkins et al.).

Indeed, a growing body of empirical research shows how communicative dynamics and relational contexts matter deeply for mental healthcare outcomes (McCabe and Priebe; McCabe and Healey; Zangrilli et al.). They are not only important in relation to diagnostic disclosure but also for a variety of clinical and functional outcomes such as perceived severity of symptoms, quality of life and satisfaction with treatment (Birkhäuer et al.). It is for all these reasons that, in order to start addressing issues of hermeneutical injustice, we first need to understand the plurality of ways in which hermeneutical challenges unfold within a certain dialogical relationship: *who* is communicating *what* to *whom*?

3. Who is Communicating What to Whom?

3.1. Who's Who in the Clinical Encounter?

In healthcare interactions, a hermeneutical gap may be present to a varying degree between the interpretive communities of patients and clinicians. This may happen in encounters about mental health as well as physical health, although in the case of psychosis—and particularly when delusions are present—the gap may become wider and of a different, ontological, kind. In this case, a fundamental asymmetry can be identified between the clinician's and the patient's agenda, potentially bringing the conversation to a halt. Some examples of this are illustrated by Georgaca through the analysis of extracts from interviews with individuals with delusions. In one of these cases, Ahmed (a second-generation Asian man in his mid-twenties) claims that his real parents are Michael Kennedy and Raquel Welch, and that he was kidnapped as a baby for political reasons and brought to England. Here is the ensuing conversation:

> I [Interviewer]: So until, until two months ago you believed that, that your parents here were your real parents.
>
> A [Ahmed]: Yes, but they don't look anything like me, you see, they are much darker than I am.
>
> I: Hmm.
>
> A: I mean, they don't look anything like me. I mean, because he doesn't look like me, he doesn't look like, say, they don't look anything like me anyway.
>
> I: Hmm.
>
> A: They look totally different. They are Pakistanis, I'm not Pakistani, I mean, they don't look anything like me.
>
> I: Yeah.
>
> A: They look totally different. They don't look exactly the same either, I mean, my foster, my foster father, he is very dark, chocolate dark.
>
> I: Mm hmm.
>
> A: But his wife, she is quite light, they don't look anything like me.
>
> I: Mm hmm. Yeah, but your, I mean your, your skin is a bit, it's not too dark but it is a bit dark, isn't it?
>
> A: It's red, it's red.
>
> I: Red?
>
> A: Yeah.
>
> I: What do you mean red?
>
> A: I mean sort of, like tomato ketchup, you know, red sort of thing.
>
> I: Hmm, what does that mean?
>
> A: That sort of means I'm red and, red and white sort of like, not so white as you, I'm not like that but …
>
> I: Yeah, yeah, yeah. [laughter] Do you want, do you want to stop or do you want to go on? (Georgaca p. 236)

As the author already points out, disagreement about perceptual knowledge (in this case the skin colour) puts the epistemic status of both interlocutors into question. While this may seem *prima facie* a matter related to the "objective" perception of reality, it is clearly inscribed within a framework of interpretation shaped by discourses of race, ethnicity and colonialism—in the absence of any ultimate truth. In the extract, the interviewer tries to offer her own interpretation of Ahmed's skin colour ("it's not too dark but it is a bit dark, isn't it?") but this only leads to what appears to be a repetitive cycle of *counter-interpretations* eventually bringing the conversation to a close. In this situation, if the interviewer had a clinical role aimed at formulating a diagnosis, they would likely assume *a priori* a position of authority as dominant knower—thus providing the normative framework against which the patients' claims are tested and judged as false (i.e. delusional). While this assumption may be implicit within the diagnostic process (where other elements such as distress and harmfulness are also considered), attention must be paid to medicalised counter-interpretations embedded within closed and inflexible communicative dynamics, as they can lead to a systematic distortion of the patient's interpretive attempts. How do we reduce threats to patients' hermeneutical power?

Let us consider the case presented above as a highly simplified example of what might happen in a clinical encounter with a patient with psychosis. Let us suppose that Ahmed's personal history includes childhood bullying due to his skin colour, subsequently reinforced by systematic exclusion from opportunities as an adult. The belief of being the son of American celebrity Raquel Welch is helping him cope with traumatic memories and providing him with a sense of meaning in life, which protects him from becoming severely depressed. The claim that his real parents' skin is much darker than his provides Ahmed with an additional reason that supports his (delusional) belief. Thus, this delusional system could be interpreted by some as self-enhancing and psychologically adaptive (Ritunnano and Bortolotti; Ritunnano, Humpston, and Broome).

What could the clinician do to reduce the risk of hermeneutical and contributory injustice? If the delusion is dismissed in a way that does not support the patient's epistemic agency and causes interactional distress, the patient may be victim of a localized form of contributory injustice. Should the clinician then endorse and promote the delusional belief as an accurate representation of reality? Not necessarily. Ensuring hermeneutical justice does not require that the two interlocutors reach a consensus on whose view of reality is the most accurate. Hermeneutical justice entails keeping an open mind as to the origins, value and function of the patient's own interpretation of reality (whether it is delusional or not).

In the example above, for instance, the clinician could sincerely engage with Ahmed's interpretation of his skin colour and explore further what this means to him, what happened to his "real" parents, why he was brough to England, what his childhood was like. Not only this can contribute to a better definition of the psychopathology, but it may also help create a shared world of meanings where the patient feels listened to and enabled in his interpretive capacity. Of course, this requires a thorough consideration of clinicians' other ethical obligations, which may take priority should the delusional belief become harmful.

Ethical issues and challenges are pervasive, though underappreciated, in all cases of epistemic interactions with people with psychosis and delusions: aspirations towards truthfulness often mean that one cannot endorse or agree with the content of the delusion; however, if the typical norms of truthfulness are not in play, what are then (and who defines) the rules of the game?[7] Some have suggested that, in such circumstances, a distinctive kind of empathy (e.g. "radical" or "second-order" empathy) may be required in order to understand, and communicate about, forms of experience that fall outside of the epistemic bedrock provided by a shared world (for a more extensive and complex elaboration on the concept of radical empathy see Ratcliffe; see also Staghellini). In contrast with mundane empathy, radical empathy entails an explicit recognition of a variable sense of belonging to a shared world, thereby expanding the range of intelligible experiences (Ratcliffe). By the same token, radical empathy allows us to contemplate the possibility that the other person's mode of believing may be governed by a different *kind* of intentionality. When this is taken into account, then standard principlist approaches to medical ethics may fall short and narrativist approaches that engage both with the existential predicaments of patients and their intersubjective lives may be better suited (McCarthy).

Granted that in some circumstances a degree of epistemic asymmetry cannot be avoided, an attitude of openness and responsiveness on the part of the clinician may still improve conditions of (mis)understanding and (mis)communication, thus reducing the risk of hermeneutical marginalization. This entails the ability to constantly engage with and oscillate between the role of "questioner" and "examiner" (i.e. the third-person perspective), and that of "listener" and "co-constructor of meaning" (i.e. the second-person perspective). Though often criticized for overlooking the importance of subjective life, the third-person perspective is useful and often crucial to the practice of psychiatry. However, it is insufficient and potentially pernicious on its own; for clinicians are made of the same flesh as their patients. In their epistemic interactions, practitioners will often draw on the "objective" language of symptoms to give a name to a certain set of feelings, experiences or behaviours which are reported or displayed: this is helpful for the diagnostic task and may contribute, to a degree, to patients' self-understanding task (e.g. in the case of Wendy Sanford above). However, the third-person approach and language may not *always* and *adequately* respond to a person's need for self-interpretation (Tekin).

This is because supporting a patient's epistemic and hermeneutical agency does not simply entail the ability to identify the other person's subjective life and its alterations as forms of distress or dysfunction. It also involves the ability to recognize the other person as a fellow human being with a fundamental need for meaningfulness, significance and belonging. In order to do so, it is important to keep in mind that, outside of the strictly medical stock of interpretive resources, patients may search for meaning in other hermeneutical contexts. This activity of searching for meaning is necessarily shaped by the collectivity of the person's values, desires, intentions and memories—as a function of her unique life story and social, cultural, and historical context. Thus, understanding a person's experience of distress and their response to it, also requires a clinician to acknowledge that they may have their own blind-spots related to cultural factors and the roots of societal disadvantage.

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[7] My thanks to an anonymous reviewer for pressing on this point, particularly the fact that all epistemic injustices are "ethico-epistemic" injustices. As further expanded in the following section, a situation of epistemic asymmetry may be unavoidable when confronted with the testimony of patients with psychosis and delusions. In these circumstances, rather than avoiding the asymmetry, it may be more helpful to think about ways of navigating and managing them with care, empathy and respect.

In order to further understand the kind of joint enquiry in which service users and practitioners are engaged, in the next section I explore the nature and meaning of the *what* (i.e. the object of communication). This exploration not only demands a particular sensitivity to the first-person perspective and a distinctive kind of empathy; it also entails a consideration of the positionality and relationality of each interlocutor.

3.2. What is the Conversation About?

In the context of psychosis, *what* is communicated is often deemed to lack meaning or to be difficult to understand. But what is the "object" that we are trying to understand?

One way in which we can understand the "object" encountered by practitioners in their clinical-epistemic interactions with people with psychosis is through a descriptive-diagnostic lens. This approach aims at identifying the signs and symptoms of illness, often through the use of a "checklist" approach (so called "operational"), which was pushed in the 1970s by a pressing need for a higher degree of agreement on diagnoses among British and American clinicians (Kendell et al.). While providing one possible way to understand the person's experience (one that worked well for Wendy Sanford in the example of post-natal depression), this approach is not free of shortcomings and may fail at promoting self-development and human flourishing (Tekin).

Among several critiques of the contemporary operationalist epistemology, phenomenologists have put forward a particularly compelling argument drawing on the views expressed by Jaspers. More precisely, the phenomenological critique is concerned with the ontology and epistemology of the psychiatric object. In this view, symptoms and signs cannot be identified or appreciated apart from a consideration of the nature of consciousness or subjectivity; in turn, subjectivity cannot be reduced to a collection of atomic entities to be accessed through "atheoretical" screening and assessment of psychopathological features. Only through a detailed exploration of the phenomenal realm can psychiatrists understand the *lived world* of the person seeking help (Parnas, Sass, and Zahavi).

While the phenomenological critique goes further and deeper than the clinical-diagnostic lens in the way of making sense of the psychiatric object (here intended as altered human subjectivity), issues of (un)intelligibility remain unsolved. According to Jaspers:

> The most profound distinction in psychic life seems to be between that which is meaningful and *allows empathy* and what in its particular way is *ununderstandable*, "mad" in the literal sense, schizophrenic psychic life […]. Pathological psychic life of the first kind we can comprehend vividly enough as an exaggeration or diminution of known phenomena and as an appearance of such phenomena without the usual causes or motives. Pathological psychic life of the second kind we cannot adequately comprehend in this way. (Jaspers p.577; emphasis original)

The kind of understanding that Jaspers alludes to is a *psychological* kind, one which requires empathy as a general precondition for the comprehensibility of others' mental states (Henriksen). Several phenomenologically inspired attempts have been put forward, to try and solve the many issues and paradoxes raised by Jaspers' notion of incomprehensibility, both in relation to schizophrenia and bizarre delusions (Henriksen; Cermolacce, Sass, and Parnas; Louis Arnorsson Sass; Parnas and Henriksen; Ratcliffe). These proposals agree on the fact that there is something wrong with a brute denial of any intelligibility of schizophrenic phenomena and work their ways towards alternative frameworks for understanding the intrinsic *strangeness* or *otherness* of these experiences. For instance, some have suggested engaging with a different kind of understanding (e.g. philosophical rather than psychological) (Henriksen) or with a radical kind of empathy (Ratcliffe; discussed in 2.1); others have suggested using a different psychological explanatory framework (e.g. ipseity disturbance) in order to fit together the different instances of bizarreness (Louis A. Sass and Byrom).

The phenomenological emphasis on *otherness* or *difference* should not be interpreted as having an ethical value, in the way of widening the symbolic and cultural inequalities oppressing and stigmatizing individuals with psychosis (Rashed). On the contrary, the stress on difference should encourage the examining psychiatrist to keep going in her attempt to understand even when such understanding seems to have stalled (Schlimme, Wiggins, and Schwartz). As discussed above, second-order or radical empathy, as incorporated into the phenomenological stance, can go a long way in expanding the range of intelligible experiences. Indeed, its application can facilitate an understanding of the transformations in the very structure of experiencing which would normally not even be a subject of reflection (let alone object of communication); it also entails an attitude of openness which allows for the possibility of mutual transformation. However, here I suggest that the phenomenological stance—as applied to the study of psychopathology—can and should be further integrated with a contextual analysis of power: that is, a consideration of *how* particular lifeworlds (both pathological and non-pathological) are shaped by social, historical and material hegemonic structures. These structures are based on a set of implicit assumptions and embodied practices which have been established over time, for instance, through colonialism, anti-Black racism, and heteropatriarchy. Guenther has offered a compelling account of the ways in which these structures are at the same time “contingent” and “quasi-transcendental”: they have developed through historical and socio-economic struggles (and are thus contingent) but have become embedded into our perceptual, epistemic and relational norms in a quasi-transcendental manner as intersubjective ways of hearing, seeing, relating etc.. In other words, as these structures become embedded in our sense-making practices, they often go overlooked and are left unexplored. This has both theoretical and practical implications:

> As long as the historical, material, social world is structured by white supremacy, consciousness – including its perceptual practices, its ways of remembering and imagining, its encounters with alterity and feelings of empathy (or lack thereof), its kinaesthetic experiences, embodied habits, and ways of moving through the world – remains immersed in the very structures that one is attempting to suspend, both to describe how they work and to interrogate them, ultimately intervening to transform or abolish oppressive structures. (Guenther)

By attending to the ways in which power and history shape the lived experience of mental illness and impact epistemic encounters, critical phenomenology adds an extra challenge to the ones addressed by a classical phenomenological stance. This challenge involves, first of all, acknowledging that hegemonic structures (such as white supremacy) are not simply static phenomena to be studied empirically or suspend; rather, they are *generative of meaning*. Depending on how one is situated in relation to these structures, they will contribute to shaping a person’s lifeworld as she engages in acts of (interpersonal) understanding and self-interpretations. What this entails for the healthcare encounter is that clinicians cannot overlook their own and their patients' *positionality* in relation to these structures, and the role of these structures in shaping the meaning of psychopathological experiences.

Therefore, special interpretive efforts are required to respond adequately and sensitively to attempts to communicate hermeneutically marginalized experiences. In the encounter with people with psychosis, these efforts should be directed not only towards explaining signs and symptoms, or subjectivity disturbances, but also towards interrogating and challenging the limits of our interpretive horizons.

By appreciating the quasi-transcendental structures that contribute to shaping meaning-making in healthcare interactions, critical phenomenology should not only engage in an individual analysis of the impact of these structures on the lifeworld of patients. Applied critical phenomenology also calls for individual and collective action to *transform* these structures in a way that breaks oppressive silences and gives appropriate recognition to a plurality of voices. While this essay focuses on localized rather than structural issues linked with hermeneutical injustice, efforts in this direction are unlikely to lead to a transformative change unless deeper engagement is sought with experts *with* significant psychiatric disabilities as well as intersecting lived experiences of other forms of structural discrimination (Jones et al.). Participatory efforts may also help redress the profound distrust that many individuals with psychiatric illnesses have towards healthcare institutions and which further erodes possibilities for collective understanding.

4. Taking a Critical Phenomenological Stance

Drożdżowicz has recently offered a well-balanced discussion of specific epistemic duties that mental health practitioners have towards their patients, arising from the need to avoid common forms of injustice. Granted that users have a certain epistemic privilege in virtue of their direct access to and knowledge of their subjective experiences, clinicians "have a *pro tanto epistemic duty* to attend to and/or solicit reports of patients' first-person experience in order to prevent epistemic losses" (Drożdżowicz). Phenomenology is well-suited for this purpose: the phenomenological toolkit is, indeed, replete with conceptual tools which may support clinicians in fulfilling these obligations as well as being a resource for patients (Carel).

In particular, person-centred dialectic approaches to the clinical encounter (Stanghellini and Aragona) already provide a hermeneutic framework for phenomenologically-informed practitioners. This involves the recognition, as previously discussed, that clinicians are engaged in complex interpretive processes—which entail a constant shift between the patient's self-interpretation of what she is feeling, and their own interpretation of what the patient is trying to articulate. On this view, which builds on the hermeneutic standpoint of the Cambridge School (Aragona and Marková), mental symptoms are not just passively imposed upon a "recipient", but rather are co-constructed in the intersubjective space created by the dialogue between patient and clinician.

As we have seen, individuals with mental disorders often start from a position of disadvantage when it comes to having adequate interpretive tools at their disposal. This is because they may already belong to a (environmentally, economically, socially, cognitively) disadvantaged group whose access to hermeneutic resources is limited, or because their interpretations are (systemically or particularly) dismissed. The plea that many have already made, that clinicians should take patients' accounts seriously, is thus of paramount importance in the assessment of psychosis (for a recent discussion on the reasons for duties of intelligibility see also, Jeppsson). The virtue clinicians should strive for is well articulated in Fricker's account of hermeneutical justice, which she defines as:

> an *alertness* or *sensitivity* to the possibility that the difficulty one's interlocutor is having as she tries to render something communicatively intelligible *is due not to its being a nonsense or her being a fool, but rather to some sort of gap in collective hermeneutical resources.* (Fricker p.169, my emphasis)

In some cases, patients may not already have the interpretive tools they need for expressing and communicating their experiences; for this reason, they should always be given the benefit of the doubt before any judgment about credibility or meaningfulness is made. In other situations, patients may be in a position of epistemic privilege, where they have developed their own interpretive resources, but these have not been accepted as authoritative by the dominant epistemic group or person.[8] In either case, clinicians should be *attentive* to the person's subjectivity and alterations thereof, as well as *alert* to the contingent historical, autobiographical and social structures shaping collective meaning-making and individual contributory practices. Pragmatically, this involves adopting a curious and critical stance towards the other's concerns, and explicitly reflecting on the communicative dynamics at play during a specific healthcare encounter.

For instance, if a communicative struggle is identified, a virtuous clinician may: actively enquire about patients' feelings of perplexity, or difficulties with linguistic expression; carefully explore their explanatory framework of hypotheses through sensitive open-ended questions and dialogue (monitoring any signs of distress this may cause); invite patients to actively participate in psychological (or philosophical) formulations; encourage them to seek support from peer workers or peer support groups; provide alternative interpretive resources and tools (in linguistic or non-linguistic forms) produced by peers with lived experience of psychosis; try alternative and creative methods for the articulation of ineffable experiences (e.g. visual, narrative and art-based methods of elicitation). Patients also share hermeneutical responsibilities, which can be supported and promoted in the context of a virtuous epistemic encounter. This interactive dimension requires users to be curious and pro-active partners in this joint search for meaning, thus, taking on themselves the role of *inquirer* (e.g. asking questions and issuing interpretations) and not just that of *informant*. Support towards undertaking these roles can be sought through individual and collective mental health advocacy. Further actions to challenge stereotypes and change attitudes can also be undertaken by patients through involvement in activist programmes or networks aiming at co-designing resources for services, co-producing campaigns, co-creating social media content, and working with policy teams or advisory boards.

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[8] The situation described here is in keeping with Mason's claim that some powerless or marginalized groups may well have the interpretive resources they need to make sense and describe their own social experiences: the problem is that dominant groups can disregard their interpretation or refuse to take up their hermeneutical resources thus wilfully perpetuating the conditions for hermeneutical marginalization.

When difficulties of expression and meaning-making are related to the intrinsic radically alien qualities of psychotic experiences (for instance, affecting the sense of reality or minimal self), concepts adapted from classical phenomenological psychopathology may be useful, as illustrated by Nelson and Sass. In this case, a 22-year-old man who experienced a catatonic episode (a group of symptoms usually involving lack of movement and communication) received psychological treatment at a youth mental health service. One day, he noticed some words relating to a phenomenological explanatory model (the ipseity-hyperreflexivity model, IHM) that had inadvertently been left on the whiteboard in the therapist's office. Adam asked about their meaning, and the therapist described the IHM model in general terms, including the concept of self-disturbance (which involves a reduced sense of existing as a subject of awareness). From the therapist's perspective:

> Adam seems to have been quite relieved to learn about this model of the illness. Indeed, it would be fair to say that the therapist experienced Adam as more enlivened than ever while discussing the IHM model and how it related to his own experience. […] The semistructured interview—with its brief descriptions of various anomalies of self-experience together with concrete examples—*provided a structure for Adam to describe his own anomalous self-experience in detail.* It also provided him with a sense that his unusual sense of self is a "recognized" disturbance in psychiatric literature, rather than an idiosyncratic or unrecognized problem. (p.497; my emphasis)

In some way, this experience of relief and recognition echoes that of Wendy Sanford, in the case of post-natal depression. Of course, we should be cautious when applying the phenomenological framework of explanation (Drożdżowicz). As with any other interpretive tools, there is always a risk of secondary forms of testimonial and hermeneutical injustice if the original description provided by the person is "forced" into preconceived categories. The clinician's task is not that of fitting the patient's subjectivity into subjectivity-disturbances (something that risks becoming akin to another operational-diagnostic move). Rather, as Gadamer suggests (1989) the task is more similar to the Socratic dialogue and dialectics, in that it critically puts into shared questioning our worldviews, feelings and intuitions in order to get as close as we can to the phenomenon itself. In interpersonal contexts, Gadamer's concept of understanding as involving a "fusion of horizons" can thus be interpreted as a dialogue that allows both participants to acquire a new perspective from which to see the subject matter—one that is grounded in and belongs to a certain experiential, linguistic, cultural and historical world (Vessey).

This move requires that we go beyond an analysis of the pre-reflective structures of experience to try and make visible those socially and historically situated quasi-transcendental structures which shape our own lived experience differently, depending on where we are situated. In order to do so, a critical phenomenological stance will entail a reflection on the patient's and clinician's respective positioning and hermeneutic resources. This may be particularly important in situations where the two do not share the same worldview or explanatory models, such as in the case illustrated by Bilu (Bilu, Witztum, and Van der Hart). Here, notwithstanding the cultural gap, the practitioner was sufficiently sensitive and attentive to the patient's mythic world to enable him to articulate his traumatic experiences and distress through the use of idioms and metaphors congruent with his Israeli ultra-orthodox cultural background. The therapy involved culturally powerful contrasting metaphors such as saint/demon and Paradise/desert, which appeared to facilitate the healing process by creating a shared metaphoric understanding of the same symbolic universe. Without the creation of this shared world of meaning, alternative possibilities for understanding, action and relationship may have been wrongfully limited.

Finally, in cases where communicative dynamics are impaired because a speaker's beliefs are judged inaccurate (e.g. delusional) with respect to the listener's own representation of reality, a degree of hermeneutical *flexibility* is required on the part of the interlocutor. This is an attitude of openness and acceptance towards the potential co-existence of competing views of the world in the absence of any ultimate truth. In this context, being flexible means being able to entertain the possibility that what someone is saying may not accurately reflect the "objective" status of some external events; nonetheless, it may carry informational value which is of significance for a particular individual in the context of their own life narrative and circumstances. As such, it should not be dismissed without considering a person's own lifeworld, their interpretive resources and the potential protective function of certain (apparently delusional) narratives.

5. Conclusion

This essay engages phenomenologically with issues of hermeneutical injustice in the encounter between mental health practitioners and patients (or service users) with psychosis. The exclusion or marginalization of service users from collective and local meaning-making practices can lead to situations where they are unable to express or communicate some distinctive and important aspects of their experience. In some cases, hermeneutical marginalization can negatively affect self-understanding insofar as it is an essential attribute of personhood to be able to make sense of oneself in relation to others and the world. As Fricker puts it:

> When you find yourself in a situation in which you seem to be the only one to feel the dissonance between received understanding and your own intimated sense of a given experience, it tends to knock your faith in your own ability to make sense of the world, or at least the relevant region of the world. (p.163)

> In certain social contexts, hermeneutical injustice can mean that someone is socially constituted as, and perhaps even caused to be, something that they are not, and which it is against their interests to be seen to be. (p.168)

Within the clinical encounter, implicit assumptions of unintelligibility and other threats to a person's epistemic agency often work against participatory meaning-making through a systematic dismissal or distortion of inchoate attempts at communicating experiences that do not yet have a shared formulation. While disagreements on a certain interpretation of reality (as in the case of delusions) may put a strain on communicative practices, I have argued that this should not be a reason for clinicians to stop *trying to understand*. To this end, I have highlighted the role of relational contexts and communicative dynamics in widening or narrowing the hermeneutical gaps created over time by certain cultural and clinical practices. I have also suggested ways in which a critical phenomenological stance may improve conditions of hermeneutical marginalization through the cultivation of virtuous clinical-epistemic habits. This stance aims for a reciprocal participation, responsiveness and cooperation between interlocutors in all aspects of their epistemic interactions. Of course, this may not suffice to completely eliminate injustice in mental healthcare. To this end, structural remedies are needed to improve social integration between epistemic communities, and work towards greater hermeneutical equality and better representation of services users in mental health research. However, applying critical phenomenology to the clinical encounter, as I have done here, is a step towards overcoming hermeneutical injustice in mental health.

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