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Epistemic Injustice and Suicidality

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EPISTEMIC INJUSTICE AND SUICIDALITY

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I. INTRODUCTION

Suicidality is defined as ongoing thoughts, ideations, desires, and behaviors to kill oneself. In the United States, suicidality is considered to be an outcome of a diagnosed or undiagnosed mental illness.¹ Indeed, the contemporary bioethical discussion that could approach a more philosophical and theoretical understanding of mental illness and its relation to suicidality has difficult run-ins with our common societal perception of mental illness and its relation to suicidality. This can be explained in one of two ways. Perhaps, bioethicists have shied away from making arguments regarding mental health and illness.² Or, more likely, bioethicists feel as though they are trapped within a landscape crowded with, what seem to be, medically indisputable truths on the rationality and decision-making capacity of mentally ill patients, ultimately creating barriers for them to craft controversial and cutting-edge claims that challenge the current understanding of suicidality.³

This article intends to contribute to the ongoing bioethical discussion regarding mental illness and suicidality. More precisely, I will first define what I mean by suicidality and its relation to mental illness before then qualifying the population to which I hope to extend this argument. Next, I outline Miranda Fricker's classic framework for epistemic injustice within Kidd and Carel's paper "Epistemic Injustice in Healthcare."⁴ Following that, I offer an account of how the stigma toward suicidality is inextricably tied to the medicalization of the act of suicidality itself. I argue that suicidal people are especially vulnerable targets of epistemic injustice in the United

¹ American Psychiatric Association. 2019. "Suicide." Accessed April 12. <https://www.apa.org/topics/suicide>

² Arthur Robin Williams. "Opportunities in Reform: Bioethics and Mental Health Ethics." *Bioethics* 30, no. 4 (2016): 221-226.

³ Janet R. Nelson. "Bioethics and the marginalization of mental illness." *Journal of the Society of Christian Ethics* (2003): 179-197.

⁴ Ian James Kidd and Havi Carel. "Epistemic injustice and illness." *Journal of applied philosophy* 34, no. 2 (2017): 172-190.

States healthcare system⁵ and I offer examples of both testimonial injustice and hermeneutical injustice in the modern day. These examples are taken from scholarly sources as well as the ethnographic data and results I have personally collected in my two previous research projects titled: “Suicidality from the Perspective of the Mental Healthcare Professional” and “An Ethnographic Inquiry into the Attitudes and Perceptions of Suicidality from Survivors of Suicide.”

The central goal of my project is to draw attention to the ongoing and pervasive epistemic injustice experienced by suicidal people. The phrase “suicidal people” in this paper will be defined as people who have lived experience of suicidal behaviors, ideations, and tendencies who have adopted those lived experiences into their internal identity, meaning that they would not know who they are without the passive or active desire to kill themselves. Although separate from the central argument, I argue that this specific population of suicidal people can fulfill the rationality requirements set for physician-assisted suicide and therefore ought to be allowed to participate in ‘Death with Dignity’ programs.

II. SUICIDALITY

The World Health Organization,⁶ the American Psychological Association,⁷ and the American Psychiatric Association⁸ all claim that suicide is preventable, and therefore, ought not to occur. When a suicide does transpire, it is considered to be an unfortunate failure of the deceased’s family, friends, and mental healthcare system. Moreover, suicide, in our social

⁵ Although this framework can be applied to healthcare systems across cultures, I choose to focus on the United States mental healthcare system for many of the tangible consequences for being suicidal in the United States are unique to the United States itself. Some of these consequences are listed later in the paper.

⁶ World Health Organization. *Suicide*. Accessed on November 7. <https://www.who.int/news-room/fact-sheets/detail/suicide>.

⁷ American Psychological Association. “Suicide.” Accessed on November 7. <https://www.apa.org/topics/suicide>.

⁸ American Psychiatric Association. “Suicide.” Accessed on November 7. <https://www.apa.org/topics/suicide>.

perception, is also inextricably tied to our social understanding of mental illness.⁹ In the past year alone, the suicides of Kate Spade and Anthony Bourdain were immediately met with Twitter and Facebook statuses lamenting the tragedy of unchecked and untreated mental illness. Our immediate social response to suicide is to equate it to mental illness, rendering any desire to kill oneself an irrational act that is counterintuitive to our evolutionary and social purpose; suicidality rips us away from our loved ones and our biological life. Ultimately, when we deem the act or attempt of suicide as merely a mistake made to end a "false sense of suffering," we simultaneously render suicide to be a medical issue to be resolved, with little to no concern for the existential aspects found within the plight of a suicidal person.

Of course, suicidality and mental illness frequently *do* present in tandem with one another. Therefore, I will not (nor can I attempt to) argue that suicidality is always a stand-alone behavior. However, it is an underlying assumption of this paper that, albeit infrequently, mental illness is not a necessary condition for suicidality. Moreover, the existential aspects of suicidality are evident, especially to those of us who have struggled with suicidal thoughts, behaviors, ideations, and tendencies. It is integral to my argument that I address the fact that people who experience and are affected by suicidality frequently grow to identify internally with the experience and thought process of the desire to kill oneself. In other words, people who are suicidal, within the population parameters I will outline next, frequently adopt this lived experience into their identity, similar to others who adopt experiences and behaviors into their understanding of themselves. Take, for example, Mia, a 25-year-old soccer player who has played the sport since she was four. Although she can visit coffee shops and not be clocked for her identity as a soccer

⁹ Clare E. Harris and Brian Barraclough. "Suicide as an Outcome for Mental Disorders: A Meta-Analysis." *British Journal of Psychiatry* 170, no. 3 (1997): 205–28.

player, Mia still may understand that without soccer, she is not entirely herself; the chronically suicidal person strikes me as no different.

However, there are many instances, if not the vast majority, in which the suicidal person is irrational and suffering from the cognitive impairment of a crisis episode. An episode of this type is known to distort the reality of the sufferer, making their outlook on life at that moment overwhelmingly bleak. Mental healthcare professionals and crisis intervention volunteers receive training to talk people down from these metaphorical "crisis cliffs." The National Suicide Prevention Line for the United States of America claims that these "crisis cliffs" are sudden, short-lived, and preventable. During a personal crisis, people often experience hikes in anxiety and feelings of hopelessness. I argue that people who are in a crisis episode or are teetering on the edge of a "crisis cliff" are both epistemically unreliable¹⁰ and do not identify internally with suicidality and therefore do not fit into my proposed population parameters.

Moreover, suicidality is frequently experienced in the years of adolescence. Once again, it is well known, or at least commonly believed, that in young people the developing brain is especially susceptible to poorly estimating the consequences of their decisions.¹¹ There are a few explanations for this: the temporal lobe, the decision-making center of the brain, is not fully developed.¹² Or, the emotional intelligence of a young person has not yet been exercised enough to control overreaction in instances that do not require the magnitude of a crisis episode.¹³ With both of those beliefs held as standard in the United States, I do not desire to extend my argument

¹⁰ The Mayo Clinic. "Suicide and suicidal thoughts." Accessed April 12. <https://www.mayoclinic.org/diseases-conditions/suicide/symptoms-causes/syc-20378048>

¹¹ Sara B. Johnson, Robert W. Blum, and Jay N. Giedd. "Adolescent maturity and the brain: the promise and pitfalls of neuroscience research in adolescent health policy." *Journal of Adolescent Health* 45, no. 3 (2009): 216-221.

¹² *Ibid.*

¹³ Yale Center for Emotional Intelligence. "Emotional Intelligence Education Has a Role in Suicide Prevention." <http://ei.yale.edu/emotional-intelligence-education-role-suicide-prevention/> Accessed on November 13, 2018.

to people under age 25 because, they too, fall into the population that is epistemically unreliable, despite their adoption of suicidality into their lived experience.

Finally, this thesis excludes some people who are considering physician-assisted suicide for a terminal physical illness. Although these people do want to kill themselves, in most cases, I interpret this experience as a different manner of desiring death, as it is not standardly incorporated into their identities.

III. EPISTEMIC INJUSTICE

In her book, *Epistemic Injustice: Power and ethics of knowing*, Miranda Fricker argues that the dominant discourse or epistemic authority often excludes and or refuses to recognize the testimony of marginalized people to the extent that the greater hermeneutical resource is left with gaps or lacunas of knowledge of the marginalized and oppressed.¹⁴ Fricker calls this phenomenon “epistemic injustice.” Kidd and Carel extend this framework to ill people within developed nations’ healthcare systems.

Both accounts argue that “[these] social and epistemic practices are integral to our rationality, identity, agency, and dignity, it is evident that injustice which harms our testimonial and hermeneutical capacities will be a source of great harm.”¹⁵ That is, when epistemic injustice goes unchecked, the harm to the epistemic minority is one that alienates their confidence and capacity as a knower of their own experience.

a. POWER, PREJUDICE, AND STEREOTYPES

A necessary condition for Fricker’s epistemic injustice is her conception of social power.¹⁶ More specifically, it is a form of passive, agential, identity power that a social agent

¹⁴ Miranda Fricker, *Epistemic Injustice: Power and the ethics of knowing*. Oxford University Press, 2007. 12.

¹⁵ Kidd and Carel, “Epistemic Injustice and Illness,” 175.

¹⁶ Fricker, *Epistemic Injustice* 31.

(the epistemic authority) passively and systemically enacts upon a less powerful agent, i.e., a “social other.”¹⁷ This power dynamic then directly contributes to and exacerbates the preexisting prejudicial or stereotypical understanding of a person’s epistemic credibility or reliability.¹⁸ These prejudices often operate “without any focused awareness” and are “culpably resistant to evidence.”¹⁹ They are therefore irrational but persist and disseminate further solely because of the agent’s powerful identity.²⁰ These stereotypes within Fricker’s initial framework connote psychological fragility, predisposition to lie or exaggerate, social vulnerability, etc.

Kidd and Carel argue that the stereotypes and prejudices ill people face are unique to the medical setting. For example, doctors (the powerful social agent) typically assume that their patients (the social other) are suffering from: “incapacitation, disability, diminished agency, social vulnerability, psychological fragility, and bodily failure” of some sort.²¹ These medical prejudices connote different derogatory perceptions of the ill than typical epistemic injustice. Kidd and Carel believe that the root of these prejudices is a diminished *sense of relevance* of the ill person; the ill lack the ability “to determine which ideas are worth taking seriously, which objections are meritorious, and so on.”²² Ordinarily, these stereotypes are implemented the moment a patient speaks to their pain, discomfort, and illness. Kidd and Carel argue that the concerns about the patient-physician relationship, the efficacy of medical care, and public trust in medicine can be usefully reframed in terms of fundamental epistemological problems.²³ Consequently, epistemic injustice in healthcare is the result of the doctor’s preference for the

¹⁷ Ibid.

¹⁸ Ibid., 33.

¹⁹ Ibid., 34.

²⁰ Ibid.

²¹ Kidd and Carel, *Epistemic Injustice and Illness*, 176.

²² Ibid., 180.

²³ Ibid., 174.

biomedical approach to illness that “focuses on the biological rather than the existential.”²⁴ These “task-based”²⁵ biomedical approaches hinder the opportunity for sustained, meaningful contact between healthcare professionals and their patients, that would hopefully mitigate the “erosion of epistemic confidence and capacities of the ill person.”²⁶

Therefore, in both frameworks, if the prejudice or stereotype is in place during the time of the initial epistemic exchange, the dominant and powerful non-marginalized person will then assume, because of the stereotype or prejudice, that the person with whom they are speaking is not their epistemic peer and will, therefore, discredit their testimony as epistemically unreliable.

b. TESTIMONIAL INJUSTICE

Epistemic injustice is principally caused by the prejudicial assumptions mentioned above. The first kind of epistemic injustice is testimonial injustice. Broadly speaking, prejudicial dysfunction in testimonial practice can be of two kinds. Either the prejudice results in the speaker receiving more credibility than they otherwise would have — a credibility excess — or it results in the speaker receiving less credibility than they otherwise would have — a credibility deficit.²⁷

These credibility assessments happen quickly and are often attributed to our initial understanding of the agent. If there is a credibility excess given to the epistemic minority, testimonial injustice is unlikely to occur. If there is a credibility deficit, testimonial injustice is likely. Testimonial injustice then is when an agent's word is not given the credit it deserves, as we now know, because of a preexisting prejudice, e.g., “women are irrational and hence are uncredible.” Therefore, despite a testimony that was both accurate and truth-seeking, it may not

²⁴ Ibid.

²⁵ The “task-based” medical model is exacerbated by the idealized professionalization of medicine.

²⁶ Kidd and Carel, “Epistemic Injustice and illness”, 177.

²⁷ Fricker, *Epistemic Injustice*, 33.

be considered the "truth" because the epistemic authority discounted the testimony due to a commonly held stereotype.

Similarly, Kidd and Carel claim that doctors and physicians are the dominant epistemic authority when it comes to illness and disease, and through their social standing, they allow prejudice to degrade ill patients' "epistemic peer" status to that of mere "epistemic objects" because of their own doubts to their patients' credibility as knowers of the medical aspects of their afflictions. The following quote from Kidd and Carel further elucidates this phenomenon:

...ill persons are often subjected to one or more of a range of negative stereotypes, which, though diverse, often include attribution which tends to undermine their epistemic competence and capacities...Such negative stereotypes will therefore prejudicially deprive ill persons of the prerequisites of reliable epistemic conduct... the consequence of this negative stereotyping is that patients' testimonies are unjustly accorded lower degrees of epistemic credibility that they otherwise would.²⁸

Kidd and Carel then utilize Gaile Pohlhaus's more recent configuration of the harm of testimonial injustice: truncated subjectivity. That is, the ill person, because of preexisting prejudices, is regulated between "epistemic other" and "epistemic object."²⁹ Patient testimonies are only sources of factual information, and anything beyond the factual is reduced to menial emotional concerns, thus, objectifying patients' bodies by considering only the parts of their testimonies that are deemed biomedically valuable.

²⁸ Kidd and Carel, "Epistemic Injustice and Illness," 178.

²⁹ Ibid.,179.

c. HERMENEUTICAL INJUSTICE

Fricker then moves to explain the second type of epistemic injustice: hermeneutical injustice. The word “hermeneutical” stems from “hermeneutics,” which is defined as the theory and methodology of interpretation. Therefore, hermeneutical injustice is signified by a lack of knowledge or information that would be utilized to evaluate, understand, and interpret testimonies. This kind of epistemic injustice is due to preexisting lacunas within the greater hermeneutical resource that ultimately makes it difficult for the dominant epistemic group to realize that an epistemic injustice is occurring, simultaneously harming the target's capacity as a knower. This is known as hermeneutical marginalization.³⁰ The consequence is the inability for the epistemically marginalized to understand their own lived experience beyond what the epistemic authority tells them, harming their confidence and capacity as knowers.³¹ These marginalized people are rendered unable to make sense of their experiences because they lack the adequate hermeneutical resource to evaluate their experiences properly.

Moreover, the epistemic authority (i.e., the “marginalizers”) cannot recognize or respond to the concerns and experiences of the ill because they too lack the hermeneutical resource to evaluate the existential experience of the social other accurately.

In accordance with Fricker, Kidd and Carel believe that ill persons are especially vulnerable to hermeneutical injustice. Within the case of illness, hermeneutical injustice arises because the resources required for understanding the ill persons' plight are not accepted as a valuable part of the dominant hermeneutical resource.³² This healthcare specific hermeneutical injustice takes hold of physicians through two types of strategies. These are known as strategies

³⁰ Fricker, *Epistemic Injustice*, 153.

³¹ *Ibid.*, 155.

³² Kidd and Carel, “Epistemic Injustice and Illness,” 184.

of exclusion, in which the hermeneutically marginalized group is excluded from practices and places where social meaning is made and legitimized³³ and strategies of expression, in which the social group is excluded because, as Fricker argues, its “characteristic expressive style [is not] recognized as rational and contextually appropriate.”³⁴ Ill persons, according to Kidd and Carel, are excepted and discounted from participating in creating medical and social meaning. They are non-dominant and not respected as accurately making sense of their medical experiences and illnesses.

The harm is then a “double injury.”³⁵ The hermeneutical marginalization of ill people makes their epistemic experience both inarticulable and ineffable; meaning that the ill person’s marginalization is exacerbated because they cannot accurately or adequately speak to their experience within the modern biomedical understanding of the illness.³⁶ Kidd and Carel argue that this is why many ill people turn to artistic forms of communication and expression as well as other groups who have had similar experiences, e.g., chronic pain groups. Both the inarticulacy and ineffability caused by the hermeneutical marginalization creates an epistemic environment that lends itself to the eventual epistemic isolation of the ill person. That is, the ill person fully understands what is going on with their body, and yet, they are unable to receive uptake from those around them, specifically those who are supposed to help heal and guide them through the process, their doctors and physicians.³⁷

³³ Ibid.

³⁴ Ibid.

³⁵ Ibid., 185.

³⁶ Ibid.

³⁷ Ibid., 186.

IV. THE MEDICALIZATION AND PREJUDICES OF SUICIDALITY

I maintain that the medicalization of suicidality directly contributes to a decreased sense of relevance of the suicidal person that directly lends itself to the stigmatization and prejudice of suicidal person. Following Fricker and Kidd and Carel, I argue that this prejudice ultimately leads to both the testimonial and hermeneutical injustice of the suicidal person. Medicalization is a process by which human conditions and problems become defined and treated as medical conditions.³⁸ The medical model of mental health is known and understood as the initial medicalization of individuals whose mood and behavior deviates from the norm. In the modern day, the medical model has become the standard. Someone who displays symptoms of depression (e.g., extreme fatigue, loss of interest, feelings of hopelessness, etc.) has very little options beyond treatment from a medical professional. The treatment of mental illness is considered to have two parts: the first being psychotherapy (talk therapy with a licensed psychologist or therapist), and the second being psychopharmacology (pharmaceutical intervention, e.g., an SSRI or mood stabilizer).

Suicidality is now formally medicalized. The DSM-V in 2014 adopted “Suicidal Behavior Disorder” as a diagnosis for anyone who exhibits or presents with suicidality.³⁹ The diagnosis can be considered comorbid, but it can act as a stand-alone diagnosis. Therefore, any instance of suicidality beyond our social perception becomes an act of mental illness/behavior disorder.

The consequences of having a documented suicide attempt, involuntary commitment, or severe chronic suicidality are actually quite depressing.⁴⁰ Ethnographic data quotes individuals who have previously been suicidal as being turned away from the United States Army, turned

³⁸ Peter Conrad. "Medicalization and Social Control." *Annual Review of Sociology*. (1992): 212.

³⁹ Maria A. Oquendo and Enrique Baca-García, J. John Mann, and José Giner. "Issues for DSM-V: suicidal behavior as a separate diagnosis on a separate axis." (2008): 1383-1384.

⁴⁰ Pun intended.

away from the United States Peace Corps, prohibited from owning a gun, and being banned from signing one's own Do Not Resuscitate order.⁴¹ Although these consequences are documented in other instances in which the mental fitness of a person is called into question (i.e., people with dementia, Alzheimer's, and schizophrenia), one would think that suicidality is often unlike these other conditions as often they occur during the previously discussed crisis episodes i.e., they occur once, during an emotionally overwhelming time and then never again.

The injustice suicidal people face grows clearer, regardless of whether or not it is adopted into their identity. However, to remain within the scope of the paper, I only mention these consequences to note that the assumptions stemming from the medicalization of mental illness and suicidality are harmful. Moreover, I argue that the liability concerns of organizations like the United States Army and Peace Corps, along with the doubt physicians feel when treating a suicidal patient are the direct result of the epistemic injustice incurred to suicidal people in the United States mental healthcare system.

The recent creation of "suicidal behavior disorder" may foster an understanding that suicidality is comparable to severe mental illnesses like dementia and schizophrenia. I would be remiss to neglect the ramifications of medicalization on a sociological and philosophical scale. Michel Foucault grew increasingly concerned about the medicalization of society in his *Birth of the Clinic*. Essentially, Foucault argued that the act of medicalization would develop into a powerful and insidious form of social control.⁴² Peter Conrad sustained this critique in his "Medicalization as Social Control," outlining the negative consequences of the medicalization of

⁴¹ Mad in America, a non-profit organization dedicated to restructuring the modern understanding of mental illness, collects these narratives. Also, see involuntary commitment laws under *Parens Patriae*.

⁴² Michel Foucault. *The Birth of the Clinic*. Routledge, (2002).

deviant social behaviors.⁴³ Conrad even mentions suicidality and argues that medicine has dislodged religion as the dominant moral ideology and that:

[m]any conditions have become transformed from sin to crime to sickness... Although physicians had little to do with it, social responses to suicide were secularized in the eighteenth century due to a general loss in confidence in diabolical powers; suicide was more or less medicalized by default.⁴⁴

The remaining parts of this paper aim to critique the medicalization of suicidality but are also dependent on the medical model of mental illness.⁴⁵ Therefore, I remain neutral, at least for the purpose of this paper, on whether or not the medicalization of mental illness itself is problematic.⁴⁶ I choose to place my argument within the context of the biomedical model of mental illness, only because that is where the current conversation exists. Consequently, if there are ways within the system that we can push back against injustice, we ought to do so in the present. I leave more revolutionary, radical, and disruptive arguments for my future work — as well as others concerned with science, psychiatry, and social justice.

V. TESTIMONIAL INJUSTICE AND SUICIDALITY

The question is whether suicidal people are especially vulnerable to testimonial injustice, more so than general ill persons. My answer is that they are. Suicidal people and suicidality writ large are immediately stereotyped and stigmatized the moment that the word suicide is uttered,

⁴³ Peter Conrad. "Medicalization and Social Control," 213.

⁴⁴ Ibid.

⁴⁵ Recall that my argument focuses on the instances in which suicidality can, theoretically, occur independently of the irrationality present in our everyday conception of mental illness.

⁴⁶ Specifically, the clearest cut cases of mental illness, those in which there is medical proof that someone's brain is poorly producing or taking-up serotonin, norepinephrine, or dopamine.

extending directly from the stigma toward mental illness. This stigma is further complicated by the societal perception that the act of suicide is a failure by both the victim and their family to manage some emotional issue, and ultimately, society affixes blame for the loss on the survivors.⁴⁷ Moreover, in the initial psychological evaluation or intake exam, the psychiatrist is required by law to evaluate the patient's suicidality, and if severe enough, the doctor is able to commit the patient involuntarily.⁴⁸

On the first pass, it seems as though sustained, meaningful contact (a facet of healthcare Kidd and Carel believe would mitigate testimonial injustice between healthcare professionals and their patients is built directly into the biomedical model of mental health. Indeed, the United States mental healthcare system insists on doctor-patient relationships as an essential aspect of treatment. Furthermore, the American Psychological Association recommends that the treatment for any mental illness ought to consist of two parts: a pharmaceutical component, such as an SSRI, like Wellbutrin or other mood stabilizers; along with a talk therapy component, such as CBT (Cognitive Behavioral Therapy) or DBT (Dialectical Behavioral Therapy).⁴⁹ However, it is clear that testimonial injustice frequently occurs in these therapy sessions when we carefully interrogate what the basis is for talk therapy and what the desired end result is.

Kidd and Carel argue that mental illness can exacerbate epistemic injustice because it reinforces the negative stereotypes doctors have toward their patients when they state:

⁴⁷ William Feigelman, Bernard S. Gorman, and John R. Jordan. "Stigmatization and suicide bereavement." *Death Studies* 33, no. 7 (2009): 591-608

⁴⁸ An equally valuable paper could be written examining the way epistemic injustice is prevalent in psychiatric wards where patients are involuntarily committed. However, to keep on track, I will only touch on this idea briefly.

⁴⁹ American Psychiatric Association. Accessed April 17. <https://www.psychiatry.org/patients-families/psychotherapy>

[B]eing cognitively impaired or emotionally compromised, owing either to their somatic condition or their psychological reactions to it (*mutatis mutandis* for psychiatric illness); or as existentially unstable, gripped by anxieties about mortality and morbidity such that they cannot think straight; or that they will be psychologically dominated by their illness in a way that warps their capacity to accurately describe and report their experiences...⁵⁰

I argue that, in spite of talk therapy, the testimonies of the mentally ill are doubted by their doctors. I can easily imagine a case in which a chronically suicidal person enters into a medical clinic and claims that they desire to kill themselves, but they are immediately met with the classic, "You don't actually want to kill yourself. That's just the depression talking."

Moreover, unlike bodily illnesses, mental illnesses and suicidality have these stereotypes built into their definition, leaving almost no wiggle room for the patient to advocate for their own lived experience or for their desire to die. The suicidal person's testimony is ignored because this stereotype is an inherent part of the illness.⁵¹ This renders suicidal patients, because of societal and medical prejudice, irrational agents. Therefore, they are hardly given epistemic credence, whereas, at least in some states, a terminally ill person would have the opportunity to participate in physician-assisted suicide,⁵² of course, assuming that their testimony is given the proper uptake and trust.

The incongruent case of physician-assisted suicide (PAS) for terminally or chronically ill patients is perhaps the most obvious consequence of epistemic injustice that suicidal people incur

⁵⁰ Kidd and Carel, "Epistemic Injustice and illness," 177.

⁵¹ To be "mentally ill" is to have a compromised mental or emotional state in some regard. Therefore, the stereotypes listed above that Kidd and Carel offer toward physically ill patients, e.g., being emotionally compromised or existentially unstable...that they cannot think straight are quintessential aspects of mental illness.

⁵² Physician-assisted suicide (PAS) also known as physician-assisted death is legal in a handful of states: Washington, the District of Columbia, Oregon, California, Colorado, Hawaii, and Vermont.

in the United States, especially when we consider the country's recent push to eradicate the stigma toward mental illness. Perhaps the most successful tactic to destigmatize mental illness is by equating it directly to physical illness.⁵³ Now, I do not intend to unpack this claim in this paper. However, if this equalization is the next step in the current crusade to destigmatize mental illness, then it only follows that – in the states where physician-assisted suicide is legal for patients with physical illnesses – the same opportunity ought to be afforded to mentally ill individuals who meet existing requirements to also die with dignity.

"Death with Dignity laws allow qualified adults to voluntarily request and receive a prescription medication to hasten their death."⁵⁴ The requirements to qualify are that patients must be 18 years or older, must be mentally competent (i.e., capable of making and communicating their own healthcare decisions), must be able to self-administer and ingest prescribed medication, and must be diagnosed with a terminal illness that will, within reasonable medical judgment, lead to death within six months.⁵⁵ Before I discuss further how epistemic injustice plays a significant role in the above requirements, I first want to make room for a popular understanding of how the second listed requirement functions in clinical settings.

Margaret Battin, professor of philosophy and bioethics at the University of Utah, has become a prominent player in discussions concerning the ethics of suicide.⁵⁶ Battin created the following five criteria that effectively outline the capacity for the rationality of the patient to meet the requirement.

⁵³ See the American Psychological Association Website or the American Psychiatric Website for direct quotes equating mental illness to physical illness.

⁵⁴ Death with Dignity, "How Death with Dignity Laws Work." Accessed on November 7.

<https://www.deathwithdignity.org/learn/access/>

⁵⁵ Ibid.

⁵⁶ Margaret P. Battin. "Can Suicide Be Rational? Yes, Sometimes." In *Contemporary Perspectives On Rational Suicide* ed. James L. Werth. (Philadelphia. PA: Brunner Mazel, 1999.) 13-19.

These are:

1. The ability to reason, which asks, “Can the person see the consequences of his or her actions and weigh the prospect of dying against existing with a terminal disease?”
2. A realistic worldview. “Does the person have a realistic assessment of the current situation?”
3. Adequacy of information. “Does the person have an accurate diagnosis and prognosis?”
4. Avoidance of harm. “Has the pain or suffering from the disease been considered to be a greater harm than suicide?”
5. Accordance with fundamental mental interests, which questions the foreseeable loss of independence, mobility, consciousness, etc.

The discrepancy between the opportunity for PAS for terminally ill people in comparison with the opportunity for mentally ill people (whose mental illness significantly diminishes their quality of life) is an outstanding example of the kinds of testimonial injustice that mentally ill people face that physically ill — or “the ill,” as Kidd and Carel put it — do not.

I imagine that those who oppose this view may, primarily, take issue with this claim for the sole reason that mentally ill people are not explicitly facing death within six months. However, this counter-argument misconstrues the purpose of physician-assisted suicide. I argue that there are two benefits of introducing physician-assisted suicide laws. The first benefit can be understood within the context of the original PAS law in Oregon state. The law, titled “Death with Dignity Act (DWDA)” was sold to Oregonians as being a peaceful and gracious alternative to suffering and ultimately dying due to a terminal illness. It was also promoted as a means for patients who were suffering to end their lives on their own terms, rather than waiting for their

illness to kill them. Patients are given the legal right to end their lives in a manner that is less chaotic.⁵⁷ The patients are given control, and, of course, dignity.

This is an example of testimonial injustice when we re-consider Battin's five criteria with a special concern for people who live with a chronic mental illness or with a mental illness that, when medicated, severely diminishes the quality of life of the patient. Consider Amanda, a thirty-three-year-old who has lived with depression since she was a teenager.

I've tried everything." She said. "Prozac, Wellbutrin, even Zoloft. You name it, I've tried it. Some of them aren't so bad. But, a lot of them, like Kolnopin, just wipes you out. You don't feel anything at all.

Amanda's lived experience is not uncommon. I have heard countless narratives of people living with a mental illness who hate taking their medication because although it makes it so they don't feel the desire to kill themselves, it also takes away any opportunity for feeling at all. With Amanda's narrative in mind, let us reconsider whether a mentally ill person can meet all of Battin's criteria for a rational suicide.

This paper is concerned with epistemic injustice; therefore, I focus only on the first three criteria, as those are pertinent to trust the lived experience of the knower.

⁵⁷ Perhaps one of the most significant selling points for states who have passed Death with Dignity laws are the anecdotes of loved ones who are thankful that they were able to properly say goodbye to their loved one as they passed. Rather than being surprised and facing excruciating heartbreak of a somewhat unexpected death or complication, Death with Dignity laws foster an open dialogue with patients and their family members about dying and why the loved one feels as though dying on their own accord, via PAS, is a better alternative to the inevitable death that will eventually overcome them at their weakest and potentially at a time where family members are unable to plan.

1. *The ability to reason:* Within the designated population parameters, it seems highly probable that people who have been suicidal for years and years and have therefore stayed alive for years without wanting to, do not seem to be irrational. If anything, living in anguish with no desire to stay alive and no foreseeable fix seems more irrational than weighing one's death against living unhappily.

2. *A realistic worldview:* It is not immediately clear how the chronically-depressed or chronically suicidal person differs from the chronically/terminally ill person in this criterion. Similarly, to the physically ill person, the chronically suicidal person has a realistic worldview as it is affected by their illness in the same way that someone with Stage 4 cancer might – a life of pain and suffering.

3. *Adequacy of information:* This is where it becomes clear that the medical model of mental illness is necessary. If the person with treatment-resistant depression has an accurate diagnosis, why must we keep them alive? This is a vastly different mentality than we hold with chronically ill patients. Is it due to the slim possibility that they might someday receive a better diagnosis? Or, is it in hopes that a new, effective medication will be released? Both of these sound like a needless extension of suffering and anguish, all for the sake of keeping the biological body alive.

VI. HERMENEUTICAL INJUSTICE AND SUICIDALITY

Recall that hermeneutical injustice occurs when there is not a proper, adequate, or accurate evaluative mechanism within the greater hermeneutical resource for attending physicians or patients to interpret their epistemic experience correctly, making their experience

both inarticulable and ineffable. Indeed, the very same circumstances Kidd and Carel understand to cause and exacerbate hermeneutical injustice are experienced by the suicidal person. This is because the epistemic authority cannot recognize or respond to the concerns and experiences of the suicidal because they too are uncertain of the reality of the experience.

Thus, the question is whether or not suicidal people are especially vulnerable to hermeneutical injustice. My answer is they are. There is no interpretive tool for the epistemic authority nor the suicidal person themselves to accurately understand the existential experience of suicidality beyond the medical understanding that views suicidality to be confused and the outcome of a diagnosed or undiagnosed mental illness. The previous experience then lends itself to the exclusion of the suicidal person from the medical and academic circles that contextualize an existential meaning of "suicidality" beyond medicalization. And, the suicidal person is also unable to properly express the severity of their plight. This is evident when we revisit the biomedical understanding of suicidality. The modern medical model views suicide always to be preventable and therefore when someone desires to kill themselves, they are irrational. Take for example, Betty, a psychiatrist practicing in the Pacific Northwest of the United States America, and her response to the probing question.

Do you think people who are suicidal actually want to kill themselves? Or, do you think it's something different?

Betty's replied: "That's not something that anybody would actually want. There is a difference between wanting to kill yourself when you are terminally ill and wanting to kill yourself when you are mentally ill." Moreover, Betty also elucidated that suicidality is also

contextually unfitting: "People who desire to kill themselves are just too depressed to actually see the value in their lives – it's my job as a psychiatrist to ensure that I give them the best go at a life they want to live." However, noble Betty's responses may be, her responses are founded in medicalized prejudice/stereotype and are therefore are the beginning of epistemic injustice.

The best-documented example of hermeneutical injustice comes from Mary P. Henman's account of "Suicidal Patients with a Do-Not-Resuscitate Order." The dilemma proceeds as follows:

An elderly woman with a known terminal illness presented in the emergency department after a suspected suicide attempt. She had a DNR order during her previous hospitalization. The emergency physician felt obligated to intubate the woman despite his recognition that she was terminally ill.⁵⁸

I argue that the only reason why this is an ethical dilemma is because of the pre-existing assumption or stereotype that all suicide attempts are irrational. Henman agrees. Not all patients who attempt suicide are necessarily incapable of making a rational decision about their healthcare. In some cases, it may be appropriate to withhold resuscitation attempts in suicidal patients who have a preexisting DNR order.⁵⁹

It does not escape me, however, that there is a lot of grey area here. Perhaps the elderly woman was in crisis, and the on-call physician was only "erring on the side of life," a common phrase and practice in bioethics. Yet, the case still acts as a thought-provoking dilemma. If the

⁵⁸ Mary P. Henman. "Suicidal Patients with a Do-Not-Resuscitate Order." *The Journal of Emergency Medicine*. (2016): 1.

⁵⁹ Ibid.

doctor was told that the elderly woman attempted suicide fully lucid and rational, would he still feel obligated to intubate her, disregarding her DNR? My intuition says yes. The current medical understanding of suicidality argues it is that always irrational and therefore must always be prevented; this initial moral understanding is caused by the epistemic injustice surrounding suicidality.

I take no specific stance on how the doctor should have acted in this scenario – similarly to my reluctance to make precipitous claims about the medicalization of all of mental illness, I am reluctant to say that anyone who has a prehospital DNR should not have their suicide intervened in, as it is incredibly difficult to determine the circumstances before their arrival in the emergency room. I do maintain that the thought pattern of most doctors, psychiatrists, psychologists, and society writ large⁶⁰ is that suicide is always irrational, and the cause of this one-track thinking is hermeneutical injustice of suicidal people. This can be explained with both the models provided for hermeneutical injustice. It either constitutes hermeneutical injustice because both the doctors and the patients do not have the knowledge available within the greater hermeneutical resource to understand that suicidality does not always constitute irrationality. Or, this phenomenon can also be understood within the causation understanding of hermeneutical injustice; meaning that doctors incorrectly apply the current knowledge within the hermeneutical resource, most likely the correct knowledge as it applies to young people and those in crisis, to those people who have adopted suicidality into their identity and live day to day with the rational desire to put an end to their numbness, pain, and strife.

⁶⁰ Recall the social responses to celebrity suicides.

I also I take no specific stance on which model of hermeneutical injustice is at play in the Henman case, nor is it immediately clear to me which model is the most fitting. I leave these distinctions and arguments for future bioethicists to clarify and argue.

VII. CONCLUSION

This paper provided an outline of both Miranda Fricker's framework of epistemic injustice followed by an outline of Kidd and Carel's extension of Fricker's framework to healthcare systems. I argued that the current medicalization of suicidality leads to irrational prejudices and stereotypes of suicidal people both of which foster the perfect conditions for epistemic injustice toward suicidal people.

I also argued that mental illness and suicidality are often inextricable within the social understanding of suicidality but can sometimes come apart. I claimed that suicidal people are especially vulnerable to testimonial injustice because the stereotypes of irrationality and emotional vulnerability are built into the diagnosis of mental illness (which follows immediately after a suicide attempt). I then offered the incongruent case of physician-assisted suicide for terminally ill people but not chronically depressed people. I continued to show that suicidal people are also especially susceptible to hermeneutical injustice, the example there being Henman's case of "Suicidal Patients with a DNR."

The ethical implications of this paper call for a reformation of societal and medical attitudes and perceptions toward suicidal people. The analysis also offers several potential avenues to combat both testimonial and hermeneutical injustice experienced by suicidal people. However, perhaps the most important implication of this paper – the implication I am most hopeful about – is a call for more bioethicists to focus on the plight of suicidal people in the United States mental healthcare system.

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