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HERMENEUTICAL INJUSTICE IN THE ATTRIBUTION OF PSYCHOTIC SYMPTOMS WITH RELIGIOUS CONTENT

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ABSTRACT: In this paper, I argue that a special kind of hermeneutical injustice occurs when someone is not permitted to interpret their experiences in a meaning-making way. I suggest that this occurs in certain cases where the possibility that the patient has a genuine religious experience is excluded by a medical diagnosis. In such cases, it is not that an experience is incomprehensible because of the absence of a valid interpretation. Instead, one perspective is not only dominant but exclusive, so the ensuing power imbalance is absolute. I begin by introducing the notion of hermeneutical injustice and subsequent refinements that have been instrumental in applying it to psychiatry. Then I show how even though voice-hearers are liable to be victims of such injustices, the literature has neglected the specific harm done to someone whose interpretation of their own experience is obliterated because of the dominance of exclusive medical views. To illustrate this, I point to a case that evinces the harms perpetrated toward patients diagnosed with psychotic symptoms with religious content and argue that depriving persons of meaning-making interpretations of their own experiences constitutes a profound and willful form of hermeneutical injustice. I then gesture toward studies on the religious reframing of anomalous experiences through contact with a normalizing framework. Finally, I pry from a successful case a general directive toward the virtue of hermeneutical justice through the attitudes of respect to first-person authority and the hermeneutical flexibility it embodies.

KEYWORDS: Epistemic injustice, voice-hearing, medicalization, hermeneutical death, meaning-making, religious experience

PEOPLE WHO ARE diagnosed with psychotic symptoms such as hallucinations and delusions with religious content are at risk of being victims of a particularly radical form of injustice, namely, having their own interpretation of their experiences unjustifiably undermined. Although this is a form of injustice that wrongs its victims in their capacity as knowers, the harms that derive from it far transcend the epistemic and

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can potentially erode the patient's perspective and constrain their interpretive capacities and agency. Accordingly, I suggest that it is imperative that we look closely to cases that illustrate both the failures and successes in dealing with patients whose religious interpretation of their experiences gives them meaning. In doing so, we can pinpoint the theoretical flaws that give rise to such injustices and potentially dire clinical consequences.

In this paper, I thus characterize a form of hermeneutical injustice that occurs when a patient diagnosed with psychosis is denied the opportunity of interpreting their own experiences within their own religious framework. In the first section, I introduce the epistemic injustice framework and the developments that facilitated its application to psychiatry. In the second section, I offer voice-hearers as a group that is particularly liable to hermeneutical, especially contributory, injustice. In the third section, I rely on a case study of a patient presenting with psychotic symptoms with religious content to characterize the form of hermeneutical injustice I am interested in and its radical consequences, concluding that its etiology crucially depends on the unjustified exclusive disjunction between religious experience and psychopathology. In the fourth section, I present studies that offer successful cases of religious meaning-making which evince the contextual nature of the development of psychopathology by comparing the context and first-person reports of clinical and non-clinical voice-hearers. Finally, in the fifth section, I pry from a successful case of the integration of a patient's religious worldview into their treatment a general directive toward the virtue of hermeneutical justice through the attitudes of respect to first-person authority and the hermeneutical flexibility it embodies.

EPISTEMIC INJUSTICE

Miranda Fricker (2007) coined the term *epistemic injustice* to pick out a wrong done to someone in their capacity as a knower. She distinguished two kinds of epistemic injustice: *testimonial* injustice, in which someone is wronged in their capacity as a giver of knowledge, and *hermeneutical* injustice, in which someone is wronged in their capacity as a subject of social understanding. However, the use of 'injustice' here is extensive and includes any instance in which a person is maltreated, not just cases involving the unfair distribution of goods or capacities (Wanderer, 2017).

Testimonial injustice occurs when one attributes less credibility to a statement than it deserves based on prejudices about the speaker, such as gender, social background, ethnicity, race, sexuality, tone of voice, or accent. Such injustices wrong someone because the decreased credibility accorded to someone's testimony is based on concerns irrelevant to whether the speaker should be granted credibility. The credibility deficit has the consequence that a person's capacity to act as a reliable giver of information is impaired or even destroyed through loss of testimonial authority and epistemic confidence.

Hermeneutical injustice happens when a gap in collective interpretive resources puts a person or a group at an unfair disadvantage when making sense of their own experiences. The ensuing cognitive disadvantage affects different social groups unequally. Those most disadvantaged are *hermeneutically marginalized*, participating unequally in the practices that generate social meanings (Fricker, 2007, p. 6). The result is that a significant area of one's experience is obfuscated from collective understanding. So, hermeneutical injustice occurs when someone's testimony is not squarely disbelieved but when a conceptual impoverishment in a particular culture prevents that person from clearly articulating their testimony or even self-understanding (Carel & Kidd, 2014).

Fricker illustrates hermeneutical injustice with an example from Susan Brownmiller's memoir of Second-Wave feminism. Brownmiller recounts that in the 1960s, a woman named Wendy Sanford was experiencing depressive symptoms after the birth of her first child. Both she and her husband blamed her for these difficulties. A friend of hers convinced her to attend a consciousness-raising group. Wendy reminisces about the first time she encountered the notion of 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" (Brownmiller, 1990, p. 182). So, Wendy had been experiencing feelings that it was in her interest to understand and communicate. Still, she did not have adequate interpretive resources to fully understand her experience because she was a member of a hermeneutically marginalized group: the concept of postpartum depression was then missing from the pool of shared meanings.

Fricker (2007, p. 168) identifies failures of understanding as the primary harms of hermeneutical injustice, which go together with secondary harms—those that occur to the victim owing to the primary harms (e.g., loss of prestige, income, etc.). Rosa Ritunnano (2022) identifies the failures of understanding in Wendy's case as tapping into three psychological-existential dimensions wherein hermeneutical harm can occur: meaning-making (the possibility of fully understanding and making sense of one's own experience); communication of experiences to others (the possibility of adequately relaying such experiences to a hearer through a linguistic action or non-linguistic representation); and self-interpretation (the possibility that a certain understanding of experience may impact on the subject's construction of their self-identity).

In Wendy's case, a failure of understanding occurs across all three domains (and thus its ensuing harms). I agree with Ritunnano that meaning-making, communication, and self-interpretation are intimately related, so that many of our experiences are interpersonal from the beginning. As meaning-making beings, our communication serves a greater purpose than simply relaying information. It facilitates self-understanding and interpretation. Our social nature and interactions with others significantly shape how we perceive ourselves, influencing our commitments, beliefs, actions, and desires. Recognizing the deeply interpersonal nature of this process, it is crucial not to underestimate our role in constructing each other's self-understanding.

Although Fricker takes hermeneutical injustice to happen solely because of gaps in collective hermeneutical resources, it is plausible that some hermeneutical harms are actively perpetrated and not just a result of omission, be it on the part of dominant individuals or groups. Rebecca Mason (2011) thus distinguishes hermeneutical injustices that involve an absence of conceptual resources from those involving a collective refusal to give uptake to conceptual resources available in particular communities—where 'giving uptake' means responding or acknowledging the speech acts of another person or group, demonstrating that one has understood what was said (Potter, 2016, cap. 6).

Similarly, Gaile Pohlhaus, Jr. (2012) introduces the concept of *willful hermeneutical ignorance* to describe hermeneutical injustices that occur when dominantly situated knowers refuse to acknowledge epistemic tools from the experience of marginalized individuals. Pohlhaus argues that even though marginally situated knowers may notice that dominant epistemic resources are not suitable for making sense of their experiences, those dominantly situated can nevertheless "dismiss both the possibility that there is anything to be known here and any epistemic resources that might have been developed to make sense of the experienced world of those marginally situated" (2012, p. 728).

Recently, Fricker herself has recognized the importance of localized hermeneutical practices. When testimonial injustice is persistent and socially patterned, it creates and sustains a situation in which "some social groups have less than a fair crack at *contributing* to the shared pool of concepts and interpretive tropes that we use to make generally shareable sense of our social experiences" (2016, p. 163, my italics). Accordingly, Kristie Dotson's (2012) concept of *contributory injustice* picks out the idea that the marginalized cannot contribute equally to the collective understanding of their experiences because their contributions are systematically dismissed by those in a position of epistemic authority. So, while Fricker's original concept of hermeneutical injustice picks out cases where both the marginalized *and* dominant groups share a lack of resources to express or understand the former's experiences, contributory injustice picks out cases where relevant resources *have* been developed and used by the marginalized group but have not been given uptake by the dominant group.

VOICE-HEARING

Havi Carel, Ian James Kidd, and collaborators have launched the application of the epistemic injustice framework to healthcare and, especially, to psychiatry. They have pointed out that perhaps even more than the somatically ill, the mentally ill (or those judged to be) are often regarded as cognitively unreliable, emotionally compromised, or existentially unstable in ways that render their testimonies suspect (Carel & Kidd, 2014). Moreover, they have called attention to the fact that ill persons are particularly vulnerable to hermeneutical marginalization because the kinds of experiences that illness affords are often challenging to make sense of and communicate (Carel, 2013). Furthermore, reflecting the distinctions Mason, Pohlhaus, and Dotson put forth, ill persons often *can* make sense of their experience. Still, their non-dominant hermeneutical resources lack social recognition and epistemic respect (Kidd & Carel, 2017).

Consider the phenomenon of hearing voices in the absence of any speaker. Its phenomenology is diverse, involving single or multiple voices, which may be known or unknown, speaking sequentially or simultaneously in the first, second, or third person, and which may give orders, comments, insults, or encouragement (McCarthy-Jones, 2012). Voice-hearing occurs in many contexts throughout most cultures and historical periods. It is prevalent in the texts and customs of most ancient and contemporary faith traditions (Cook, 2019). And it affects around 75% of people with schizophrenia (Nayani & David, 1996). Still, while schizophrenia affects around 1% of the population (Johns & van Os, 2001), estimations of the prevalence of voice-hearing put it at approximately 10% to 15% (Pechey & Halligan, 2012; Tien, 1991). Notably, while many people who hear voices are distressed by them, being subsequently diagnosed with a psychiatric condition, and receiving clinical treatment, many are not distressed, do not look for medical treatment, and hence do not receive a diagnostic label (Verdoux & van Os, 2002).

Paul Crichton et al. (2017) indicate that stereotypes of voice-hearers as unreasonable are prevalent, which puts them at risk of being viewed as illegitimate bearers and conveyors of knowledge and thus subjected to being epistemically undermined within society (Sanati & Kyratsous, 2015). Clinical voice-hearers (i.e., those in receipt of clinical attention) also report having to explain their voices by adopting concepts that they may not feel entirely represent their experience, such as medicalized approaches. They report feeling disempowered in conversations with professionals, which causes distress and reinforces self-perceptions of being “not normal” (Lee et al., 2019). Voice-hearers may also be vulnerable to what Dotson (2011) calls *testimonial smothering*: when a speaker truncates their own testimony because of the reasonable risk of being misunderstood or the anticipated reactions from specific individuals to their testimony. For instance, consider the following report from a non-clinical voice-hearer:

> I don’t tend to tell people but it . . . it’s really hard to describe it’s like their energy towards you changes . . . I think they’ve learnt a lot of this behaviour from tv . . . I have had the question *well if you hear voices why aren’t you in a mental hospital* and that’s quite upsetting to me cause like that’s not that’s you know that’s not the place for everyone. (Harris et al. 2022, p. 959, *my italics*)

Angela Woods notes that “Before 1987, there were no voice-hearers” (2013, p. 264), although countless people were diagnosed with auditory verbal hallucinations. Woods means that the concept of *the voice-hearer* did not exist as a cultural resource available so that people could articulate and share specific experiences, values, and viewpoints until recently. This absence left a gap through which hermeneutical injustices (in Fricker’s original, structural sense) could thrive. Since then, as experts by experience, voice-hearers have established robust networks of self-help while challenging the authority and practices of experts by profession. One such service-user-led organization is the Hearing Voices Network, inspired by the work of Marius Romme and Sandra Escher (1989). In partnership with clinical and non-clinical voice-hearers, Romme and Escher promoted an approach that emphasizes accepting and making sense of the experience, providing frameworks for coping and recovery, and exploring the role of psychosocial adversity in voice onset and maintenance.

Alex James Miller Tate (2019) observes that the significant feature of HVN groups is that individuals' interpretations are not dismissed for not fitting a pre-existing theory. Instead, participants are treated as equals in a discussion encompassing the nature of voice-hearing. The concept of the voice-hearer thus asserts voice-hearing as a meaningful experience and builds identity through sharing life narratives. It also challenges the perceived authority of psychiatry as constituting a monopoly on how experiences are interpreted (Scrutton, 2017, p. 349). So, since the concept of the voice-hearer and its related tools exist now, contributory injustice occurs when clinicians and researchers refuse to give uptake to the hermeneutical tools developed by voice-hearers to understand and cope with their own voices (Miller Tate, 2019). Such an injustice does not emerge from an all-out absence of conceptual resources.

Although the hermeneutically marginalized may have to overcome more hurdles to achieve social recognition and epistemic respect, they may develop the ability to perceive and hold multiple perspectives rather than simply the dominant one (Gosselin, 2022). Working from diverse perspectives, including that of being voice-hearers themselves, researchers like Eleanor Longden and Jacqui Dillon have advocated moving past the view of voice-hearing as mere auditory verbal hallucinations. Construing distressing voices as representations of one's sense of self, they have championed a robust clinical rationale for engaging with voices that promotes more peaceful, positive interactions between hearer and voice, the reduction of dissociative divisions, and the recognition of their protective function by drawing attention to unresolved emotional conflicts (Longden et al., 2018). As Dillon summarizes, "Each voice is an echo of the person's experience, so an attitude of curiosity, understanding and compassion toward all voices is the best stance as it will encourage and support internal communication and, ultimately, self-acceptance" (2012, p. 22).

Radical Hermeneutical Injustice

Consider the following case study offered by Mohammed Rashed (2010, pp. 187–188; 2019, pp. 154–155).

"Femi" was a 29-year-old man born in West Africa. He had lived with his father in the United Kingdom for 15 years. His mother had left them two years before, but he insisted that had had no adverse effects on him. He was in good health, with no psychiatric history. He had always been religious, attending weekly sermons with his father at a Pentecostal church, and seemed keen to conform to Christian teaching. Two months before admission, Femi became disenchanted with his father's church and stopped attending sermons, finding them 'uninspiring.' Instead, he would spend hours reading the Bible. He contacted a church in his native country that emphasized an understanding of God through personal experience. Listening to recorded sermons and being absorbed in reading, his isolation grew. He stopped going to work, instead taking extended daily walks.

One month before admission, Femi began to have intense experiences wherein God spoke to him, consoling, advising, and ordering him to surrender his possessions. He also started feeling his body 'taken over' by the 'Spirit.' He did not doubt the authenticity of these experiences, but his father and his former pastor deemed his behavior harmful and excessive. Finally, a few days before admission, Femi began fasting to 'further cleanse his soul.' He was found disoriented and depleted in public, after which someone called an ambulance. When a psychiatrist and a social worker assessed him, he said he had been in direct communion with God for a month. The clinicians challenged the authenticity of the voice, but he had no doubts—he heard it not in himself but in the surrounding space, and he had finally understood God. The final assessment considered him to present with second-person auditory hallucinations, command hallucinations, volitional passivity, and significant risk to self amid social and occupational deterioration and the disapproval from his father and former church. He was placed under Section 2 of the Mental Health Act of the United

Kingdom, which allows compulsory admission for up to 28 days.

Upon admission, Femi resisted all forms of treatment. He could not understand why he was being incarcerated and saw the process as a test of his faith. One week after admission, following mental state assessments and nursing observations confirming the persistence of his symptoms, the clinicians diagnosed him as having an acute psychotic episode, upon which they felt justified in forcing medication on him. Several days later, he started to accept treatment. Two weeks later, he conceded, for the first time, that he might have been ill. He finally stopped hearing the voice of God, no longer felt the anticipation of a significant change in his life, and 'was transformed into an unsure young man: unmotivated and apathetic.' (Rashed, 2010, p. 188)

Although social and occupational deterioration did exist from the outset, *harm*—not simply incapacity but negatively evaluated experience of incapacity (Rashed, 2010, pp. 189–90)—came into the picture *after* Femi's involuntary hospitalization and forced treatment. Besides restricting his physical freedom, in Femi's case, there was the additional invalidation of his experiences and subsequent renunciation of his religious project. Rashed (2010, p. 190) concludes that the response of the psychiatric authority transformed what was a positive into a negative experience. Only after this did Femi's experiences become a problem *for him*. Although not denying that Femi and other people undergoing intense religious experiences may need support and clinical help, Rashed questions where and how they should get it. Perhaps if Femi had received support from a community (and therapists) that respected the value he attached to the experience while understanding that he was vulnerable at the time, he would not have his own interpretation of his experiences undermined.

I argue that a specific form of hermeneutical injustice occurs when individuals are denied the opportunity to interpret their experiences in a positive and meaningful way within their religious framework. In cases like Femi's, the diagnosis and treatment of psychotic symptoms with religious content can perpetuate this injustice. Femi's (very real) symptoms were interpreted solely as indicative of a psychotic episode rather than considering the possibility of a religious experience. Although the etiology of epistemic injustice often involves negative stereotypes, lack of conceptual resources, implicit biases, practices of epistemic privileging, patronizing attitudes, and wrongful (de)pathologization (Kidd et al., 2022), I propose that *interpretive exclusivism* plays a crucial role in causing hermeneutical injustice when attributing psychotic symptoms with religious content. By attributing psychosis, the possibility of the patient having a genuine religious experience is disregarded and excluded from the therapeutic process.

Why is it assumed that psychotic and religious experiences cannot coexist? More importantly, why is it assumed that the same experience cannot be a genuine religious experience *and* an instance of psychopathology (Scrutton, 2023)? Moreover, what could ever justify someone in the judgment that someone's religious experiences are illegitimate? A clinician can be justified in a judgment about social and occupational deterioration, as was undoubtedly Femi's case, but what is it about the attribution of psychosis that prevents an *inclusive* disjunction of religious experiences and psychopathology? Such interpretive inclusivism does not necessarily mean that the experience *is* genuinely religious but leaves that question open while contemplating salient epistemic and meaning-making possibilities. As Larry Davidson protests, "In the form of a tautology, once I know that you experience psychosis, I feel entitled to question the credibility of your experiences. Then, once I establish the lack of legitimacy of your experiences, I am able to infer from this that you have a psychotic disorder" (2004, p. 154).

When someone chooses to recount their experiences to clinicians and receives negative, pathologizing responses because the latter ignore the positive, meaning-making resources and contexts through which the subject interprets their own experiences, then a wrong has been done to them in their capacity as a knower. Of course, there can be valid moral, prudential, or epistemic reasons to question certain interpretations or resources. This is especially important when those interpretations hold personal significance in the present but carry potential long-term harm. If an individual suddenly experiences a religious intuition that conflicts with the values and beliefs they have upheld and defended throughout their life, it introduces a new and incompatible "trait" within their personality that may be unrecognizable to the person themselves. If the patient's interpretation leads them to plan harmful actions towards themselves or others, then the mere fact that this interpretation grants the person a sense of meaning, identity, and purpose does not justify accepting or endorsing it.

When this is not the case, however, undermining persons' meaning-making interpretations of their own experiences by unjustifiably assuming them to be exclusively psychopathological constitutes a profound and radical form of hermeneutical injustice. It is enough to shatter one's confidence in one's own ability to make sense of the world, as Femi's utterance after several days of treatment testifies: "You say I am ill, and the voice I am hearing is not from God. Am I ill?" (Rashed, 2010, p. 190). We must recognize the effects of losing one's interpretive confidence because sharing and participating in meaning-making practices is essential to a dignified human life.

Unlike paradigmatic forms of hermeneutical injustice, here it is not the case that an experience is incomprehensible because of the absence of a valid interpretation. Moreover, unlike paradigmatic cases of contributory injustice, here we bear witness to a case in which one perspective is not only dominant but *exclusive* so that the ensuing imbalance of power is absolute. Furthermore, the harms resulting from undermining persons' meaning-making interpretations of their own experiences transcend the epistemic since, as Tasia Scrutton observes, changing the way an experience is interpreted, in turn, can change how it is *experienced* (Scrutton, 2018). If an experience ceases to be interpreted in positive or meaningful terms, it may effectively cease to be so. The consequences of such attitudes are critical, not only because they close off potentially therapeutic avenues but because the framing of experiences in exclusively medical terms can amount to a self-fulfilling prophecy, as Femi's case illustrates.

RELIGIOUS MEANING-MAKING

How can someone's interpretation be respected while acknowledging that the subject may also suffer psychiatric symptoms? Voice-hearers have reported an increased ability to make sense of their experiences when they have access to ideas and concepts that enable them to understand them meaningfully. Religion often provides such a framework for understanding experience and cognitively reframing one's world (Park, 2005), with traditions operating with their own requirements for what counts as a genuine religious experience (Dein & Cook, 2015). Although certainly not every voice-hearer would classify their experiences as religious or be open to reframing them in such a manner, many do so from the beginning, and others through contact with communities that validate their experiences. In these contexts, anomalous experiences may be considered a gift that can enrich and enhance one's life. Of course, this does not take away from the fact that religion can be a source of abuse and trauma (Ramler, 2022), as well as hermeneutical injustice (Panchuk, 2020), and that religious interpretations may be imposed upon people who do not share them and would rather receive medical treatment.

Charles Heriot-Maitland et al. (2012) interviewed people who reported having anomalous experiences. They divided the participants of their study into two groups of equal size, one clinical and the other non-clinical. Participants in both groups reported religiously inflected experiences (e.g., receiving words and visions from God and spirits), so it would be impossible to identify which participants belonged to which group based solely on the content of their experiences. The authors analyzed inter-group similarities in the triggers and subjective nature of experiences, group differences in interpersonal and personal contexts, and how subjects incorporated the experiences into their lives. Importantly, they distinguished the factors involved in having anomalous experiences from those entailed in these subsequently becoming diagnosable as pathological. They found that while triggers and the initial subjective experience were similar in clinical and non-clinical participants, validating the experience was associated with a non-clinical outcome. The following accounts illustrate this difference (the first from a clinical and the second from a non-clinical participant).

> [I] relayed this experience to psychiatrists in the [hospital] and was sent for EEG tests, was told that I was hallucinating . . . this guy just didn't listen to, just obviously hadn't heard anything really that I'd said . . . I just felt that this really positive experience was just scrutinized and just not, just liked mocked. I didn't feel offended, I just thought they were being really stupid, and disregarding this kind of, yeah, really important thing. ("Holly," quoted in Heriot-Maitland et al., 2012, p. 46)

Somebody came up to me and said "well, you know, we really need to hear from you. That's a very powerful message to people, and they need to hear that message." And that did matter to me ("Clive," quoted in Heriot-Maitland et al., 2012, p. 46).

Heriot-Maitland et al. concluded that nothing in the experiences themselves determines its interpretation as a clinical condition but instead the broader personal and interpersonal contexts through which this experience is subsequently integrated. In other words, there is nothing inherently pathological in such anomalous experiences since they do not cause distress or dysfunction in every context (Scrutton, 2018). Instead, pathology emerges from experiences "when the meaning of the [anomalous] experience is failed to be acknowledged through a lack of integration with the inter-personal and background personal contexts" (Heriot-Maitland et al., 2012, p. 50).

Similarly, Olivia Harris et al. (2022) conducted the first study of epistemic injustice among clinical and non-clinical voice-hearers. They investigated people's experiences of epistemic injustice concerning voice-hearing to understand how these may differ between clinical and non-clinical voice-hearers. Whereas previous literature in this area was mainly theoretical (Lee et al., 2019; Miller Tate, 2019), their study presents empirical data on the lived experience of people who hear voices and corroborates the findings of Heriot-Maitland et al. showing that the degree of distress and impairment associated with voices relates to how individuals make sense of their experiences and how others respond to their identity as voice-hearers. Harris et al. constructed three themes related to identity, relationships, and power across the clinical and non-clinical groups and two shared themes within both groups relating to testimonial and hermeneutical injustice. Both clinical and non-clinical voice-hearers described experiencing testimonial and hermeneutical injustices, be it in clinical contexts or broader society.

Across both groups, a recurrent theme was the impossibility of making sense of voice-hearing when it first occurred due to the complete absence of shared, societal concepts which allowed for meaningful sense-making (hermeneutical injustice). Voice-hearers felt forced into using the only available concepts to put words to their experience and thus had to draw on a medicalized approach, which they felt at odds with and pressured into using (Harris et al., 2022, p. 960).

However, although both groups experienced stigma, for non-clinical voice-hearers, a "safe haven" ameliorated this impact by allowing people to connect with others with similar experiences within a non-judgmental and accepting community. In this context, participants found voice-hearing placed them in elevated positions of influence, looked up to and even revered; they reported that the voices increased their social contact, integrating them into a community where they felt cherished; and reflected that voice-hearing had positively added to their identity, giving them a sense of purpose. (Harris et al., 2022, pp. 958–959). The authors argue that this is because such communities provided a space where individuals were socially connected and held ongoing social capital due to being viewed as epistemic equals and sources of knowledge—factors that mitigate the internalization of stigma (Pyle et al., 2018).

One example of such a haven cited by Harris et al. is Spiritualist churches. In their study of British Spiritualist mediums, Elizabeth Roxburgh and Chris Roe (2014) identified themes that illuminated aspects of the mediumistic experience with therapeutic implications. Unsurprisingly, chief among these was the theme of the search for meaning or the normalization of mediumship. When Roxburgh and Roe asked their subjects how they became (or found out that they were) mediums, most reported experiences that had normalized mediumship for them, and their explanations focused on how mediumship had always been an ordinary occurrence in their lives or how it helped to construct a personal framework for making sense of reality as they experienced it.

Religious reframing of anomalous experiences through contact with a normalizing framework echoes cognitive models that hypothesize that beliefs about voices are crucial to understanding distress and maladaptive responses in pathological voice-hearing (Chadwick & Birchwood, 1994). Conversely, such a cognitive model explains why mediums tend to view their voices as benevolent and engage more with them than clinical voice-hearers (Andrew et al., 2008). A religious tradition that develops positive feelings toward one's voices can thus be therapeutic. It is thus somewhat predictable that in a study of people who had positive experiences of hearing voices, only one out of twelve subjects did not belong to a religious group (Jackson et al., 2011). Most participants felt their voice-hearing experiences were meaningful and pursued understandings other than a medical view. Meaningful reframing transformed their experience because, as one participant reported, it enabled "understanding what was happening for me, giving it meaning and breaking down the fear that I had around not knowing and thinking that I was a complete freak, really different and ill" (Jackson et al., 2011, p. 492).

HERMENEUTICAL JUSTICE

Now consider the following clinical vignette by Yoram Bilu et al. (1990, pp. 108–116):

"Avraham" was a 35-year-old ultra-orthodox Sephardic Jew who presented in a mental health office mute but extremely agitated, vehemently and repeatedly moving his arms. He was diagnosed as psychotic and prescribed medication, but as that did not have any positive effect, trauma and dissociation therapy was initiated, involving his wife in the process. His therapists, 'both secular and of European background' (1990, p. 106), learned that he had previously witnessed a terrorist attack near the Western Wall of Jerusalem. Though not injured, he was in shock and suffered from anxiety and difficulty concentrating. His wife reported that he frequently spoke about death, talked to himself, overate, cried, lost his libido, had sleep problems, and neglected himself.

Avraham talked about a figure that haunted him, whom he called 'the Black.' His description of it was congruent with that of demons in Jewish folklore—nonhuman, red eyes, and the legs and feet of a chicken. Even though they were not believers, the therapists gave him a traditional incantation to help him fight the demon. Instructed to visualize where he last saw the demon, he said it was in 'a desolate place in the desert.' They used this as a guiding metaphor for his current state and urged him to look around for signs of protection. Avraham saw a garden where the therapists suggested he could find shelter. When he walked toward it, 'the Black' appeared, trying to hold him back. The therapists asked Avraham to beckon the demon so he could capture it. Surprisingly, it was afraid to come closer, which gave him confidence.

In the following sessions, Avraham came closer to the garden. He described it as beautiful, surrounded by high walls and a gate. The therapists suggested he pray at the tomb of a *tzadik* (saint). Avraham requested his help and felt empowered by his support, but his troubles continued. Finally, Avraham cried, "I am not afraid of you! Go away!' and recited verses from the Psalms. Standing up, he gestured with his hands and legs, kicked in the air, and said that the demon had run away. The therapists urged him again to approach the garden. Avraham requested the guardian at the gate to let him in. Inside were many *tzadikim* with faces enlightened. Consistent with Jewish mythology, he said he was entering the Lower Paradise, where he met his grandfather, father, and Rabbi. The therapists suggested that all these *tzadikim* from now on would aid Avraham. Six months into the treatment, his wife said he slept well, and his previous symptoms had disappeared. On the anniversary of his father's death soon after, he visited his grave and cried there, feeling immense relief. In a 10-year follow-up, Avraham was functioning well, did not present behavioral problems, and resumed his studies at the yeshiva that had expelled him at the outset of his symptoms.

In Avraham's case, regardless of the cultural gap between him and his therapists, the latter decided that engaging with and validating his "mythic world" was crucial for successful treatment. Contrary to what happened in Femi's case, the therapists enabled Avraham to articulate his experiences and cast his symptoms in the mold of the prevailing idioms of his own background. The therapy involved culturally powerful metaphors that facilitated the healing process by creating a shared understanding of the same symbolic universe. The therapists employed traditional counter demonic measures; they engaged with 'the Black'; and they integrated the patient's language through blessings, prayers, and Biblical verses in their communications. Without devising this shared world of meaning, such possibilities for understanding, action, and relationship would probably have been lost, as in Femi's case, in which we witnessed what José Medina (2017) calls a *hermeneutical death*—the absolute erosion of the patient's perspective and radical constraint of one's interpretive capacities and agency—in the face of an exclusively medicalizing view of his experiences.

In contrast, in Avraham's case, we see a successful integration of perspectives. Because Wirtzum and van der Hart understood the therapeutic value of respecting and working with the patient's meaning-making perspective, language, and coping mechanisms, they were sensitive to the first-person authority of the patient (Scrutton, 2017). However, giving uptake to the patient's understanding of the experience and what they judge is best for them according to their own values will not entail rejecting the authority of healthcare practitioners unless one abides by an exclusivist rather than a collaborative conception of epistemic authority. As Wirtzum and van der Hart remind us, acceptance without criticism and deference without judgment are not the only options. The more fruitful but challenging option consists of scrutinizing our presuppositions about the role experients can play in understanding their own condition.

Finally, an antidote to exclusivism about religious experience and psychopathology that can prove remedial to the specific kind of hermeneutical injustice at hand is the attitude of openness that Ritunnano (2022) aptly calls *hermeneutical flexibility*. Because there is nothing against which we can verify or falsify the patient's claims that the exclusively medical view assumes are false, we should thus contemplate the co-existence of competing world views in the absence of any exclusive claim to truth. As Avraham's case demonstrates, even if what the patient is relaying is not objectively verifiable, it may carry significant informational value for the individual in their narrative. When the patient's expressions are not seen as objects but as dynamic acts of meaning that clinicians can attend to and engage with while remaining open to their inherent ambiguities and contradictions, such hermeneutical flexibility can feed into healthy discursive flexibility. As Rashed (2019) suggests, when conducting critical discourses about complex and contested phenomena such as psychosis, we must broaden our cultural repertoire beyond medical and psychological constructs and frameworks. Such flexibility constitutes the intellectually, morally, and therapeutically sound view.

Conclusion

In this paper, I have presented Fricker's notion of testimonial and hermeneutical injustice and subsequent refinements and developments by Mason, Pohlhaus, and Dotson that have been instrumental in applying the epistemic injustice framework to psychiatry. I have shown how voice-hearers are liable to be victims of such injustices, particularly contributory ones. Nevertheless, the literature has neglected the specific harm done to someone whose interpretation of their own experience is obliterated because of the dominance of exclusive medical views. Drawing on the case of Femi, I have introduced a kind of hermeneutical injustice perpetrated toward patients diagnosed with psychotic symptoms with religious content. Although one can commit similar injustices toward patients whose meaning-making interpretations are not religious, I have focused on religious meaning-making due to the overwhelming majority of non-clinical voice-hearers who successfully cope with their experiences in such contexts, as exemplified by qualitative studies that offer a pathway toward correcting medical exclusivism. Lastly, offering the case of Avraham, I attempted to pry from it a general directive toward the virtue of hermeneutical *justice* through the attitudes of respect to first-person authority and the hermeneutical flexibility it embodies. For us to correct hermeneutical injustices beyond the confines of religious communities, clinical services must provide a haven for those undergoing psychotic symptoms where they are heard, permitted access to their own meaning-making frameworks, and treated as epistemic equals. Whenever and wherever patients are silenced, constrained, and denied the opportunity of making sense of their own experiences because their perspectives are excluded from the logical space, a wrong has been done to them in their capacity to share and participate in the construction of meaning. In this paper, I have argued that this does not happen because of a gap in interpretive resources but because of the refusal to give them uptake, which ultimately stems from an implicit adherence to an unjustified interpretive exclusivism. Since the ultimate consequence of this attitude may be the erosion of a person's hermeneutical capabilities, I maintain that cases like this merit attention and further theorizing so we can flesh out the hermeneutically flexible attitudes that can aid in someone's interpretation be respected while acknowledging that the subject may also suffer psychiatric symptoms.

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