

FROM CONCEPTUAL LACUNA TO CONCEPTUAL DISTORTION: THE CASE OF SELF-ILLNESS AMBIGUITY

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ABSTRACT

Epistemic injustice has received considerable attention in the philosophy of psychiatry in recent years. While testimonial injustice, and epistemic injustice more generally, have been widely discussed, hermeneutical injustice has received comparatively little attention. Furthermore, hermeneutical injustice has generally been framed in terms of conceptual lacuna, following Fricker's (2007) approach. The aim of this paper is to expand the notion of hermeneutical injustice beyond the cases in which it results from a conceptual lacuna. I analyse instances in which hermeneutical injustice arises as a consequence of a *distortion* of available hermeneutical resources. In this scenario, there are available concepts that may contribute to making experiences intelligible; however, these concepts are distorted. Moreover, some of these conceptual resources, which could serve as a form of *hermeneutical dissent* against hermeneutical injustice, ultimately contribute to this very injustice due to their distortion. To illustrate this point, I focus on how these conceptual distortions affect those who are dealing with self-illness ambiguity, that is, the difficulty that people diagnosed with a psychiatric condition often experience in distinguishing oneself, or “who one is”, from the diagnosis. I analyse how hermeneutical injustice may arise from both the absence of and especially the distortion of the new hermeneutical tools developed by social movements such as the Neurodiversity Movement and Mad Pride.

Keywords: philosophy of psychiatry; hermeneutical injustice; Neurodiversity movement; Mad Pride; hermeneutical dissent.

Introduction

Epistemic injustice has received considerable attention in the philosophy of psychiatry in recent years (e.g., Ballesteros 2025; Bueter 2019; Carel and Kidd 2014; Crichton et al. 2017; Drożdżowicz 2021; Drożdżowicz and Grodniewicz 2025; Kidd et al. 2025). According to Fricker (2007), epistemic injustice is understood as a wrong done to someone specifically in their capacity as a knower. She distinguishes between testimonial injustice and hermeneutical injustice. Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word. Hermeneutical injustice is "the injustice of having some significant area of one's social experience obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource" (Fricker 2007, 155). While testimonial injustice, and epistemic injustice more generally, have been widely discussed in philosophy of psychiatry, hermeneutical injustice has received comparatively little attention (Aftab 2022; Ritunnano 2022). Furthermore, hermeneutical injustice has generally been framed in terms of conceptual lacuna, following Fricker's (2007) approach.

Hermeneutical injustice and its harmful consequences are particularly evident in the phenomenon of self-illness ambiguity (Ballesteros et al. 2025; Dings and Glas 2020; Dings and Golova 2025; Golova and Dings 2025; Jeppsson 2022; Sadler 2007). Self-illness ambiguity (SIA) refers to the difficulty that people diagnosed with a psychiatric condition often experience in distinguishing oneself, or "who one is", from the diagnosis; that is, the difficulty in determining whether a trait, thought, feeling, or experience belongs to one's identity or to the condition. This ambiguity can be addressed through the externalization of the psychiatric condition, by which symptoms are understood as something different from the self, or through the integration of the condition into one's identity, thereby considering it part of oneself.

Although psychiatric diagnostic criteria can guide the diagnostic process, they cannot resolve self-illness ambiguity: whether one should externalize the mental condition or identify with it, whether to think of oneself through a traditional medical lens, or through alternative frameworks, or some combination of these. Resolving self-illness ambiguity is, rather, a practical and ethical issue related to one's identity, settled by what works best for each individual in her unique circumstances (Jeppsson 2022). The boundary between what belongs to the self and what belongs to the mental condition is a matter of construction and interpretation, and it is precisely for this reason that conceptual resources play a crucial role in addressing SIA.

The aim of this paper is to expand the notion of hermeneutical injustice beyond the cases in which it results from a conceptual lacuna. I analyse instances in which hermeneutical injustice arises as a consequence of a *distortion* of available hermeneutical resources (Delgado and Picazo 2026; Falbo 2022; Jenkins 2017). In this scenario, there are available concepts that may contribute to making experiences intelligible; however, these concepts are distorted. Moreover, some of these conceptual resources, which could serve as a form of *hermeneutical dissent* (Goetze 2018) against hermeneutical injustice, ultimately contribute to this very injustice due to their distortion. To illustrate this point, I focus on how these conceptual distortions affect those who are dealing with self-illness ambiguity. I analyse how hermeneutical injustice may arise from both the absence of and especially the distortion of the new hermeneutical tools developed by social movements such as the Neurodiversity Movement and Mad Pride.

The paper proceeds as follows. In the next section, I briefly explain what self-illness ambiguity is and the different ways of addressing it, using it as a case study through which to examine the effects of the two forms of hermeneutical injustice discussed in this paper: conceptual lacuna and distortion of hermeneutical resources. In Section 2, I introduce the Neurodiversity and Mad Pride movements and the hermeneutical resources developed by these movements, which provide alternative hermeneutical frameworks to the medical model for understanding and valuing mental difference. In Section 3, I analyse, in terms of conceptual lacuna, how hermeneutical injustice affects those who are dealing with SIA. In Section 4, I expand the notion of hermeneutical injustice based on a conceptual gap to a different scenario in which this injustice is the consequence of a distortion of available hermeneutical resources. In the final section, I briefly mention the harmful consequences of these two forms of hermeneutical injustice.

1. Self-illness Ambiguity

The phenomenon of self-illness ambiguity (SIA) has received considerable attention in recent philosophy of psychiatry literature (e.g., Ballesteros et al. 2025; Dings and Glas 2020; Dings and Golova 2025; Golova and Dings 2026; Jeppsson 2022; Sadler 2007). As mentioned, self-illness ambiguity refers to the difficulty that people diagnosed with a psychiatric condition experience in distinguishing oneself from their diagnosis. Different ways of coping with self-illness ambiguity can lead to different understandings

of the diagnosis, depending on how the mental condition¹ is integrated into the individual's identity. This can occur even among individuals with the same diagnosis. For instance, someone who views her depression as a brain disorder may relate to it differently from someone who understands it as an adaptive strategy for coping with early trauma.

Different proposals have examined how the phenomenon of SIA is socially mediated (Ballesteros et al. 2025; Russell 2025), or how cultural differences affect the experience of SIA (Crippen 2025). In terms of recovery, it has been argued that solving SIA may contribute to self-management, but it is not always a necessary step (Dings and Glas 2020). Moreover, it has been argued that keeping this ambiguity unresolved may be helpful in dealing with certain conditions, such as addiction or eating disorders (Drożdżowicz 2023; McConnell and Golova 2023). For the purposes of this paper, I will focus on cases in which the diagnosed person prefers and seeks to resolve this ambiguity, even if only provisionally.

SIA can be addressed through the externalization of the psychiatric condition, by which symptoms are understood as something different from the self, or through the integration of the condition into one's identity, thereby considering it part of oneself. It is possible to regard something as part of oneself, for example, a personality trait, and also consider it negative and wish to get rid of it. It is likewise possible to experience that trait as not belonging to oneself, but as something that has overtaken one in a positive way and is appreciated. However, identification is usually accompanied by a mixed, neutral, or positive evaluation of the mental condition, whereas externalization tends to be associated with a negative evaluation and/or pathologization.

Externalization and, often, pathologization are the common tendencies of the medical model in addressing psychiatric conditions. In some cases, externalizing the psychiatric condition may be beneficial in several ways. Distancing the symptom from one's identity can enable greater control over behaviour and facilitate a more objective analysis of responsibility and blame. One example is the case presented by Miranda Fricker (2007, 148-149) in relation to postpartum depression. Considering the diagnosis of postpartum depression as external to her identity enables the woman in the example to stop blaming herself for being a bad mother. Instead, she can understand it as something that has happened to her—a combination

¹ In this paper, *mental condition* and *psychiatric condition* refer to mental and cognitive differences, such as psychological or emotional experiences or traits, that may or may not be formally diagnosed, including forms of neurodiversity or cases in which the condition is not considered pathological.

of physiological and social factors, such as isolation—rather than something she is. She realizes that she is not a bad mother, but postpartum depression, an external illness, has overtaken her. This way of understanding can allow her to feel better about herself. In this sense, conceiving the psychiatric diagnosis as external to the self often provides individuals with feelings of relief, validation, and empowerment (Levinovitz and Aftab 2025).

In addition, externalizing a psychiatric condition may make it easier to develop effective strategies for dealing with it. Externalizing some aspects and identifying with its alternative may empower the embraced alternative and enhance agency. This strategy may be helpful in dealing with conditions such as addiction or phobias (Rego 2004). People with these diagnoses may feel that they are bad, weak, or fearful, and that they must become better and stronger in order to resist temptations or face their fears. However, this direct confrontation is often futile. Viewing the symptoms as something separate from one's identity enables individuals to reject and fight the condition's undesirable behaviours, feelings, or thoughts without feeling as though they are fighting against themselves. In this sense, they can develop more indirect and effective strategies.

While this option may be beneficial in some cases, it is not always the most appropriate approach. In many cases, it is not possible to draw a clear boundary between what belongs to the self and what belongs to the mental condition. Indeed, for some people the idea of fighting against certain traits that are rooted in one's own mind, yet regarded as something alien, can become an impossible, harmful, and deeply unsettling strategy. As Steph Ban (2025) describes regarding her diagnosis of Obsessive-Compulsive Disorder (OCD),

It's no wonder I couldn't find the place where 'I' ended and 'OCD' began; it's unclear if such a place even exists. I was given books to read that framed OCD as a malevolent outside force, and framed living with OCD as a constant battle. (...) I was deeply uncomfortable with the suggestion that I needed to fight my own brain or that I was being held hostage by an outside entity. (Ban 2025, 3)

The alternative to externalization is the identification with the mental condition, either wholly or partially. In such cases, individuals understand their condition as part of their authentic self. They may also consider that there are positive and meaningful aspects that would not exist, or at least not in the same way, if this condition did not exist. While it is not denied

that there may also be negative aspects, these are considered a price worth paying (Ban 2025; Jeppsson 2022; see also Jeppsson and Lodge 2025).

In dealing with self-illness ambiguity, there is no “right” way to solve it. There is no objective or scientific criterion to delimit which traits, behaviours, thoughts or emotions belong to the self and which to the mental condition. There are at least two reasons for this. First, psychiatric diagnostic criteria are inherently imprecise and open to interpretation; there is always a grey area between the mentally disordered and the “normal”. Second, even if someone clearly fulfils diagnostic criteria for a specific mental disorder, questions about how to interpret and relate to the condition still remain.

First, in clinical practice the threshold between whether a trait must be considered pathological or not is not rigid. As in other areas of psychiatry, the diagnostic process is affected by the so-called “boundary problem”, which refers to the difficulty of defining “mental disorder” and distinguishing it from non-pathological conditions, something particularly problematic to achieve in a useful way for guiding clinical practice (see, e.g., Schramme 2021). The distinction between what is considered normal and what is pathological is heavily influenced by social and cultural values, which change over time and whose boundaries are often fuzzy (Cooper 2020). Some notions that have been used as criteria for defining mental disorder are distress, disability, and dysfunction, but these are imprecise and value-laden notions, and their necessity and sufficiency are disputed (for an overview, see Aftab et al. 2024). There may be some provisional criteria that serve as external guidance for determining whether someone approximately fulfils the profile for a diagnosis of a mental disorder. But it is important to keep in mind that their application is complicated and strongly depends on subjective interpretation (Speyer and Ustrup 2025).

However, even if the criteria were stricter and there was broad agreement among psychiatrists on how to apply them, there would still be room for different interpretations regarding self-illness ambiguity, and different evaluations of similar conditions. Imagine two people who meet the criteria for depression, who have been diagnosed by their respective psychiatrists, and both accept their diagnosis. Even so, one patient may consider depression symptoms as traits of her identity. Even when including negative aspects, she may view them as part of who she is, shaped by past experiences, adaptive strategies to difficult environments or due to her sensitivity. The other patient may understand the depression as something external to her identity, an illness devoid of any redeeming aspects, from which she hopes to recover. The point is that even in cases where psychiatric criteria and their application are uncontroversial, two

patients may relate to their experiences differently, leading to different interpretations of their condition.

Such differences in interpretation may be extended to personal experiences as a form of self-illness ambiguity. Clinical and psychiatric criteria seem to be insufficient for solving this ambiguity. These criteria cannot objectively assert which of the two interpretations, externalization or identification, is correct and which is wrong. They cannot either provide a clear boundary between what feelings or thoughts belong to the psychiatric condition and what belongs to one's own identity. In fact, it is highly questionable to assert that such a boundary between self and illness exists, and if it did, whether it could be found. Sofia Jeppsson (2022) points out that the attempt to determine whether a trait, thought, or behaviour is a symptom of a psychiatric condition or an aspect of one's identity can result in a never-ending questioning, since there is no ultimate standard that allows for a definitive attribution to either, and every new thought or conclusion can itself be questioned again. As a consequence, Jeppsson argues that, rather than something that can be discovered, the boundary between self and illness is a matter of interpretation and construction.

Resolving this ambiguity is therefore a practical and ethical issue related to one's identity, guided by what works best for each individual in her unique circumstances. For some, it may be more helpful to view their condition as something external to the self, while others may identify with it wholly or partially. These different alternatives may even occur among people with the same mental condition, and may change over time or depending on the environment (Jeppsson 2023; see also Jeppsson and Lodge 2025).

Precisely because it is not possible to find a clear boundary between the self and illness, but rather this is a matter of construction and interpretation, conceptual resources play a crucial role in addressing SIA. The situations in which hermeneutical injustice occurs as a consequence of the lack of conceptual resources (Section 3) or due to a distortion (Section 4) have important consequences with respect to the construction of this boundary, the possible integration of a mental condition into one's identity, and the way different traits associated with these conditions are evaluated.

In the next section, I briefly present the new frameworks and hermeneutical resources developed by the Neurodiversity and Mad Pride movements. Then, I examine how their absence, and especially their distortion, affects those dealing with SIA.

2. Hermeneutical Dissent: Social and Political Movements

The Neurodiversity Movement and Mad Pride are important social and political movements that have developed new concepts and frameworks for understanding and valuing mental difference. The Neurodiversity Movement (ND) is a social justice movement that advocates for civil rights, equality, respect, and full societal inclusion for the neurodivergent (see, e.g., Núñez de Prado-Gordillo 2025). The ND challenges the idea that there is one “normal” or “healthy” type of brain or mind, or one “right” style of neurocognitive functioning. This movement is grounded in the neurodiversity paradigm, which holds that neurocognitive variation is considered the norm, and is both natural and valuable. The assumption that there is a single, standard form of mental or neurocognitive functioning is rejected as a culturally constructed fiction (Walker 2014). Based on this paradigm, the ND has opened the door for certain conditions historically classified as mental disorders—such as autism or ADHD, among others—to be recognized as expressions of natural cognitive variation. From this standpoint, there is a fundamental commitment to resisting the medical pathologization of cognitive disability. Nevertheless, the ND also rejects the undue normalization of these psychological conditions, highlighting that in some cases neurodivergence can be disabling and may require appropriate support.

Neurodivergence is subject to the same social dynamics as other forms of human diversity, such as gender, ethnicity, or culture, which often involve social inequalities (Walker 2014). As a consequence, neurodivergent suffering is primarily (although likely not entirely) a product of societal exclusion and marginalization, rather than the consequence of any inherent pathology in neurodivergence (Chapman 2020). In this sense, the oppression of neurodivergent people should not be understood as mere social prejudice or medical misdiagnosis, but rather as a systemic phenomenon rooted in a socio-historical structure through which institutions and cultural norms define what is considered “normal” and what is not, based on their own interests (Chapman 2023).

The Neurodiversity Movement presents a vital and necessary challenge to the pathologization of certain mental conditions by reframing them as natural variations of the human mind. Furthermore, for many individuals, identifying as neurodivergent provides a meaningful framework through which they can integrate their condition into their identity, rather than viewing it as an external problem to be cured or eliminated.

In a similar vein, Mad Pride (MP) is a social movement that reframes traits, states, thoughts, feelings, and experiences typically associated with

psychiatric conditions or madness by psychiatry and mainstream society as a valuable part of one's identity. The movement finds value in, and even celebrates, aspects of mental difference that are often pathologized, highlighting the potential worth of traits such as empathy and creativity. Rather than treating these experiences as problems to be eliminated through medical interventions, they posit that certain traits linked to these conditions can be positive and meaningful (Cutler 2019). The movement argues that, in many cases, the distress experienced does not stem from the condition itself, but rather from social factors, such as the stigma and discrimination associated with it.

Mad Pride advocates the recognition of madness as an identity (Rashed 2021). For this reason, MP activism resists the medicalization of mental distress and rejects the language of "mental disorder". Accordingly, they reclaim and appropriate words such as mad and madness, redefining them as sources of identity and cultural value. Many Mad Pride activists reject impositions based on the medical model of mental illness, which forces psychiatrized people to conform to idealized notions of normality (Sen 2011).

Mad Pride is a highly heterogeneous movement that accommodates a wide range of perspectives. For some, madness is understood as a gift and an integral part of their identity, and activism becomes the most meaningful way of coping with mental illness (Jackman 2025). For others, Mad Pride is a struggle for civil and political rights, and although their psychiatric condition involves suffering, they nonetheless find pride and value in the result of their experiences (Beazer 2017; see also Núñez de Prado-Gordillo 2025).

MD and ND are not merely political movements; they provide alternative hermeneutical tools through which certain mental conditions can be interpreted in a helpful way outside the framework of the medical paradigm. Whilst these social movements do not exhaust the possibilities when it comes to addressing SIA,² I focus on the hermeneutical resources that such movements have developed for two reasons. First, they make explicit the possibility of understanding a mental condition as a part of one's identity, which may be useful for those who are dealing with SIA and who understand their mental condition as part of themselves. These movements also reevaluate and reinterpret different mental conditions, opening up the possibility that they might be seen as something positive or meaningful, or at least neutral, rather than as pathological. Second, I

² It is possible to interpret a mental condition from multiple perspectives, for example in religious or spiritual terms (see, e.g., Farber 2012).

consider that, through these alternative frameworks, such social movements are contributing to the eradication of hermeneutical injustice through *hermeneutical dissent*, that is, where marginalized groups have produced their own interpretive tools for making sense of their experiences (Goetze 2018).

Despite the potential of hermeneutical dissent embodied by these movements, I argue that it does not yet prevent instances of hermeneutical injustice. In many contexts, these concepts are still lacking. As Trystan Goetze points out:

Hermeneutical dissent is not a straightforward process of inventing interpretive tools for marginal experiences and pushing them out to a wider and wider congregation. Different social groups and individuals may acquire or resist interpretive tools from other social groups, meaning that filling in collective gaps proceeds unevenly. (Goetze 2018, 85)

Given the growing attention these movements have received in certain contexts, such as academia, it might seem that these paradigms are widely known. The reality, however, is that outside academic contexts—and particularly when it comes to people with a psychiatric diagnosis—the hermeneutical resources offered by these movements are scarcely known (for instance, in clinical practice, therapy, and similar contexts where psychiatrized people do not have access to these hermeneutical tools). And even when these resources are known, they are often distorted or misapplied, as I argue in Section 4. In those cases, they not only fail to contribute to a better understanding of certain experiences or to the integration of a mental condition into one's identity, but instead perpetuate hermeneutical injustice.

3. Lack of Hermeneutical Resources

As mentioned earlier, epistemic injustice is understood as a wrong done to someone specifically in their capacity as a knower (Fricker 2007). The persistent negative stereotypes and stigma associated with mental illness make psychiatrized people especially vulnerable to suffering epistemic injustice.

While epistemic injustice more generally has been widely discussed, hermeneutical injustice has received comparatively little attention (Ritunnano 2022). Moreover, following Fricker's (2007) original discussion,

when hermeneutical injustice is discussed in philosophy of psychiatry, it has generally been framed in terms of a conceptual lacuna.

In particular, Rosa Ritunnano (2022) analyses how hermeneutical injustice affects people with psychotic experiences. She identifies two possible reasons why hermeneutical injustice occurs: either adequate concepts are lacking from the collective resource (they do not exist for anyone), or adequate hermeneutical resources exist within a certain social group but are not widely known (see also Mason 2021). This second scenario is relevant for analysing instances of hermeneutical injustice in the context of self-illness ambiguity in relation to hermeneutical resources developed by social movements.

In dealing with self-illness ambiguity, the lack of adequate hermeneutical resources due to limited knowledge of them significantly restricts the possibilities for addressing mental conditions in the most beneficial way for individuals. For instance, this may lead to a psychiatric diagnosis being viewed as inherently negative and in need of a cure, when it could instead be understood as a form of neurodivergence (Chapman and Carel 2022). This lack of hermeneutical resources may also lead to the denial of meaningful aspects that a mental condition may entail, and that a person could appreciate and decide to identify with.

Consider an example in which an autistic person lacks access to the notion of neurodiversity and thus understands her condition as a mental pathology (Aftab 2023). She is also disconnected from the neurodiversity framework and the support of its communities. Her autism is seen as an inherent deficit, rather than as a form of neurodivergence. The focus is placed on an internal problem rather than on removing environmental barriers. Due to the lack of information and in the search for a cure, she may adopt harmful strategies aimed at “recovery” or “being normal”, such as camouflaging, i.e. performing neurotypicality due to pressure to appear more “normal” (Chapman and Botha 2023). This lack of conceptual resources, along with the harmful strategies adopted to address mental differences, prevents her not only from understanding autism as a form of neurodivergence but also from integrating it into her identity. She may shape her identity under deficit-based assumptions and think of herself as suffering from a terrible chronic pathology. Furthermore, strategies such as camouflaging have been found to negatively affect identity itself, often making it difficult for autistic individuals to distinguish who they are from the neurotypical behaviours they adopt to fit in (Petrolini and Schmidt-Boddy 2025).

The lack of hermeneutical resources may also lead to mental conditions being considered solely as inherently negative. From this perspective, the

positive aspects that a mental condition may entail are disregarded, denying the person the possibility of appreciating, valuing, and identifying with her condition. For instance, consider an individual diagnosed with depression, who has been told that it is simply the result of faulty neurochemistry. The lack of access to an alternative approach leaves her without the possibility of contextualizing her distress and understanding her depression as meaning-laden (Aftab 2023). Rather than being seen as a brain chemical imbalance, her depression may be understood as an adaptive strategy for dealing with early trauma or as a consequence of living in an oppressive environment. This change of perspective may help her make sense of her current feelings and behaviour as part of her identity, with these traits partly shaped by her past lived experiences.

In such cases, the lack of access to alternative interpretations may arise for several reasons. These include situations when medical explanations are privileged, or assumed to be complete descriptions of the phenomena, making that other modes of understanding become inaccessible (Aftab 2023). Due to the negative prejudices generally associated with psychiatric conditions—such as the idea that individuals are irrational and unaware of their situation—it is not uncommon in psychiatric practice to take control of the interpretative tools of people diagnosed with a mental disorder. In this way, the possible alternatives for interpreting a mental condition are limited to the medical model, which tends to pathologize and externalize mental illness. This limitation prevents access to alternative understandings, giving rise to a situation of hermeneutical injustice.

This lack of hermeneutical resources is not attributable to cases of epistemic bad luck, such as Miranda Fricker's example of someone with an unknown medical condition who lacks the appropriate concept to make sense of her experiences because it does not yet exist. In the cases I highlight, different concepts and alternative frameworks for interpreting a mental condition already exist, yet there is no access to or knowledge of them. This lack arises from hermeneutical marginalization, that is, the unequal hermeneutical participation in significant areas of social experience, resulting from the subordination and exclusion of members of a disadvantaged group from practices that would have value for them (Fricker 2007). Systematic marginalization and negative prejudices against people with a psychiatric diagnosis often lead to their interpretations of their own experiences being dismissed as unworthy of consideration. Consequently, they are excluded from decision-making and denied full agency in determining what is best for them.

Specifically, I suggest that these cases of hermeneutical injustice are often a consequence of “willful hermeneutical ignorance”, which occurs when

members of dominant social groups dismiss or ignore the interpretive resources created by members of marginalized groups to conceptualize and describe their experiences (Pohlhaus 2012). The Neurodiversity and Mad Pride movements have developed alternative frameworks that enable individuals to understand a mental condition as a form of neurodivergence and recognise its potentially valuable aspects. However, these alternatives are sometimes overlooked in favour of the medical model and remain unknown to those who could use them to make sense of their experiences. It is in this sense that willful hermeneutical ignorance produces and maintains deficits in the collective hermeneutical resource, which results in hermeneutical injustice (Mason 2021). Due to this lack of hermeneutical resources, some people have to deal with self-illness ambiguity with a deficit in the available hermeneutical tools, limiting the options for how to relate to and identify with their condition.

The analysis of hermeneutical injustice in terms of conceptual lacuna is an important contribution and helps to understand hermeneutical injustice in relation to SIA. However, I argue that hermeneutical injustice in the psychiatric context does not arise only as a consequence of a conceptual gap. In the next section, I expand the notion of hermeneutical injustice beyond the cases in which it results from a conceptual lacuna to those in which it arises from a distortion or misapplication of available hermeneutical resources.

4. Distortion of Hermeneutical Resources

In the previous section, I presented how the lack of hermeneutical resources may lead by default to interpretations of mental conditions through a traditional medical lens. According to this model, psychiatric conditions are usually understood in terms of pathological inherent deficits. The distortion of available hermeneutical tools leads to a different scenario, in which attempts to highlight the positive aspects of some mental conditions may overshadow the suffering they sometimes entail. For some individuals, it is impossible to integrate their diagnosis into their identity, to appreciate its positive aspects because there may not be any, or to understand their mental condition as a form of neurodivergence. They argue that their suffering is not solely the result of an ableist environment, but that there is something intrinsically negative about the condition itself (Nadelhoffer 2022), and that none of its potential positive aspects compensate for this.

It has been argued that some disability activists, particularly advocates of the social model of disability, and similarly, some radical mental health

activists, have been hesitant to confront the personal difficulties and limitations that may arise from an individual's condition when these cannot be attributed solely to disabling social arrangements (see, e.g., Spandler and Anderson 2015). This reluctance may stem from a reasonable fear of shifting the problem back onto the individual rather than in discriminatory social relationships and structures. For instance, the concept of "impairment" clashes directly with the neurodiversity paradigm's advocacy of natural cognitive variation. The notion of impairment "presupposes that the species-norm is a legitimate standpoint from which to judge functioning levels" (Chapman 2020, 63), whereas the neurodiversity paradigm rejects this assumption. While the social model could make room for considering the difficulties that may occur with disability, the use of concepts such as "impairment" risks falling back on species-standard norms, which contradict the idea of diversity as the norm. However, as Chapman points out, avoiding these issues is itself problematic:

The risk here is that slightly adapting the social model might end up with what we might call 'hardship denying'—in short, overlooking or bright-siding genuine issues that do primarily seem to stem from cognitive traits, and which cannot be easily reduced to a matter of marginalisation and oppression. (Chapman 2020, 63)

A similar concern is raised by Jonathan Beazer (2017), who points out that, although it occurs in a few cases,

[B]y reading some Mad Pride authors one could be forgiven for thinking that there is nothing negative about any expression of madness. Perhaps these (few) overly positive perspectives explain why some people living under diagnoses do not wish to identify as 'mad'. (Beazer 2017, 8)

He argues that the distress involved in some mental conditions should be acknowledged. Beazer is aware of the complexity of this question, because whether incorporating negative experiences into the narrative of madness might be strategically counterproductive for the Mad Pride movement is itself uncertain, given that many diagnosed individuals—and especially the general public—are still unfamiliar with Mad Pride and often view madness through a stigmatizing lens. A more nuanced portrayal could risk undermining efforts to achieve recognition and justice.

The silence surrounding the difficult aspects, and the tendency to ignore or avoid the question of the roots of madness and distress, has been referred

to as the elephant in the room (Spandler and Anderson 2015). This silence, along with the exclusive focus on a positive perspective regarding mental conditions, may negatively affect people who are dealing with its more painful or distressing aspects. For some people, even when they identify with their mental condition, it may be impossible to appreciate any positive aspects because there might be none. For instance, consider someone who does not understand her depression simply as a chemical imbalance, but rather addresses her depression—and the distress it involves—as a meaningful consequence of her past experiences, a difficult environment, or trauma. Nevertheless, she may argue that her depression is inherently negative; it is suffering with no compensating positive aspects. In cases like this, the discourse that aligns with the appreciation and celebration of the positive side of psychiatric conditions may have detrimental effects. This experience can lead individuals to feel *doubly guilty*: both for having a psychiatric diagnosis and for being unable to cope with it in the way others in similar situations seem to do or to find value in aspects that others may appreciate.

This kind of toxic positivity has sometimes permeated certain contexts, such as social media, leading to a distorted understanding of mental conditions. There appears to be a reduction in stigma, but with the undesirable consequence of romanticising certain traits associated with mental conditions (Issaka et al. 2024; Jackson 2017), or the trivialization of the condition, which leads to the dismissal of the distress involved (Spencer and Carel 2021). All of this may give rise to a form of epistemic harm whose origin lies in what Lucienne Spencer and Havi Carel (2021) call “positive stereotypes”. They apply this notion in relation to what they term “wrongful depathologization”,³ but I suggest that the idea of positive stereotypes and their potential harms could be extended to a more general conception of psychiatrized conditions (considered pathological or not) as well as to neurodivergence.

Positive stereotypes are a kind of identity prejudice with a seemingly positive valence, but despite their allegedly complimentary appearance, they may be harmful and more difficult to detect than the negative ones (Smith 2025). Regarding mental conditions, these positive stereotypes focus on the supposedly positive aspects of the condition, emphasizing the

³ Spencer and Carel (2021) define *wrongful depathologization* as a devaluation of the epistemic status of people with mental illness by reducing their symptoms to mere personality traits, thus denying them a fully recognized psychiatric identity. In contrast to the view of Spencer and Carel, my aim is not to address whether a mental condition is considered pathological or not, but rather to highlight how mental conditions are evaluated through positive stereotypes, and how they contribute to obscuring some aspects (the more negative ones) and rendering certain experiences (such as suffering and distress) invisible.

usefulness and benefits of some traits while obscuring the more distressing ones. As a result of positive stereotypes, Spencer and Carel (2021) identify several detrimental consequences. Due to the focus on the positive aspects, when people with psychiatric conditions refer to the distress involved, their testimony may be dismissed as exaggerated (see also Smith 2025).

Another harmful consequence is that when a positively stereotyped individual fails to live up to the unrealistic ideal, this may put additional pressure on her. It is in cases like this that the *double guilt* mentioned above may arise, adding to the potential guilt of being diagnosed with a psychiatric condition the additional burden of failing to appreciate the supposed positive aspects assumed by the positive stereotypes. This double guilt arises from the fact that, due to a perspective shaped by toxic positivity, individuals are provided with a framework for relating to their condition that denies part of it as they experience it. In this sense, for the person there is a mismatch between how she feels and how it is supposed to feel. As a result, they cannot interpret, in those terms, part of their experience—namely, the negative aspects or suffering—which, for those who defend this toxic positivity, do not exist. Therefore, having a part of one's experience that does not fit this discourse gives rise to the idea that “one is doing something wrong”, or that one is unable to understand one's mental condition in the way that such discourses prescribe. This distortion, due to positive stereotypes and toxic positivity, results in a form of hermeneutical injustice in which the negative aspects cannot be made intelligible and indeed remain invisible.

Differing from the cases presented in the previous section, where there was a lack of hermeneutical resources, here the appropriate hermeneutical resources are available, but this does not guarantee their proper use (Falbo 2022). It is important to consider the framework in which they are embedded—in this case, a context biased by positive stereotypes. This distortion may reduce the capacity of hermeneutical resources to make certain experiences intelligible, both to oneself and to others.

Similarly, the misapplication of hermeneutical resources developed by the neurodiversity paradigm may also occur. Concepts developed in defence of neurodiversity have spread into everyday language, which is positive, but it entails certain risks, such as their misappropriation or misuse (Spencer and Carel 2021). In some cases and across different contexts—among therapists, on social media, and even in everyday language—the terms “neurodivergence” and “mental disorder” have been used interchangeably, as if referring to the same thing. This is problematic because the two concepts are not the same. This misuse may stem from several reasons. In some cases, it may be because the term

“neurodivergence” sounds more positive than “mental disorder”. However, there is no further understanding about what the neurodiversity paradigm is, nor the neurodivergence as an alternative perspective. In such cases, neurodivergence is again understood through the medical lens. For instance, a clinician might diagnose someone with autism and call it a “neurodivergence”, but still describe the condition in a traditional, medical and deficit-focused way. In other cases, it may be an attempt to offer a less stigmatized or less negative view of a diagnosis. Here, I suggest that the positive stereotypes mentioned before may be operating in relation to the image of neurodivergence. Focusing only on the positive aspects and valuable traits of neurodivergence may lead to overlooking the difficulties that neurodivergent community faces in a neurotypical environment and trivializing their implications.

The distortion and misapplication of the conceptual resources developed by the ND movement (as in the example in which neurodivergence and mental disorder are used interchangeably) can be attributed to willful hermeneutical ignorance (Falbo 2022; Mason 2021; Pohlhaus 2012), in a similar vein to the cases mentioned in Section 3. In this example, there is no conceptual lacuna because the concept already exists, but it is distorted until it fits the dominant traditional medical model. In doing so, it disregards what the ND movement means when referring to neurodivergence and its demands. This distortion removes the capacity of ND concepts to act as forms of hermeneutical dissent, preventing the framing of these experiences as forms of neurodivergence and as part of identity.

The cases in which hermeneutical injustice arises from a distortion in contexts of toxic positivity are more difficult to trace for several reasons. First, because there are individuals who do understand their mental condition as entirely positive and, despite the stigma and discrimination that psychiatrized people have to face, they do not find anything negative in their condition *per se*. This point of view is undoubtedly helpful and meaningful for some individuals, but it becomes problematic when attempts are made to apply it (or even impose it) to others without regard for individual perspectives, preferences, contexts, or actual coping possibilities. Second, because in some cases, behind this toxic positivity there may be apparently good intentions (Jackson 2017), aimed at focusing on the positive side in an attempt to help people, trying to offer a more optimistic view. However, as has been mentioned, these approaches obscure the negative aspects. The discourse of toxic positivity results in people who experience suffering in relation to their mental condition lacking the resources to render it intelligible and to have it recognized (Hänel 2020).

Discourses that misuse and distort these concepts, or that align with forms of toxic positivity, should be avoided. The hermeneutical resources developed by these social movements have the potential to, and often do, function as hermeneutical dissenters. This helps to remedy cases of hermeneutical injustice caused by a conceptual lacuna. However, the aforementioned cases of distortion work precisely in the opposite direction, undermining their potential to make experiences intelligible and to provide alternative perspectives for relating to a mental condition. This significantly contributes to complicating SIA, leading people to make their experiences intelligible in ways that are ultimately harmful, giving rise to harms that affect identity.

5. Harms

Now, how do the analysed notions of hermeneutical injustice result in harm for individuals dealing with self-illness ambiguity? Following Fricker, the primary harm of hermeneutical injustices pertains to the communicative dimension and

[C]onsists in a *situated hermeneutical inequality*: the concrete situation is such that the subject is rendered unable to make communicatively intelligible something which it is particularly in his or her interests to be able to render intelligible. (Fricker 2007, 162)

This harm occurs both when hermeneutical injustice arises as a consequence of a conceptual lacuna and when it arises from the distortion of hermeneutical resources (Falbo 2022).

Fricker argues that, as a consequence of this primary harm of hermeneutical injustice, subjects are also unfairly disadvantaged with respect to the construction of selfhood. In this line, Ritunnano distinguishes two kinds of harm of hermeneutical injustice, in addition to the communicative one: “one concerning meaning-making (i.e. the possibility of fully understanding and making sense of one’s own experience)” and another related to “the existential dimension of self-interpretation (i.e. related to the impact that a certain understanding of experience may have on the subject’s construction of their self-identity)” (2022, 246).

This connects directly with the harms that hermeneutical injustice entails in dealing with self-illness ambiguity for one’s identity. First, the lack and the distortion of hermeneutical resources hinder the possibility of understanding and making sense of one’s own experiences. When there is

a conceptual lacuna and only the traditional medical model is available, that interpretation is imposed. This frequently leads to the externalization and pathologization of the mental condition. In cases of conceptual distortion, as in the case of toxic positivity, there appear to be alternative perspectives to the traditional one, but these still leave people who deal with the more negative aspects with part of their experiences that cannot be made sense of.

All of this has repercussions for the existential dimension and the construction of one's identity. In the case of a lack of hermeneutical resources, it leaves people without alternatives for dealing with SIA. It is assumed that the mental condition is a deficit and there is a tendency to externalize it, although in some cases it may be much more helpful to understand it from other perspectives and as part of identity, as in the case of neurodivergence. In the case of distortion of hermeneutical resources, it gives rise to misleading perspectives on how people should relate to and integrate their mental condition into their identity. The mismatch I mentioned in Section 4 between how a person feels and how it is supposed to feel, may make people try to integrate the mental condition into their identity in ways that are ultimately harmful. Since solving self-illness ambiguity is a matter of interpretation and construction, the distortion of hermeneutical resources severely complicate finding what works best for a person. The lack of hermeneutical resources prevents the existence of options, but the distortions provide alternatives that eventually undermine identity.

6. Conclusion

In this paper, I have analysed how hermeneutical injustice operates in relation to self-illness ambiguity. I have addressed how hermeneutical injustice, understood in Fricker's classical sense as a consequence of a conceptual lacuna, gives rise to the imposition of a single interpretation of mental conditions in terms of inherent deficits as pathologies. Beyond these cases, I have expanded the notion of hermeneutical injustice, drawing on recent literature, to cases in which it is the consequence of the *distortion* of concepts. In particular, I have used the hermeneutical resources developed by social movements such as the Neurodiversity Movement and Mad Pride as an example. I have argued that these resources, which can function as hermeneutical dissent, end up contributing to the perpetuation of hermeneutical injustice when they are distorted, for instance, through the positive stereotypes associated with toxic positivity.

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