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## “Clinician Knows Best”? Injustices in the Medicalization of Mental Illness

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## “Clinician Knows Best”? Injustices in the Medicalization of Mental Illness

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### Abstract

This paper uses a non-ideal theory approach advocated for by Alison Jaggar to show that practices involved with the medicalization of serious mental disorders can subject people who have these disorders to a cycle of vulnerability that keeps them trapped within systems of injustice. When medicalization locates mental disorders solely as problems of individual biology, without regard to social factors, and when it treats mental disorders as personal defects, it perpetuates injustice in several ways: by enabling biased diagnoses through stereotyping, by exploiting and coercing people who are seen as insufficiently competent, and by perpetuating idealized conceptions of choice and control that do not take into account people’s real limitations and the social context of health. Through practices of diagnosis, treatment, and recovery, medicalization can perpetuate injustices toward people who have serious mental disorders.

**Keywords:** medicalization, mental illness, stereotypes, epistemic injustice, marginalization

### 1. Introduction<sup>1</sup>

Medicalization is “the process by which a mental or physical condition comes to be seen as a medical condition deserving of medical attention” (Reiheld 2010, 73).<sup>2</sup> Often medicalization involves putting behavior, experience, and bodies under medical control through means such as ideology, technology, and surveillance

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<sup>2</sup> Peter Conrad defines medicalization as “seeing a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it” (Conrad 1992, 211; see also Purdy 2001).

(Conrad 1992, 215–218).<sup>3</sup> Medicalization is a morally neutral concept. Medicalization can be beneficial as it provides a conceptual framework that can be useful to make sense of experience (Wardrope 2015, 344–347); this increases understanding, enables contact with others who share the experience, provides access to resources to address the experience such as through medical treatment, and de-marginalizes groups of people who have had trouble with access to resources and social support (Reiheld 2010, 80–83). Medicalization is unjust, however, when it views mental disorders chiefly as problems of individual biology without regard to social factors, seeing disorders as personal defects in the context of an individualistic, idealized view of self.<sup>4</sup> This paper focuses on ways that mental disorders<sup>5</sup> are medicalized within the United States health care system.

This paper concerns the medicalization of serious mental disorders, focusing on schizophrenia and bipolar I disorder because they both have psychotic features, which are seen as seriously undermining agency. Schizophrenia is a mental disorder that impairs cognition, perception, and behavior. “Positive” symptoms include those commonly associated with psychosis, including hallucinations, delusions, paranoia, and catatonia, as well as disorganized thought, speech, and behavior. “Negative” symptoms include social withdrawal, apathy, and inattention to personal hygiene and self-care. Bipolar disorder is a mood disorder involving episodes of mania and depression; bipolar I disorder includes full manic episodes and frequently psychotic features, while bipolar II disorder includes hypomanic episodes and longer periods of depression. Mania includes symptoms like pressured speech, racing thoughts, excessive energy, grandiosity, and delusion; depression includes symptoms like poverty of thought, cognitive dulling, low energy, apathy, and preoccupations with guilt. Both involve shifts in sleep and appetite and can involve psychosis when

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<sup>3</sup> Case studies of how certain behaviors and experiences became medicalized over time abound. See, for instance, Conrad and Schneider (1992), Hacking (1999), Reiheld (2010), and Shorter (1992).

<sup>4</sup> In order to combat some of the problems with medicalization of women’s experience in particular, feminist bioethicists have questioned the goals of medicine, arguing for a “feminist medicine” (Purdy 2001; see also Garry 2001).

<sup>5</sup> In general, I use the term “mental disorder” to refer to the clinically significant cluster of symptoms that constitutes a particular diagnostic category, while “mental illness” refers to the illness experience that some people feel as a result of having the cluster of symptoms (Bolton 2008, 277; Nordenfelt 2007, 54–59.) “Serious” mental disorders have more severe effects and so generally create an illness experience. For this reason, and because this paper is considered with “serious” mental disorders, I use the terms “mental disorder” and “mental illness” interchangeably in this paper.

delusions, hallucinations, or paranoia are present. Lifetime prevalence is estimated at 0.87% for schizophrenia and 0.24% for bipolar I disorder (Perälä et al. 2007). In the US, bipolar disorder and schizophrenia are both typically diagnosed in people who are in their late teens to late twenties, and most studies suggest that rates of diagnosis are equal among men and women (Kawa et al. 2005; Piccinelli and Homen 1997; Saha et al. 2005).<sup>6</sup>

Schizophrenia and bipolar disorder both have clear biological bases and distinctive biological profiles<sup>7</sup>, so it seems appropriate that we medicalize them. Medicalization is a problem, however, when it views mental disorders primarily as problems of individual biology without regard to social factors, and when it sees

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<sup>6</sup> Some studies indicate higher rates of schizophrenia in men than women (Messias, Chen, and Eaton 2007; Piccinelli and Homen 1997). For information about sex differences in age of onset, symptoms, course of illness, and illness behavior, see Hafner and an der Heiden (1997).

<sup>7</sup> Current science demonstrates certain biological markers for schizophrenia and bipolar disorder. Markers for schizophrenia include excessive disorganized glial cells in the brain (Bernstein, Steiner, and Bogerts 2009; Duncan et al. 2014; Takahashi and Sakurai 2013); abnormalities in dopamine and glutamate transmission (Coyle 2006; Frohlich and Van Horn 2014; Goff and Coyle 2001; Krystal et al. 2003; Olney and Farber 1995; Stone, Morrison, and Pilowsky 2007); deficits in GABAergic transmission (Beasley et al. 2005; Gonzalez-Burgos, Hashimoto, and Lewis 2010; Gonzalez-Borgos and Lewis 2008; Hashimoto et al. 2003; Volk et al. 2001; Wassef, Baker, and Kochan 2003); abnormalities in the *relationships* between different neurotransmitter systems, especially dopamine (Carlsson et al. 2001; Coyle 2004; Howes and Kapur 2009; Reynolds 2009). While schizophrenia has a distinctive biological profile, studies have recently determined that the cluster of symptoms that we identify as schizophrenia probably has multiple causal mechanisms, like autism, and in that sense represents different disease entities (Howes and Kapur 2009). Markers for bipolar disorder include abnormalities in the prefrontal cortex, including smaller left prefrontal gray matter volumes (López-Larson et al. 2002); abnormal frontal-limbic activation (Chen et al. 2011; Strakowski, DelBello, and Adler 2005); and peripheral markers related to oxidative stress, inflammation, and neurotrophins (Berk et al. 2011; Kapczinski et al. 2011). Schizophrenia and bipolar disorder share certain biological abnormalities, including reduced gray and white matter volume and increased lateral ventricular volume (De Peri et al. 2012; Hulshoff Pol et al. 2012), dysfunction in GABAergic neurotransmission (Benes and Berretta 2001; Benes et al. 2007; Fatemi et al. 2005; Guidotti et al. 2005), and various brain abnormalities in the prefrontal cortex associated with impaired executive functioning (Chai et al. 2011).

disorders as personal defects in the context of an individualistic, idealized view of self. In these contexts, medicalization obscures existing power relations and thereby perpetuates them, trapping people with serious mental disorders in a cycle of vulnerability. This paper explores the way certain medical practices and approaches involved with diagnosis, drug treatment, and recovery can perpetuate injustice. In making this analysis, I adopt a non-ideal approach advocated by Alison Jaggar.

### **1.1. Non-ideal Theory Approach**

For Alison Jaggar, philosophical analysis is done most fruitfully through a non-ideal theory approach which begins by examining actual situations of injustice in order to expose the social and political structures that lead to these injustices. Throughout her work, Jaggar has rejected ideal theory in moral and political philosophy in favor of empirically based non-ideal theory. Within a political context, she observes that traditional political theories start with an ideal of the just state and then reason from there about what is required for current political conditions to become more just (Jaggar 1983, 2014a, 2014b). Jaggar argues that this traditional approach is backwards. By assuming an ideal of agency stripped of the particularities of actual human experience, these approaches conceal and thus perpetuate potentially harmful and unjust biases. The aim of philosophical analysis ought to be to uncover such biases by examining the empirical conditions in which justice and injustice occur.

This non-ideal approach is preferred in moral contexts as well, in what Jaggar calls “feminist social ethics” (1994a) or practical ethics. Feminist social ethics politicizes everyday practices by moving them “from the private sphere to a public site” of critical inquiry (Tessman 2009, xiv). This provides a level of transparency to the practice, allowing all those who engage in the practice to examine it critically; through this critical examination, patterns can be discerned which expose power relations underlying the practice (Bar On 2009, 12–13). Some examples of politicizing everyday practices include Jaggar’s work (1973, 1994b, 2009a) on abortion and sex work and Susan Moller Okin’s work (1989) critiquing the unpaid labor women perform such as caretaking and housekeeping. In examining gendered practices that hitherto had been taken for granted, social ethics analyzes the sexist biases that underlie these practices and uses this as the basis for theorizing about these practices.

The non-ideal approach seeks to describe the world as it actually is and rejects idealized models in moral philosophy that assume perfectly rational agents reasoning about an uncomplicated world. Building on work by Jaggar (2000, 1983), Onora O’Neill (1993, 1987), and other feminist ethicists, Charles Mills (2005) distinguishes two senses of the “ideal” in ideal theory: ideal-as-normative, where theory constructs normative ideals to strive for, and ideal-as-model, where theory is

a model for practice and the ideal is a representation of the social world.<sup>8</sup> Focusing on ideal-as-model, Mills further distinguishes two senses of this modeling: in the descriptive sense, the ideal is the model that most accurately represents the world, while in the “idealized” sense, the ideal is the moral exemplar. Idealized theories abstract away from the particularities of people, including the different experiences and backgrounds they have, such as the experiences of injustice, and the ways these influence interests and choices. Ideal theory assumes an idealized social ontology, idealized human capacities, silence on oppression, ideal social situations, an idealized cognitive sphere, and strict compliance to theory (Mills 2005, 168–169). Yet how people are socially situated, what kinds of injustice they experience, and how they relate to various social institutions affects the ethical reasons and political commitments they develop (Rivera 2009). Non-ideal theory examines the basis for people’s ethical reasons and political commitments and develops theories of justice from the actual practices in which people engage.

People with privilege have the least cognitive dissonance between descriptive and idealized models, while people with less privilege experience more distance between the two.<sup>9</sup> Because philosophers constructing ideal theory tend to be more privileged, they are less likely to be aware of the distance between the two and so less able or less interested in accounting for oppression, exploitation, marginalization, and other forms of injustice in their political theory. In fact, as Jaggar (2006) points out, their intellectual position allows them to assert their moral authority and to determine for themselves how to interpret people’s lived experience rather than let people interpret their own experience; this perpetuates relations of power such as colonialism. In contrast to such dominating approaches, Jaggar advocates for “legitimate moral consensus,” which requires “moral dialogue under fair conditions” (Jaggar 1993, 82). Jaggar (1994a) recognizes that in our social world we are “living with contradictions,” as her edited volume of the same title points out. She notes that the best we can do to resolve moral tensions is “to be as

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<sup>8</sup> Laura Valentini (2012) conceptualizes the “non-ideal” in ideal theory differently. She argues that the non-ideal can be understood as partial compliance, in contrast to the full compliance of ideal theory; as realistic theory, in contrast to utopian ideal theory; or as a transitional theory in contrast to the end-state of ideal theory. These distinctions do not adequately explain the way ideal theory is silent on oppression and other injustices and the reasons why non-ideal theory can account for injustices.

<sup>9</sup> For example, in his Presidential Address to the American Philosophical Society’s 115th Central Division meeting, Charles Mills (2018) argues that Rawls’s ideal theory specifically, and ideal theory in general, is a “whitopia” (a utopia of Whiteness), which creates epistemic injustice for people of color and other marginalized groups because of the way they are distanced and marginalized from the ideal.

open and sensitive as we can to the diversity of interests and range of values involved. This in turn requires us to commit ourselves to seeking as many different perspectives as possible.” (1994a, 11) These different perspectives must include the perspectives of marginalized groups. In her work with Theresa Tobin on naturalizing ethics, she critiques the idealized reasoning of discourse ethics and proposes a case study approach that starts with “real world moral disputes in which people lack shared cultural assumptions and/or are unequal in social power” (Tobin and Jaggar 2013, 409; see also Jaggar and Tobin 2013). Philosophers pursuing non-ideal theory, like Jaggar, attempt to describe the world as accurately as possible, exposing sites of injustice, and thus highlighting differences between the actual world and idealized worlds.

In her work, Jaggar begins with people’s real-life experience of injustice, accounts for humans’ necessarily limited and partial reasoning, and theorizes for a world that includes various forms of injustice.<sup>10</sup> Jaggar’s articles that analyze the justice of everyday practices tend to follow a certain outline. They explain the social circumstances that lead to current experiences of injustice. They consider current, problematic approaches to the issue. And they propose criteria for developing a theory of justice that accounts for people’s experiences of injustice. For example, in her work on global gender justice (2001; 2002; 2005; 2013a; 2013b; 2014c), she routinely introduces data describing the current state of women’s working and living conditions; she addresses typical approaches to these conditions that are problematic; and her analysis and her proposed approaches to the issues account for the actual experiences of structural injustice faced by particular groups of women.

Modeled after Jaggar’s outline, this paper uses a non-ideal approach to examine particular sites of injustice caused by the medicalization of mental disorders and theorizes from this analysis to propose the following principles of justice in the context of medicalization:

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<sup>10</sup> In an article comparing John Rawls’s ideal theory to Iris Marion Young’s non-ideal critical theory, Jaggar (2009b) describes Young’s approach in ways that are just as applicable to her own work. Jaggar notes that rather than beginning with a comprehensive normative vision of injustice, Young reflects on particular injustices, demonstrating her philosophical priorities and a tendency to move from the particular to the general rather than vice versa. Rather than abstracting away from the particularities of people’s actual perspectives and motivations as ideal theory does, Young refers to real people whose reasoning is necessarily partial and limited. And, rather than theorizing for an impossible hypothetical world, she theorizes for the real world which includes structural inequality and cultural exclusion.

- A just approach to diagnosis must confront stereotyping and bias and must consider the social factors of behavior as well as the biological.
- A just approach to drug treatment must actively seek out patient<sup>11</sup> perspectives and encourage open dialogue between patients and doctors about treatment effectiveness, outcomes, and decisions, and it also must not exploit people for financial gain. Those in power must confront and overcome stereotypes and biases in order to trust the credibility of patient testimony, and they must make epistemic space and encourage the use of hermeneutical resources to make sense of experience.
- A just approach to recovery must take into account people’s real limitations and the ways these both create material needs and constrain choice, and it must frame mental health care as a social rather than individual good and recovery as requiring social change and not simply individual treatment.

Using a non-ideal approach, this paper looks at examples of medical practices and approaches related to diagnosis, drug treatment, and recovery and uses these to develop theoretical principles.

This paper uses a cycle-of-vulnerability model to analyze the medicalization of serious mental disorders. Susan Moller Okin (1989) initially developed this model in a specifically gendered context as a way to explain the ways in which women are trapped in a cycle of power relations that reinforce already existing inequalities. In the gendered cycle of vulnerability as it applies in the US in the early-middle twentieth century, women who were raised to prepare themselves for marriage, rather than for paid work, found themselves unable to access the resources needed to be able to leave abusive marriages; for example, they lacked the job skills required for financial independence as well as the job opportunities that would enable independence. The cause of being trapped in this way was structural: specific institutions and practices created these conditions. Alison Jaggar (2014c) applies this

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<sup>11</sup> Throughout this paper I use the terms “doctor” or “clinician” (as in “mental health clinician”) to refer to the treatment provider and “patient” to refer to the treatment receiver. The term “doctor” refers specifically to a psychiatrist. “Mental health clinician” is a more inclusive term that includes psychiatrists, therapists, social workers, and other professionals who work with clients in a mental health setting. Because one of the primary power relations examined in this paper is what we call “the doctor-patient relationship” I use the term “patient” to refer to the person who receives treatment; I prefer the term “patient” to “client” because it refers specifically to the medical context that is being examined here in a way that “client” does not. I do not favor using currently popular terms like “mental health service user” or “consumer” because of their capitalist/consumerist bias.



model to the transnational context, showing that women around the world are trapped in sets of power relations that perpetuate existing inequalities due to global political and economic structures.

I apply this model similarly here to a different population of marginalized people to show the ways that people with serious mental disorders can become trapped in a cycle of vulnerability where oppression is perpetuated through certain practices of medicalization. Some of the power relations through which medicalization perpetuates oppression include race, gender, socioeconomic status, the doctor-patient relationship, and the economic dominance of pharmaceutical companies. I identify three contexts in which medicalization traps people with mental illness in a cycle of vulnerability: when they are diagnosed according to stereotypes about who has mental illness, when they are coerced or manipulated to engage in drug treatment, and when they are subject to a framework of idealized individual choice and control that does not take their limitations and circumstances into account.

## **2. The Medicalization of Mental Disorders**

In this section, I analyze three sets of medical practices and approaches through which mental disorders are medicalized: diagnosis, drug treatment, and recovery. I show that in each of these practices, people with serious mental disorders can become trapped in cycles of power relations that perpetuate oppression. In these sites of injustice, I focus on two aspects of medicalization that contribute to this cycle of vulnerability: treating behavior identified as symptoms of mental disorders as problems of individual biology without regard to social factors, and conceptualizing mental disorders as personal defects. Coupled with negative stereotyping, and with a view of the self as individualistic and idealized, these aspects of medicalization contribute to injustices. In the interest of transparency, I want to disclose that I have bipolar I disorder; I reference my experience a couple of times as illustration.

### **2.1. Injustices in Diagnosis**

Medicalization contributes to injustices when it regards behavior identified as symptoms of mental disorders as problems of individual biology without regard to social factors, especially when this is coupled with negative stereotypes about “who” has mental disorders and what disorders look like. Many social factors go into the process of identifying someone as having a serious mental disorder; this is as true in medical contexts of diagnosis as it is in social contexts. Social stereotypes and stigmas play a huge role in our judgments of “who” has mental illness and what mental illness looks like (how it manifests).

Stereotypes are generalizations about a group of people based on a shared attribute (Fricker 2007, 30). When we endorse negative stereotypes about a group, we develop stigmas, or negative reactions toward members of the group which comprise both beliefs and affective attitudes (Courtwright 2013; Livingston and Boyd 2010; Manzo 2004; Rusch, Angermeyer, and Corrigan 2005). Often we do not hold stigmas consciously but rather through the unconscious categorization schemes of implicit bias (Gendler 2011; Holroyd, Scaife, and Stafford 2017b). In the US, people hold three dominant types of stigma toward severe mental illness, regarding people who have mental illness as dangerous and violent, as incompetent and needing to be taken care of, or as having a character flaw like lack of willpower (Corrigan and Kleinlein 2005, 16; Rusch, Angermeyer, and Corrigan 2005, 530). When we endorse the stereotype of people with severe mental illness as dangerous, we are more likely to perceive people who look or act in ways that defy social norms as scary and interpret their behavior through that lens. When we endorse the stereotype of people with severe mental illness as incompetent, we are more likely to notice the ways in which their personal hygiene and dress suggests they are not able to take care of themselves and the ways in which their behavior suggests mental disorganization. When we endorse the stereotype of people with mental illness as lacking willpower, we are more likely to notice unorthodox appearance and behaviors and to blame people for not adhering to social norms.

Stereotypes and implicit bias affect what behavior doctors pay attention to when making diagnoses. When they have preconceived ideas of what a person with the disorder looks like, they make the associated diagnoses, recognizing the disorder in the people in whom they expect to find it and not seeing it in people with whom they do not associate the disorder. For instance, in the early 1930s–50s, schizophrenia was regarded as an illness of sensitive people, such as artists, and of middle-class White women who had “split personality” (McNally 2007) and who were “driven to insanity by the dual pressures of housework and motherhood” (Metzl 2009, 37). Diagnoses of schizophrenia occurred largely among middle-class, White people, especially women. The idea that schizophrenia resulted from the pressures of daily life fits a White feminine stereotype of women becoming ill in response to stress (Metzl 2009, 37–40) and the stereotype of people who have mental illness as incompetent.

Many mental illnesses have been gendered in this way, including hysteria, which reached epidemic proportions in the late nineteenth century (Shorter 1992; Showalter 1997), and depression and anxiety today (Herzberg 2009, 47–82). While disorders such as depression and anxiety are associated more with women through cultural stereotypes, they also are in fact diagnosed more in women, not because women are too weak to deal with daily stresses but because women share a disproportionate amount of the stress of daily living (Gosselin 2014; Ussher 2010;

WHOMSD, n.d.). While women are more likely to be diagnosed with certain mental disorders, they are also more likely to have their medical needs disregarded by doctors and to have physiological problems such as pain explained away as psychosomatic (“it’s all in her head”), suggesting psychological weakness (Dusenbery 2018; see also Norman 2018). Seen through the lens of gendered stereotypes, women’s physical and psychological experiences have been typically dismissed as the product of weakness, and their testimony frequently has been discredited. Today gender disparities in schizophrenia have largely dissipated as the disorder is diagnosed roughly equally among women and men.

Schizophrenia became associated with poor Black men later in the twentieth century, as more Black men were increasingly diagnosed with psychotic illness (Jarvis 2008). By the 1960s–70s, schizophrenia became associated with hostility, aggression, and violence, behavior which was associated with young Black men seeking empowerment. In his comparison of psychiatric admissions at a state institution in Michigan, Jonathan Metzl found that people diagnosed with schizophrenia before the 1960s were primarily White, and evenly divided among women and men, while people diagnosed in the 1960s and 1970s were mostly “Negro” men. The descriptions of their symptoms were disturbingly racialized in this time period: words describing “Negroes” were largely related to aggression, hostility, and violence, while words describing Whites were more often related to indifference, flat affect, and withdrawal (Metzl 2009, 148–151). The later mid-century idea that schizophrenia was a disease of aggression, diagnosed predominantly in Black men, drew upon stereotypes of Black men as angry, scary, and violent as well as the stereotype that people with mental illness are dangerous. Doctors who expected to see paranoid schizophrenia in young Black men interpreted hostile behavior as symptoms, ignoring the social factors underlying their behavior. Studies are mixed about the prevalence of Black stereotyping among clinicians today, with some studies suggesting that White clinicians are still affected by negative stereotypes of Black men (Abreu 1999; Loring and Powel 1988; Spector 2001) and other studies suggesting that attitudes among White clinicians toward Black men have shifted away from negative stereotypes (Woods 1999).<sup>12</sup> While the

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<sup>12</sup> One study shows that British psychiatrists are less likely to view Black psychiatric patients as more violent than White patients (Minnis et al. 2001), though a study from a previous decade suggested that British psychiatrists did hold negative stereotypes toward Black men (Lewis, Croft-Jeffreys, and David 1990). It is hard to say how these findings compare to psychiatrist bias in the US, but I would guess that there has been progress in reducing at least some bias against Black men by American psychiatrists due to greater cultural awareness of implicit bias about race,

prevalence of schizophrenia in the community is equal among Black and White people, schizophrenia is still more commonly diagnosed in young Black men (Chien and Bell 2008; Minnis et al. 2001; Schwartz and Blankenship 2014).

In associating schizophrenia with middle-class White women in the early mid-century and with Black men in the late mid-century, the public interpreted behavior as pathological based on stereotyping. Because people expected White middle-class women to have nervous conditions caused by stress, and later expected Black men to be angry and hostile, such behaviors in people were more easily picked out and generalizations were made to explain them based on stereotypes. Public representations of these behaviors in media, such as magazine articles and advertisements for medicine, presented these behaviors as medical, as symptoms of mental disorder (Metzl 2009). The medicalization of these behaviors led the public to view these behaviors as pathological and in need of treatment. When patients showed up in the medical clinic, hospital, or jail, doctors recognized these behaviors as symptoms and diagnosed them accordingly. The medicalization of behaviors marked as schizophrenia was propagated in these ways by framing these behaviors chiefly as problems of individual biology.

The medicalization of behaviors like these makes it easy to ignore social factors such as stereotypes which underlie these behaviors and to ignore the way people adopt these behaviors in response to social factors. Nancy Nyquist Potter (2014) argues that Black people adopt certain behaviors, often unintentionally, in response to White culture; these then get medicalized inappropriately. For example, she suggests that oppositional defiant disorder is disproportionately diagnosed in Black boys because the criteria of the disorder pick out features of behavior that are predominant among Black young men due to social, not biological, reasons. Similarly, schizophrenia may be disproportionately diagnosed in young Black men when behaviors like paranoia are interpreted as symptoms of pathology without regard to social context. While paranoia can be interpreted as a symptom of psychosis, it can also be a reasonable reaction to certain social conditions. In a culture in which the public sees Black men as scary and violent, it is understandable that Black men would feel paranoia and feel like White people in authority, from police officers to doctors, are “out to get them” (Dottolo and Stewart 2008; Hollar 2007, 31). Arthur Whaley (2004) notes that African Americans adopt a variety of coping methods to deal with racial prejudice, some of which can resemble psychiatric symptoms; men who are psychiatric patients are more likely to have their behaviors interpreted as symptoms than as reactions to social conditions. Whaley emphasizes that in order to avoid racist bias in interpreting behavior, it is

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but, due to its pervasive nature (Kelly and Roeddert 2008), it is hard to say how far this progress stretches.

important to distinguish clinical and cultural aspects of paranoia. When behaviors and experiences are medicalized in a way that does not account for relevant social factors such as racism, treating the behaviors as merely a problem of individual biology, this obscures those social factors and reinforces existing power relations like racism.<sup>13</sup>

Implicit bias continues to inform how behavior is interpreted and diagnosed. Clinicians have more positive attitudes toward people with mental illness who have professional backgrounds and hold more negative stereotypes related to violence and incompetence toward people who do not (Lauber et al. 2006). Because psychotic illnesses are associated with lower socioeconomic class, clinicians are more likely to recognize these disorders in people who appear disheveled and impoverished than in people who are well dressed and professional. Clinicians may assume that a person who is psychotic necessarily lacks insight into their condition<sup>14</sup> and that a person who is well groomed and whose behavior conforms to social norms cannot have psychosis. When I had psychotic depression last year, some mental health clinicians were incredulous that I, as a philosophy professor, had psychotic symptoms and, as a consequence, I did not receive adequate treatment immediately. On the other hand, mental health clinicians might assume that a person who is not well groomed and whose behavior does not conform to social norms has schizophrenia when they may not. Since lack of insight is seen as a symptom of a disorder like schizophrenia, a person who “appears” schizophrenic and denies that they are having schizophrenic symptoms may still be diagnosed with

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<sup>13</sup> Similarly, the medicalization of depression has perpetuated the oppression of women by obscuring the oppressive paid and unpaid working conditions of women in many cultural contexts that leads to experiences of depression (Gosselin 2014; Ussher 2010).

<sup>14</sup> For the sake of gender neutrality, in this paper I use the pronouns “they, their, theirs” in referring to singular persons. These pronouns are becoming more acceptable to use as singular pronouns, particularly since the *New York Times* now uses these pronouns in the context of transgender individuals. My reason for using gender-neutral pronouns is to avoid invoking gendered stereotypes, including stereotypes of women having mental illness because they are weak, and of men with mental illness as being violent. I find the traditionally plural, third-person “they, their, theirs” to be less troublesome to use than other ways of attempting gender-neutrality such as “he/she” (or “she/he”) “s/he,” “he or she” (or “she or he”), or alternating male and female pronouns. Third-person, traditionally plural pronouns that are used to reference singular hypothetical persons may strike some readers as “wrong,” but they are smoother to read and avoid raising gendered issues that arise through language.

schizophrenia in part based on their denial. People who in fact have a psychotic illness may appear incompetent and dangerous when they also appear to have low socioeconomic status; people with psychotic illness who appear well groomed and of higher socioeconomic status are more typically regarded with pity or compassion, or distrusted if it is assumed that they cannot have a severe mental illness.

Using a non-ideal theory approach modeled after Alison Jaggar’s work in practical ethics, we can see that medicalizing behavior without regard to social factors traps marginalized people who are seen to have serious mental disorders in systems of oppression such as racism. Diagnosing people based on stereotypes reinforces existing power relations that marginalize people and prevents effective treatment in those who need it. From this analysis of the effects of medicalization and stereotyping on marginalized people, we can draw the following conclusions. A just approach to diagnosis must confront stereotyping and bias and must consider the social factors of behavior as well as the biological. Clinicians should become aware of their own biases and actively work to reduce not only stereotyping but also acts of microaggression that treat target marginalized people (Owens, Queener, and Stewart 2016). Clinicians have responsibilities to correct harms and mitigate costs of implicit bias by becoming aware of their own biases, controlling for beliefs and attitudes based on stereotyping, and addressing the effects of bias (Brownstein 2016; Holroyd, Scaife, and Stafford 2017a; Holroyd 2012). In addition, mental health institutions should examine the ways that their practices and policies reinforce biases and work actively to address these.

## **2.2. Injustices in Drug Treatment**

People who have mental illness are vulnerable to many kinds of injustice with respect to treatment. Medicalization perpetuates these injustices when it conceptualizes mental disorders as personal defects, which supports stereotypes of people with mental illness as incompetent and unable to make autonomous choices about their treatment. People who have mental illness are vulnerable to coercion, exploitation, epistemic injustice, and other forms of oppression by agents that exercise power over them. In this section I examine this vulnerability in two contexts. First, I show how people with mental illness are vulnerable to coercive and exploitative practices by pharmaceutical companies; next, I show how they are vulnerable to testimonial and hermeneutical injustices when doctors do not take their concerns and choices seriously. Both of these vulnerabilities stem from the assumption that people with mental illness are incompetent, which is one of the dominant negative stereotypes of mental illness.

In order to focus my discussion here, I analyze these vulnerabilities specifically in the context of antipsychotic drugs used to treat psychotic symptoms like hallucinations, delusions, and paranoia. While certain therapies have been

found useful in managing symptoms of psychosis, namely cognitive behavioral therapy (Kinderman and Bentall 2007, 279) and Acceptance and Commitment Therapy (Morris, Johns, and Oliver 2013), the dominant treatment approach is medication. In the medicalized model, recovery is conceptualized as alleviation or minimization of symptoms, and antipsychotic medicines are the seen as the first line of treatment.

Pharmaceutical companies routinely exploit, or take advantage of, patients for financial gain. For example, in recent years pharmaceutical companies have jacked up prices of essential and previously inexpensive drugs such as EpiPen (Duhigg 2017) and daraprim (Miller 2015) for no other reason than to make a handsome profit. Pharmaceutical companies often engage in morally questionable practices to increase their market, for example by marketing antipsychotics to children or the elderly when these drugs were not approved for that use (Mental Health Weekly 2013), or by widening the boundaries of diagnostic categories (Moncrieff 2014). When pharmaceutical companies exploit people based on how they are socially situated—taking advantage of stereotypes that suggest incompetence, for example—this exploitation reinforces existing power relations, supporting and perpetuating injustices. When people are considered incompetent, they have diminished credibility and are not allowed the opportunity to transcend or negotiate existing power relations, making them easily subject to manipulation or coercion. Since the initial development of antipsychotic drugs in the 1950s, pharmaceutical companies have subjected people with serious mental illness to this cycle of vulnerability when they have taken advantage of the stereotype that people with serious mental illness are incompetent in order to market and sell their drugs.

When the first antipsychotics were developed in the 1950s–60s, they were hailed as a breakthrough. Initially called major tranquilizers, these drugs were rebranded as antipsychotics because they diminished psychosis in most patients who took them (Healy 2002; Shorter 2009, 34–72). When it was discovered in the 1960s and 1970s that they worked by blocking dopamine transmission at D2 receptors, the dopamine hypothesis was developed, claiming that excessive dopamine was the cause of the psychosis characteristic of schizophrenia. The dopamine hypothesis supported the medicalization of psychosis as a defect of individual biology. While the dopamine hypothesis was scientifically problematic because the causal relationship between antipsychotics and dopamine transmission was not conclusively established (Healy 2002, 191; Whitaker 2002, 197–198), pharmaceutical companies marketed it aggressively because it supported the use of antipsychotics in the treatment of schizophrenia.

Many patients did not like taking antipsychotics because of their unpleasant effects. Antipsychotics can cause sedation, akathisia (inner restlessness), tremors, extrapyramidal effects (uncontrolled muscular movements), and excessive dry

mouth. Taking antipsychotics over the long term can cause tardive kinesthesia, severe and sometimes irreversible uncontrollable movements that resemble Parkinson’s disease. For decades, however, pharmaceutical companies, because they wanted to hold onto their market share, and psychiatrists, who were influenced by the drug companies, ignored claims by patients and their families that the extrapyramidal effects that they experienced were caused by antipsychotic drugs, suggesting instead that the symptoms were imaginary or, if they were real, that they resulted from schizophrenia (Gelman 1999). In dismissing patients’ claims, drug companies and psychiatrists asserted their dominance over patients who were seen as discreditable due to perceived incompetence, and drug companies continued to market antipsychotics in ways that exploited this perceived incompetence.

By the 1980s, tardive kinesthesia was finally recognized as a problem, and a new generation of antipsychotic drugs were developed which supposedly had fewer side effects. These drugs were branded “atypical antipsychotics”; pharmaceutical companies encouraged doctors and their patients to assume, falsely, that the term “atypical” referred to a lack of extrapyramidal side effects. By encouraging this false association, drug companies exploited patients as well as psychiatrists for the sake of profit (Healy 2002, 254; see also Moncrieff 2008). In fact, these antipsychotics too have extrapyramidal effects, though it is not clear if they can cause tardive kinesthesia.

In these situations, people who had serious mental illness were exploited due to negative stereotypes about their mental illness, and they were subject to testimonial and hermeneutical injustice as well. Testimonial injustice occurs when a person’s testimony is discredited due to possessing a trait that is stereotyped negatively; hermeneutical injustice occurs when a person is denied hermeneutical resources to make sense of their experiences (Fricker 2007; Hookway 2010). People with serious mental illness were trapped in a cycle of vulnerability in which, due to stereotyping, they were assumed not to have a credible say in their treatment options and then were not given the epistemic space or hermeneutical resources to develop or demonstrate their credibility.<sup>15</sup> When patients were forced or coerced to take antipsychotics, as they often were (especially in institutional settings), their

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<sup>15</sup> Havi Carel and Ian James Kidd (2017) describe the way people with various kinds of illnesses are subject to testimonial and hermeneutical injustices, where their testimony is discredited because of the discounting of firsthand experience and the disvaluing of emotional styles of expression, and where they are denied hermeneutical resources on account of lacking authority through third-person expertise on their condition. See also Carel and Kidd (2014), Kidd and Carel (2017), and discussion in Scrutton (2017).



desires were disregarded because they were seen as discreditable due to their illness, and so they were subject to testimonial injustice. In addition, when doctors and pharmaceutical companies denied a link between antipsychotics and extrapyramidal symptoms, they left patients without a conceptual framework for making sense of side effects they were not supposed to have. Thus, when doctors and pharmaceutical companies ignored tardive kinesthesia, and when drug companies led people to believe atypical antipsychotics lacked extrapyramidal effects, people who experienced these symptoms were denied the hermeneutical resources to make sense of their experience, so they lacked a conceptual framework with which to make claims about those experiences. Deception regarding antipsychotic side effects was both exploitative and hermeneutically unjust.

Drug treatment is a prime site of the kind of “contradiction” Jaggar identifies (1994a) that has no easy resolution. Here what seems to be in the best interests of the patient is sometimes in tension with patient autonomy (Roberts and Geppert 2004). For example, intravenous shots of antipsychotics are considered effective for treatment of acute psychosis and are often given coercively when patients are too incompetent to make decisions for themselves (Bauer et al. 2016; Bowers et al. 2012; Powney, Adams, and Jones 2012). Patients retrospectively feel mixed about having been coerced to take medicine; some feel powerless, affecting treatment outcomes (Morant et al. 2018), while some are appreciative (Greenberg Moore-Duncan, and Herron 1996; Patel et al. 2010). In addition, long-acting injectable antipsychotics are sometimes used to address medication nonadherence so that patients do not have to make decisions daily about taking their medicine (Moser and Bond 2009). Patients feel mixed about these too (Das, Malik, and Haddad 2014; Iyer et al. 2013; Uvais 2018). Reducing coercion and involving patients in decision-making as much as possible is better for treatment outcomes and medication adherence and is also more just (Danzer and Rieger 2016), but there are circumstances where coercion may still be necessary when a patient is in imminent danger of harm to self or others.

When patients do not take their medicine as prescribed, this is sometimes seen as noncompliance. Noncompliance suggests that a person’s refusal to take their medicine as prescribed is willful and deliberate and can even suggest defiance, as if the patient is trying to upend power relations by willfully opposing the doctor. There are many reasons why patients may not adhere to treatment, however, many of which have nothing to do with power relations or even willfulness.<sup>16</sup> Often

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<sup>16</sup> Some of the factors that impact adherence include symptoms that interfere with the will or rationality required to follow directions, lack of acknowledgment that one has an illness needing treatment (lack of insight, also called *anosognosia*), intolerable side effects, attachment to symptoms (i.e., symptoms are familiar and

patients struggle with adherence as part of their attempts to self-regulate and assert control over their experience (Conrad 1985; Swartz 2018b). Understanding nonadherence as noncompliance ignores these factors, framing patient experience in terms of a doctor perspective rather than a patient perspective and offering patients and doctors limited ways to understand patient experience.

Doctors understandably get frustrated when patients do not take their medicine and may try to assert their authority such as through lecturing, punishing, or coercing. Doctors easily commit “civilized” oppression, in which they perpetuate injustice unknowingly and despite good intentions (Harvey 2007). Empathetic understanding is crucial in such situations to perceive the oppression that others experience and to change one’s own behavior to avoid perpetuating injustice (Emerick 2016). When doctors do not attempt to get outside their own perspective and to understand patient experience from the patient’s perspective, they limit the epistemic space needed for genuine dialogue, and they deny patients the hermeneutical resources to make sense of their experience. Moreover, ignoring patient perspectives is counterproductive. Studies have concluded that dialogue between doctor and patient is crucial for medication adherence even when depot medications are given (Lorem et al. 2014; Patel et al. 2008), and that the quality of the patient’s relationship with their doctor in general affects medication adherence (Day et al. 2005).

Additionally, when doctors adopt negative stereotypes about their patients, they discredit their patients’ testimony about their experience. For example, female patients may be regarded as neurotic, anxious, hypochondriac, borderline, or hysterical, and their concerns easily dismissed; members of marginalized groups such as youth, elderly, people of color, and people of low socioeconomic status may be regarded as oppositional, manipulative, ignorant, childish, or irresponsible, and may be easily discredited. In such situations, patients are not regarded as credible witnesses to their own experience and so are subject to testimonial injustice through testimonial quieting. Believing that their views will be discounted, marginalized patients may decide to self-silence and not contribute to discussion, leaving uncontested and unproblematized the position and authority of the doctor, an act that Kristie Dotson calls “testimonial smothering” (Dotson 2011; see also Swartz 2018b) Through testimonial quieting and smothering, patients are prevented

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comfortable or provide a sense of meaning), lack of worth (not deserving of treatment), stigma, substance use disorders, inconsistent health care treatment, lack of affordability, cultural factors that influence people not to take medicine, and socioeconomic status that limits access to treatment and frames the meaning of treatment (Conrad 1985; Phan 2016; Buckley et al. 2007; Lehrer and Lorenz 2014; Wade et al. 2017).

from participating in discourse around their treatment. Through this they are denied the hermeneutical resources to make sense of their experience, making them subject to hermeneutical injustice as well (Swartz 2018b).

I want to be clear that in criticizing some of the ways that antipsychotics have been marketed and prescribed to patients, I am *not* arguing that antipsychotics should not be prescribed or used. They are effective at treating symptoms of psychosis for many people; for many people the side effects are tolerable and the alleviation of psychosis is worth the side effects. In the spirit of full disclosure, I admit that I take ziprasidone (an atypical antipsychotic) daily for my bipolar symptoms. I experience some of the extrapyramidal effects described above. But, in addition to silencing the voice that I used to hear, the ziprasidone organizes me and clears away the clutter in my mind so I can think clearly. To me, taking the drug is (usually) worth it, though for various reasons I sometimes struggle with adherence myself. In such cases I appreciate it when my psychiatrist invites me into conversation about my medication use instead of asserting his authority in a dominating way, as he could do. The latter approach would silence me; in addition to shutting down, I would be unmotivated to change my behavior and so the effort would be unproductive anyway. By inviting me into conversation my psychiatrist creates epistemic space for us to develop hermeneutical resources for understanding the situation together. Antipsychotics are essential for alleviating symptoms of psychosis; whether the marketing and prescribing of them is just to the people who take them depends on how these practices are done.

As we have seen in this section, treating mental disorders as problems of individual biology conceptualizes them as personal defects, which supports the stereotype of people with serious mental illness as incompetent. Using a non-ideal theory approach modeled after Alison Jaggar's work in practical ethics, we can see that viewing psychosis as a defect and stereotyping people with psychotic illnesses as incompetent enables exploitation, manipulation, and coercion of people with mental illness as well as various epistemic injustices. Through these mechanisms, medicalization perpetuates power relations by oppressing people who are already vulnerable. From this analysis of unjust approaches to drug treatment, both in marketing by pharmaceutical companies and in prescribing by doctors, we can draw the following conclusions. A just approach to drug treatment must involve actively seeking out patient perspectives (Swartz 2018a) and encouraging open dialogue between patients and doctors about treatment effectiveness, outcomes, and decisions. Those in power must confront and overcome stereotypes and biases in order to trust the credibility of patient testimony, and they must make epistemic space and encourage the use of hermeneutical resources to make sense of experience. In addition, pharmaceutical companies must avoid exploiting patients for their financial gain.

### 2.3. Injustices in Recovery

The medicalization of schizophrenia and bipolar disorder, in which these disorders are viewed primarily as problems of individual biology, supports a clinical model of recovery. In this model, the goal of recovery is the alleviation or remission of symptoms and the regaining of functioning, enabling a person to live relatively independently and to be integrated into the community (Adenponle, Whitley, and Kirmayer 2012, 109; Cooper 2007, 2012; Gill 2012, 95; Schrank, Wally, and Schmidt 2012, 133; Slade 2012, 78). Recovery is evidenced by measurable outcomes in areas such as employment, education, housing, and independence in activities like personal hygiene and self-care. For psychotic illnesses, alleviation of symptoms is achieved most efficiently with drug treatment. The widespread use of antipsychotics, especially the atypical antipsychotics which are tolerated more easily (though, as noted above, not without significant side effects), has allowed many people who in the past would have been institutionalized to live relatively independently and within the community. From the perspective of medicalization, drug treatment has been successful at enabling the recovery of many individuals with serious mental illness. While medicalization of mental disorders has been beneficial in some ways, however, it has also perpetuated injustices when it conceives of mental disorders as problems of individual biology and as personal defects, especially within a framework of an individualistic view of self with idealized conceptions of choice and control.

While the clinical model of recovery sets admirable goals, we must be careful in how we understand these goals. The goal of living independently illustrates the problems that arise when goals are made with idealized conditions in mind without regard for people’s actual situations and limitations. Since the 1960s we have seen a shift from housing people in institutions like state hospitals, to community care centers and group homes, and more recently to independent living in apartments without continuous care or supervision (Earley 2006; Powers 2017). A recent expose in the *New York Times* showed that in New York State, many people who were moved from group homes to independent living have been unable to care for themselves, living in unhealthy and unsafe conditions sometimes leading to illness or even death (Sapien and Jennings 2018). Not everyone has the capacities required to take care of themselves on their own, but the goal of living independently has been conceptualized in idealized terms as one that everyone should be capable of regardless of mental impairments (Deegan 1988, 17).<sup>17</sup>

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<sup>17</sup> The National Alliance on Mental Illness (NAMI) recommends that “based on individual needs and choices, living independently in the community should be given priority” (NAMI 2019), while the Substance Abuse and Mental Health Services

Independent living is a goal that is highly valued within an individualistic society like the US that valorizes a liberal conception of self. In this view, the self is seen as essentially a rational chooser, someone who can and has the right to choose their own conception of the good and select from an array of options what choice would best suit their interests and desires (Sandel 1996). This view of self is often idealized, valued as an ideal without reference to the constraints on choice that people actually experience (O'Neill 1993, 309). In this idealized conception of self, individual choice, effort, and responsibility are exalted, and individual actions are seen as the product of will and effort and what happens to an individual is seen as a result at least in part of their own action. Independent living is thus regarded as an achievement of individual choice and effort, while economic dependence is conceived of as laziness or ineptness (Jaggar 2002, 130). The capacity for economic independence is based on structural factors as much as personal factors, however. Some people are simply unable to work at wage-paying jobs because of the ways that jobs are structured (Terzi 2004). Many women are responsible for caretaking duties within their families that prevent them from being able to work outside the home; many jobs are structured in such a way that people with different abilities are unable to meet employment requirements. People with serious mental illness may have such severe mental impairments that they cannot meet the requirements of a wage-paying job. Some people necessarily have to rely on others' wage-earning abilities in order to survive in a capitalist economy; this includes caregivers who provide full-time unpaid care to others and the people who receive that care. In contemporary US culture, this financial reliance on others is construed as dependency (Fraser and Gordon 1997). Within a liberal individualistic framework, economic dependency is construed as inherently negative.

In the liberal framework, recovery is seen as an achievement of the individual, and goals like independent living are seen as being under the control of the person with mental illness. Failure to achieve such goals and failure to progress in recovery may be seen as bad "choices" that a person makes for which they are responsible, or as meaningless "choices" due to incompetence. The assumption that nonadherence to treatment amounts to willful noncompliance is an example of a perceived "choice" for which patients are judged and held responsible. As Alison Jaggar notes, one of the harmful aspects of the way dependency is construed in the contemporary US is that it frames economic dependence "as an individual defect of body or character, rather than as a relation between particular bodies and specific social structures" (Jaggar 2002, 130). Failures to meet outcomes of recovery may be

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Administration (SAMHSA) indicates that one aspect of purpose, a pillar of mental health, is having "the independence, income, and resources to participate in society" (SAMHSA 2019).

seen as the product of individual defects of bad choice or incompetence. The emphasis on individual choice and effort in the US leads individuals to believe that they ought to have control over their illness, and so are fully responsible for it, or to believe that they have no control over their illness and so are defeated by it (Watters 2010, 163–165). In either case, individuals with mental disorders believe that recovery is or should be up to them, and they feel blamed when they fail to get better. This self-blame negatively impacts recovery.

Transcultural studies of mental disorders show that people with disorders like schizophrenia fare better in certain cultures with less individualistic views of self than they do in Euro-American contexts, even when these are non-Euro-American subcultures within developed countries (Adenponle, Whitley, and Kirmayer 2012). Even when they lack access to Western medicine such as psychiatric drugs, people with disorders like schizophrenia often have higher levels of functioning and well-being in some developing countries than in many developed countries like the United States (Davies 2003, 35–36; Kulhara and Chakrabarti 2001).<sup>18</sup> This is presumed to be a result of lower expressed emotion in families and stronger integration into the community (El-Islam 1991; Watters 2010). In cultures that emphasize a sociocentric or relational view of self, mental disorders like schizophrenia may be experienced in less disruptive ways. This is partly a result of viewing mental disorders not as problems of the “sick” individual but rather as transient, alternative states of being which are dependent on a person’s interactions with their environment and their place in the community, and which have mixed harms and benefits (Davies 2003, 35–36; Waldron 2010, 52–55; Watters 2010). People with serious mental disorders have statistically better outcomes when they have greater social capital and when they are more integrated into family, social, and economic life (McKenzie 2008).

We might wonder if alternative models of recovery in the US are less individualistic and so are less harmful than the clinical recovery model. They are not. The other dominant model is the personal recovery model, which views recovery as a process rather than a set of outcomes, emphasizing hope, self-fulfillment, and personal meaning (Anthony 1993; Deegan 1988, 1997). Instead of symptom reduction, the goal in this model is to live a meaningful life despite one’s symptoms (Adenponle, Whitley, and Kirmayer 2012, 109–112; Davidson 2012; Gill 2012, 95;

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<sup>18</sup> This is not universally true, of course. In some areas, such as Indonesia and West Africa, people with mental disorders are shackled and abused; in others, including Russia, they receive woefully inadequate treatment (Carey 2015; Human Rights Watch 2016; Savenko and Perekhov 2014). Multiple factors account for global disparities in how people with serious mental disorders are treated; the community’s view of the self is only one such factor.

Schrank, Wally, and Schmidt 2012, 133–134; Slade 2009; 2012, 78). Rather than viewing mental illness as something bad to overcome, the personal recovery model regards it as an instigator of change and growth, with both positive and negative aspects (Slade 2012, 89). Some theorists find value in both the objective outcomes delineated by a clinical model and the subjective experience of recovery process as emphasized by the personal recovery model and propose multidimensional models of recovery that incorporate elements of both (Jacobson and Greenley 2001; Lysaker and Lysaker 2012; Whitley and Drake 2010). Like clinical models, personal and multidimensional models of recovery are individualistic, emphasizing personal will, effort, and meaning in the context of an idealized view of choice and control without deep consideration of the relational and communitarian aspects of self (Adenponle, Whitley, and Kirmayer 2012).

Clinical and personal recovery models both support a medical model of disability which sees disability as an impairment to be fixed or accommodated, a problem of the individual requiring changes to the individual. In contrast, a social model of disability sees disability as socially caused barriers for people of different abilities to participate in various areas of social life (Morris 2001; Terzi 2004). In the social disability model, society must be restructured to eliminate these barriers. A social disability model conceptualizes mental illness as a social problem to be addressed through social changes. This includes changes in our interpersonal interactions and changes in institutional structures which are stigmatizing, prejudicial, and discriminatory—for example, in the realms of employment and housing (Corrigan and Kleinlein 2005). The social disability model supports a model of health care as a social rather than purely individual good (Austin 2001; Hanson and Jennings 1995), and it is compatible with the sociocentric view of self as relational.

Using a non-ideal theory approach modeled after Alison Jaggar's work in practical ethics, we can see that idealized views of individual choice and control trap people who have serious mental disorders in systems of oppression by denying people the material and social resources to transcend their situations. Medicalized approaches to recovery (as well as personal recovery and multidimensional approaches) easily perpetuate idealized conceptions of choice and control that do not take into account people's real limitations, making mental illness a problem of the individual and recovery a matter of personal will and effort. These conceptions obscure the material needs of people who have serious functional limitations and obfuscate the importance of changing social structures for recovery. From this analysis of the effects of idealized views of choice and control propagated by dominant approaches to recovery, we can draw the following conclusions. A just approach to recovery must take into account people's real limitations and the ways these both create material needs and constrain choice, and it must frame mental

health care as a social rather than individual good. A just approach to recovery sees mental illness as a social problem requiring social change and not simply as an individual problem requiring individual treatment. Moreover, American society would treat people with serious mental illness more justly if it endorsed a sociocentric view of self and provided more social capital so that people with mental illness would have more support, resources, and opportunities.

### **3. Desiderata for Good Approaches to Medicalization of Mental Disorders**

In this paper I have shown that practices involved with the medicalization of serious mental disorders can subject people who have these disorders to cycles of vulnerability that keep them trapped within systems of oppression. When medicalization locates mental disorders primarily as a problem of individual biology without regard to social factors, it enables biased diagnoses through stereotyping. When it conceives of mental disorders as defects of the person, it endorses a stereotype of people with mental illness as incompetent, which enables the exploitation, manipulation, coercion, and epistemically unjust treatment of people with serious mental disorders. And when its view of disorders as problems of biology supports a liberal view of the self as ideally individualistic, it reinforces idealized conceptions of choice and control that do not take into account people’s real limitations and views recovery as change that must occur within the individual rather than within society.

This paper has made a justice analysis of practices of medicalization through a non-ideal theory approach of examining places where people have experienced injustice due to medicalization, and theorizing from that analysis to develop principles of justice. From this analysis we can make the following recommendations:

First, the most obvious point to make here, and one that ought to go without saying but somehow needs nonetheless to be said, is that pharmaceutical companies should not exploit patients for financial gain, and the US government should change marketing and health care access policies that permit such exploitation.

Second, clinicians should be acutely aware of the power relationship in which they have significant authority over their patients. They should be mindful of the ways that, however inadvertently, they can dominate or oppress their patients, such as through stereotyping, asserting their moral and epistemic authority, and endorsing idealized views of individual choice and control. Just as we all should, clinicians should confront actively the ways in which they perpetuate “civilized” oppression and work on changing their attitudes and behaviors accordingly. Medical practices and institutions should be restructured in ways that avoid stereotypes, encourage patients to assert more epistemic authority, give patients hermeneutical



resources and epistemic space to make meaning of their experience, and take into account the real limitations that constrain patient choice.

Clinicians should develop self-awareness of their own biases, including gender, racial, and socioeconomic stereotypes about who has certain mental disorders as well as stereotypes about people who have mental disorders (Gosselin 2018). This means being attuned to negative beliefs or affective reactions they hold and correcting for these. Stereotypes are promulgated through shared reality bias, which is the convergence of beliefs and attitudes that become so dominant that they silence other perspectives (Anderson 2012, 170). By developing epistemic virtues of open-mindedness, epistemic conscientiousness, and epistemic humility, clinicians are able to recognize and challenge shared reality bias and be open to having their perspectives challenged, despite their medical authority.

Clinicians should also actively seek out marginalized voices and alternative perspectives that make nonstandard meanings of experience. This requires developing hermeneutical sensitivity (Medina 2013), in which we are attentive and responsive to nondominant perspectives. Mental health clinicians can use a phenomenological tool kit in which they bracket the natural attitude toward illness, thematize illness, and examine how illness changes a patient's being in the world in order to better understand their patients' experiences (Carel and Kidd 2014).<sup>19</sup>

I fully acknowledge the practical difficulties with enacting my proposals for clinicians, as clinicians usually have very limited time with patients, heavy caseloads, and abundant paperwork. Developing awareness of bias and how injustices are perpetuated is not necessarily time-consuming, although it does take some conscientious effort to pay attention to and monitor one's attitudes and behaviors and to try to change them accordingly. Adopting a phenomenological toolkit and seeking out patient stories that have nonstandard meanings may take time and energy to learn and implement but will become second nature with practice. Postgraduate education programs could teach and foster these behaviors so clinicians can incorporate them into their practice with greater comfort and ease.

On the patient side, patients should create self-narratives that make meaning of their experience from their own perspective in order to develop a self-concept that goes beyond diagnostic identity (Tekin 2011). In this way, patients can take control of their experience by framing it on their own terms. These can be written narratives or stories they carry with them as they engage in clinical encounters. Patients should be willing to share these narratives and make efforts to

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<sup>19</sup> My recommendations here are compatible with a narrative medicine approach (e.g., Brody 2003; Frank 1995; Nelson 2001), but my proposal incorporates awareness of, and response to, epistemic justice issues more robustly than narrative medicine approaches traditionally do.

share them in contexts where it seems appropriate. Offering to share their narrative is a way of reclaiming power in an otherwise lopsided power relationship where the clinician and the medical establishment in general has the most authority. When the patient’s perspective differs from the dominant (i.e., clinician) perspective, it is a counternarrative (Nelson 2001) and can be used to claim recognition (Radden 2012).

Finally, as a society we should move away from an individualistic conception of self as essentially a rational chooser, with idealized notions of choice and control, and toward a sociocentric view of the self as essentially relational. We need to strengthen various forms of social capital so that people with mental disorders have more support, resources, and opportunities as they live with their disorders. We also need to adopt more supportive ideologies. In addition, patients need the hermeneutical resources, such as a rights framework, to make claims regarding their health care needs and treatment.

All of these points need to be developed in significantly more detail than I can give here. I hope I have shown some ways that medicalization of mental disorders can perpetuate injustices and pointed to ways that we can try to address these injustices by changing how we approach medicalization.

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