

# **VULNERABILITIES COMPOUNDED BY SOCIAL INSTITUTIONS**

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## Abstract

How can social institutions complicate and worsen vulnerabilities of particular individuals or groups? We begin by explicating how certain diagnoses within mental health and medicine operate as interactive kinds of labels and how such labels can create institutional barriers which hinder one's capacity to achieve well-being. Interactive kind modeling is a conceptual tool that elucidates the ways in which labeling can signal to others how the labeled person ought to be treated, how such labeling comes about and is perceived, and how it compounds vulnerabilities. We argue that this shift in standpoint helps us recognize and mitigate compounded vulnerabilities.

## **Introduction**

We aim to provide a definition of “vulnerability” that can justify special protections and take into consideration the multifaceted ways in which a person's holistic well-being can be threatened. We will argue that the different dimensions of well-being are interrelated, and diminishment along any one of these dimensions gives rise to first-order vulnerabilities. We introduce the notion of compounded vulnerabilities that result from social institutions creating further barriers to well-being. These barriers can come in many forms, but we explicitly discuss

how nosological categories can worsen and multiply the first-order vulnerabilities of these groups.

First, we believe that developing a more nuanced concept of vulnerability in bioethics begins with the recognition of our relational nature as human beings. It would be a mistake to think of ourselves as isolated “willers” who do not need social support for efficacious intentional action. In order to develop and sustain our agency, we require assistance from others and close affiliative bonds. Further, no person is immune to the power relations that determine the possibilities for agency in any given context. Thus, we can be vulnerable in a plethora of ways not captured by the isolated-willer account. Vulnerabilities tend to be multidimensional, and they point to a number of (often) interconnected threats to one’s well-being.

Second, within the context of bioethics, we must be clear what *kinds* of vulnerability are of concern and *who* makes up that population. Although we agree that frailty is a ubiquitous feature of humanity, we want to avoid positing vulnerability as a “natural fact,” since doing so would minimize or obliterate the need for special protections for certain individuals (see Luna 2009, 128). We use the term “vulnerability” to refer to the morally problematic disadvantaged placement of an individual within the context of social practices, which translates into threats to the agent’s holistic well-being. Those who comprise “the vulnerable” are not one homogenized group of individuals. Even groups often labeled as vulnerable, such as women and other historically marginalized<sup>1</sup> populations, are not, in virtue of being labeled vulnerable, so rendered. Rather, we need to look at the practices that make a person vulnerable.

Third, we need to understand the influences on our vulnerabilities that stem, not just from others as individuals, or situations as understood in people’s lived experiences, but from certain social institutions that can predictably and forcefully compound vulnerabilities. When an agent is

already vulnerable, social institutions can compound her vulnerability by creating additional barriers to her well-being. In shifting the focus to social institutions, we keep the scope of applicability wide enough to cover historically marginalized populations more generally while still working with a contextually rich, sufficiently narrow definition of “vulnerability” within a relational autonomy framework.

We begin by explicating how certain labels within mental health and medicine operate as interactive kinds. What makes a label interactive is not the category it creates, but the relationship between the labeled kind and the entities that fall under them; the person classified responds to the manner in which they have been labeled, and others within the surrounding social practices give credence to the label. In particular, when these effects influence how others believe a person *should* be treated, we might call such labels *normative labels*. Medical practice, as an authoritative institution with an extensive sphere of influence, issues judgments with social and normative import. Medical labels signal to others how someone ought and ought not to be treated within the community based on social norms. The dynamic interaction between variables within and outside of the individual should and will influence how this normative labeling comes about and is perceived. We argue that when interactive kinds are at play, different kinds of models are needed to represent how the symptoms under description are themselves obfuscated by normative social variables. Recognizing how and when interactive kinds arise will give us another piece of the puzzle, helping to put together a more holistic picture of the kinds of vulnerabilities within situated contexts.

We then move to explore how certain diagnostic categories can create institutional barriers which limit one’s capacity to develop or achieve wellness of being. Building on the theory of well-being put forward by Madison Powers and Ruth Faden, we investigate how

interactive kinds of labels present limitations to foundational dimensions of a decent human life. We offer another standpoint from which we might discover and develop new ways of recognizing and mitigating compounded vulnerabilities. We elucidate our account of how medical diagnoses, as normative labels, can be interactive in kind and can have these compounding effects through an analysis of Premenstrual Dysphoric Disorder (PMDD).

### **Medical labels and interactive kinds**

In his book, *The social construction of what?*, Ian Hacking distinguishes among the way we classify things, the sorts of things under classification, and which kinds of things interact with their classifications (1999, 103-124). While Hacking does not strictly define “interactive kinds,” he distinguishes them from indifferent kinds. Hacking describes indifferent kinds as the sorts of things that do not interact with the idea of their classification. To use a recent example, it makes no difference to the thing we call “Pluto” whether we categorize it as a planet or as an asteroid. By contrast, the person labeled homosexual, the person diagnosed with HIV/AIDS, and the person labeled feeble-minded act differently under such labels. Moreover, the actions of the labeled and the actions of others toward the labeled persons result in a looping effect (i.e., feedback loop) between the label and the classification itself. The characteristic of an interactive kind is being the sort of thing that, when labeled, is aware of labels and responds to them. This awareness is one that is “shared and developed within a group of people, embedded in practices and institutions to which they are assigned in virtue of the way in which they are classified” (ibid. 104).

Labels are especially worrisome when they carry a stigma,<sup>2</sup> marking what is taken not just to be a difference, but a deviation from, or deficiency relative to, what is regarded as “normal.” This stigma reinforces the standard of normalcy in such a way that deviation from the

standard, and being labeled as such, helps to reinforce and perpetuate unjust institutions and systemic inequalities amongst social groups. Even in cases where there are narrow nosological criteria, as is the case with HIV/AIDS or Type II Diabetes, this does not preclude stigma and vulnerabilities from entering the picture.

The stigma, in such cases, has to do with the prototype of *who* gets diagnosed with a disorder or disease, when that *who* mirrors the “standard case” (Hacking 1999, 24). Such stigma arises when the label carries a normative judgment about the individual’s behavior which reinforces, for example, perceptions of promiscuity, dangerous or irresponsible lifestyle choices, or ignorance; moreover, this judgment is not only about the individual, but the individual *as* a member of a categorized population. Seeing the way in which medical labels function dynamically between the individuals so labeled and the network of social practices and institutions is a challenge, one that falls through the cracks when these labels are viewed through either the traditional medical-biological model or the social construction model alone.

Some medical and mental health nosological schemes, diagnoses, and treatments are problematic, in part, because there is more than one way to map the relationship between the variables that are candidate causes of the observed phenomenon.<sup>3</sup> Choosing from among different kinds of variables and regarding one (or some), but not others, as the root cause of a medical or mental disorder is not something that is without consequence. According to the medical-biological model, the abnormality is directly caused or triggered by a change in an internal biological determinant. Describing the root cause in this way narrows the course of treatment or remedy to “fixing” the abnormality. Fixing the abnormality in this context means fixing the person. Additionally, by narrowing the causal mechanisms to biological determinants, social determinants are excluded from consideration as contributing to the causal mechanism

behind the abnormality. Likewise, social construction modeling looks to social determinants alone as the root cause of manifested symptoms, which may foreclose the possibility of recognizing and relieving physiological symptoms--even when longer-term socio-cultural and public policy changes are also needed.

Yet, these two models, the medical-biological model and the social construction model, present explanations as if they were necessarily mutually exclusive of one another when this need not be the case. Human beings are both biological and social creatures. Our environments, including societies and cultures, help shape our cognitive processes, which indirectly inform when and how our chemical and hormonal processes react to situations. Diane Halpern argues that “[e]ven hormones, which are usually considered biological variables, do not act in fixed or preprogrammed ways, but act within a context” (2006, 116). By modeling how such labels function as interactive kinds within the institution of medicine, we might open up a wider space of inquiry and a more fruitful starting point when developing measures to prevent and remedy harms caused by socially instituted vulnerability.

When labels are placed on individuals, the label itself causes changes that ripple out and loop back to the individual. In the case of interactive labels, we need a way to account for and model the possible interactions between the labels, how they affect a person situated in a given context, and how this change may influence how the phenomena show up to medical and mental health professionals. By tracking how labels affect people, we are also better situated to address how populations receiving certain labels are made vulnerable in virtue of receiving them. Many historically controversial medical labels contain conditions that fall into one of two categories: 1) those that designate a specific population as an essential feature of the diagnostic criteria and 2) those which are not explicit in this regard but de facto apply to a specific population in their

diagnostic practices. Therefore, we should scrutinize and probably reconsider labels that are purportedly rooted in biological facts that de jure or de facto single out populations that have been historically marginalized or oppressed.

Determining the causal relationship between symptoms and correlated biological processes is not clear cut, and it becomes less so when the population under diagnosis is receiving a label that plays into the stigma historically associated with oppressive stereotypes. When oppressive stereotypes, which are clearly social determinants, enter into the picture of a biologically-based diagnosis, they compound vulnerability by adding additional barriers to the development and achievement of well-being for those individuals who are thus labeled. Using interactive models to capture how medical labels render social groups vulnerable or exacerbate existing vulnerabilities can also open up different ways of understanding and responding to compounded vulnerabilities within medical institutions.

### **Vulnerabilities and well-being**

Our conception of vulnerability is meant to be dynamic and to capture the particularities of an individual's situation within a community that has practices and norms situated within a specific history. Florencia Luna points out that *situations* render groups vulnerable (Luna 2009, 122). Beginning with a concept of vulnerability as a mere label often covers over the intersections and interrelationships between overlapping factors which give rise to the vulnerabilities within the lives of particular individuals, not just groups of persons (ibid.129). Luna uses the metaphor of layers as a means to understand vulnerabilities in a more nuanced way. Luna's analysis addresses different kinds of harms, and the different kinds of vulnerabilities can be seen to parallel the types of first-order vulnerabilities we describe. However, addressing

different layers will not necessarily address institutionalized forces which complicate and worsen vulnerabilities.

We agree with Luna that this term should not be fixed; as a category, it should incorporate contextual details and particularities of individual circumstances. What we do not get from Luna's metaphor is a deeper understanding of the interconnections between the layers; the metaphor does not elucidate how different vulnerabilities interconnect and feed into one another and how interactive kinds of labels cut across first-order vulnerabilities. Without shifting our standpoint from the situations in the lives of individuals to the dynamic interactions between institutions and persons, we might miss opportunities to mitigate and address the ways in which the institution of medicine intersects many of the layers discussed by Luna. We define "vulnerability" as follows:

An individual is vulnerable when he/she is in a position which threatens his or her ability to develop and achieve the most fundamental dimensions of well-being. Vulnerability can be caused or exacerbated by both internal and external variables including, but not limited to, an individual's mental state, economic independence, political standing, physical security, or physical health.<sup>4</sup>

As a technical term, "vulnerability" should not be expansive enough to cover susceptibility to any kind of loss whatsoever. Rather, whether someone is vulnerable depends on the physical health and social, political, and economic circumstances of that individual. These circumstances will partially determine the *type* of vulnerability that is present; for example, someone might be vulnerable to exploitative work conditions without being vulnerable to community abandonment. If specific circumstances systematically create certain types of vulnerabilities, we have reason to suspect that unjust asymmetric power relations are at play. As we want our definition of

“vulnerability” to take into consideration the moral nuances of particular people as historically situated beings, we incorporate the theory of well-being put forward by Madison Powers and Ruth Faden.

Powers and Faden provide a theory of six irreducible dimensions of well-being. Each dimension has independent moral worth, and this list is meant to cut across cultural differences and personal preferences; generally, no matter what other plans or values someone has, these dimensions will matter for their well-being (Powers & Faden 2006, 15). Even if things are going well in other respects, a basic level of functioning along these dimensions is required for a life to meet the decent minimum for flourishing (Nussbaum 2000, 71). Deficiency along any dimension amounts to a type of first-order vulnerability.

This theory incorporates concrete facts about the human condition in order to determine the most urgent moral needs to be addressed by the society.<sup>5</sup> Powers and Faden’s position presupposes that some people will be less vulnerable than others, making their theory non-ideal (2006, 30).<sup>6</sup> Within the context of mitigating vulnerabilities, establishing a baseline of human needs gives us a standard of measure and the groundwork for understanding how the dimensions of well-being are interrelated. Given the closely intertwined nature of the dimensions of well-being and the interlocking features of any given society, inequalities in one area will beget further inequalities (ibid. 31). Vulnerabilities will thus be multifaceted rather than singular or isolated.

The six foundational dimensions of well-being are:

1. Health: physical and mental functioning with minimal pain and loss of control over one’s body
2. Personal security: absence of assault, and threats

3. Reasoning: ability to gain knowledge about the physical and social world for practical decision-making
4. Respect: recognition of each person's intrinsic moral worth and dignity
5. Attachment: feeling of belonging, like we have a place in the world; emotionally deep bonding with others
6. Self-determination: ability to make and pursue options for ourselves (Powers & Faden 2006, 17-28)

These dimensions highlight the moral nuances of human flourishing. No one dimension is more foundational than others, so vulnerability along one dimension is not more urgent than vulnerability along any of the others. As can be seen from this list, a first-order vulnerability can relate to internal or external variables. Someone with severely diminished health could fall below the threshold of the decent minimum required for well-being, and this first-order vulnerability would be the result of a variable internal to the agent. A pattern of being ostracized, on the other hand, could similarly prevent someone from achieving well-being, but this first-order vulnerability (along the fourth and fifth dimensions as listed above) would be the result of variables external to the agent. In the context of medical labels, the labeling of mental and medical illness can result in vulnerability along any one of these dimensions.

To be compromised on any of these elements is also to be compromised as an agent. Without, for example, social bonds or self-respect, it will be very difficult to set and achieve ends. This view stands in contrast to a classically Kantian view of agency, according to which Reason and the Noumenal Will are all that persons need to count as fully agential. The Kantian view, which is the received view in Western, post-Enlightenment thought, stresses "self-sufficiency, independence, a capacity for deliberation and rational transcendence of emotion"

(Carse 2006, 35-36). The intuitive force of Powers and Faden's view is supported when we move from such a Kantian theory of agency to a relational one. This theory of well-being begins with the presumption that we are dependent beings, and a good life for us necessarily involves full and satisfying relations with other people. If our social mobility or connections are in danger, then we experience deep harms to our agency.

Alisa Carse and Margaret Little give a useful example for how the term "vulnerability" is narrowly applicable. If Bill Gates agrees to an unfair price for caviar because he does not wish to spend time haggling, we would not say that he has been *exploited* by his caviar vendor. Carse and Little explain: "If there's one thing Bill isn't, it's economically vulnerable" (2007, 210). He is not situated such that he is on the losing end of asymmetric economic power relations; in other words, the situation does not *render him vulnerable*.

While our primary example (PMDD) concerns mental illness, we believe that other disease labels can a) be interactive and b) compound vulnerabilities. HIV/AIDS serves as an example of an interactive kind that can--for some individuals--compound vulnerabilities. If someone without any first-order vulnerabilities were to receive this diagnosis, he/she would not have any vulnerabilities compounded. For example, a wealthy, heterosexual white man who is not vulnerable prior to the diagnosis would (probably) not have any vulnerabilities compounded by the medical label, since he is not part of a historically marginalized and disenfranchised group. In contrast, individuals who are vulnerable along the six dimensions of well-being (see Powers & Faden 2006, 15) prior to the diagnosis could have those vulnerabilities compounded by the label. If a poor, homosexual black man were diagnosed with the same illness, he would (probably) have his vulnerabilities compounded. The stigma of HIV/AIDS could potentially reinforce stereotypes that contribute to his current marginalization and disempowerment in his

current society, thus creating institutional barriers to the achievement of a sufficient level of well-being. Our account successfully explains this crucial difference in how disease labels can affect individuals of certain populations differently. To get a grasp on how social practices and institutions create and reinforce vulnerabilities, we must explore the connections between agency and well-being and how medical labels operate in relation to these two concepts.

One might argue that our definition of “vulnerability” is too abstract or too vague. We are in a world that could arguably “threaten” most anyone as a holistic person. For example, it could be argued that in an oppressive patriarchal society, women will necessarily be in a position of vulnerability; that is, their capacities and functioning will ipso facto be diminished. However, what counts as a socially instituted vulnerability is always at an intersection of social practices, the individual, and her situation; it does not inhere in the individual herself or in gender as such. We are not hereby claiming that vulnerable populations are forever trapped in a state of immobilized agency in all areas of their lives; vulnerable individuals can discover outlets that will permit them agential freedom. For example, a woman who cannot find a foothold politically or economically could nonetheless flourish in other spheres, and she could conceivably uncover “loopholes” within oppressive social structures and ultimately discover options and opportunities within these practices. However, we do not want to underplay the serious effects of compounded vulnerabilities; individuals whose attainment of well-being is thus hindered have experienced a significant loss of agential freedom. Their ability to develop, set, and accomplish ends is thwarted as a direct result of being marginalized by social practices that make successful end-setting possible.

We certainly do not want to gain flexibility at the expense of clarity and sufficient narrowness of applicability. It will not generally be the case that fixed traits of persons threaten

them as holistic beings; rather, how people are perceived and treated within normative social practices--that is, social practices that set certain norms for the behavior and treatment of people--determines whether they are vulnerable. Illnesses can create first-order vulnerabilities, but these vulnerabilities are not necessarily compounded. How social institutions respond to and accommodate first-order vulnerabilities is not determined by any “natural” fact of the matter. To better situate our position and clarify how we distinguish ourselves from others in the vulnerability literature, we will briefly distinguish vulnerability as a general human condition from vulnerability as a social ill.

### **Ways to interpret “vulnerability”**

Michael Kottow argues that “vulnerability” needs to be distinguished from “susceptibility”: “the vulnerable are intact but at risk, in the same way a fine piece of porcelain is unblemished but highly vulnerable to being damaged. The susceptible are already injured, they already suffer from some deficiency” (Kottow 2003, 464). He believes that all humans are vulnerable, but only certain people at specific times are susceptible. If we overlook this distinction, Kottow insists, we neglect important differences in necessary levels of protection and requirements for social justice (*ibid.*, 465).

In a similar vein, Alisa Carse argues that accepting our frailty as limited creatures is necessary for beneficence and compassion. We rely on others to support us as we develop our character and capacities as agents. In our close social relationships, this acknowledgement of human frailty is essential for emotional closeness and empathic engagement (Carse 2006, 40-41). Used in this way, “vulnerability” denotes an essential ingredient to human flourishing, and it is not, in itself, a social ill (*ibid.*, 45). The willingness to make oneself vulnerable to other people is sensible in the context of intimacy, trust, or sympathy.

However, when social practices or institutions create or reinforce vulnerability, we are faced with an entirely different context; in this scenario, systematic disadvantage is the result. By reinforcing vulnerability in populations, these practices create, sustain, or reinforce asymmetric power relations. Those who control (and control can come in many forms) the institutions are privileged in ways that are not shared by those who are made vulnerable. Moreover, if certain groups of people are habitually “willing” to make themselves vulnerable in a wide range of social relationships, we have reason to wonder whether undetected institutional pressures are responsible for this pattern.

We believe that the conceptual parameters of “vulnerability” as a technical term in bioethics should not be so wide as to cover all of humanity; our terminology therefore differs from Kottow’s<sup>7</sup> and Carse’s. We would say that, due to our being limited creatures that are often subject to affliction, humans are *frail*. The philosophical topic of human frailty, however, does not directly concern us here. We do not want “threatens” in our definition to be construed too broadly. For example, the fact of being a woman does not, in itself, threaten a person’s well-being.<sup>8</sup> Being a woman is not analogous to being a “fine piece of porcelain” that is “highly vulnerable to being damaged.” Following from our previous arguments, women (and other groups) are not, everywhere in everyplace in every context, vulnerable. Situational factors will determine whether people in a particular segment of the population are in a position that threatens them as holistic beings, where threats are understood in terms of the six dimensions of well-being. Being a woman could make a person vulnerable if, for instance, she is situated in a society that promotes, explicitly or implicitly, oppressive sexist norms, or again if she is partnered with an individual who is fiercely misogynistic. Additionally, there can be variations in

vulnerabilities among individuals within a certain group. Deficiencies along the dimensions of well-being depend on the specific circumstances of the individual.

### **Compounded vulnerabilities**

Compounded vulnerabilities arise when systemic or institutional conditions intersect in a manner that creates additional barriers to the agent's ability to develop or achieve well-being. Historically disadvantaged populations are particularly susceptible to being kept in disadvantaged positions when an institutional standard or condition plays into, reinforces, and perpetuates the stigma of the population stereotype. Just as shifting to interactive models enables us to see more clearly how the social and the biological variables dynamically shape each other, shifting toward a concept of compounded vulnerabilities as socially instituted vulnerability enables us to see more clearly how certain kinds of medical and mental health categories might magnify first-order vulnerabilities. Likewise, when a diagnosis incorporates such labels, treatment options should seek to mitigate and minimize the harms that compounded vulnerabilities present.

When a diagnostic label of a medical or mental disorder targets a historically marginalized and disadvantaged population, that diagnosis compounds the vulnerability to which that population is already subject. People who receive the label of mental illness are often mistrusted as agents; there are common misperceptions about their competence, dangerousness, tendency toward violence, and unpredictability (see Angermeyer & Dietrich 2006, esp. 170-171). Moreover, when the nature of the diagnosis is such that it reinforces stereotypes and biases that are the source of the group's vulnerability, there are additional reasons to question whether the diagnosis is legitimate or necessary.

Especially when someone is vulnerable as a member of a historically marginalized group, biases can be internalized that hamper that person's well-being. If the diagnosis reaffirms the content of stereotypes that have been leveled against an individual or group, then there are further barriers to that individual's coming to terms with him-/herself as an agent. Recent research demonstrates the real effects of internalized stigma for such populations.<sup>9</sup> Hope, self-esteem, empowerment, self-efficacy, overall quality of life, social support, and treatment adherence all suffer considerably for the majority of patients who internalize the stigma of mental illness (Livingston & Boyd 2010, 2155-2156). The ways in which we perceive the world, navigate our community, perceive evidence, and self-reflect are shaped by social practices. The fact of historical marginalization is enough to make a group or individual vulnerable; when institutional structures bolster that marginalization, vulnerability is compounded by the added difficulties in attaining a sufficient level of well-being.

### **Premenstrual Dysphoric Disorder: A case study**

We have analyzed how compounded vulnerabilities can arise from interactive kinds of medical labels, and we now wish to anchor our discussion in a timely example in mental health, Premenstrual Dysphoric Disorder (PMDD). Our analysis serves two purposes. First, by turning to a contemporary example, we have a more concrete way of understanding how modeling certain diagnoses as interactive kinds allows us to recognize the resultant institutional barriers and how these barriers can limit one's capacity to develop or achieve well-being. Second, through analyzing PMDD in particular, we are able to bring our analysis to bear on mitigating actual harms in the lived experiences of women who receive the diagnosis.

### **PMDD as an interactive kind**

To be diagnosed with PMDD, a woman must experience at least one of the following the week prior to her period: depressed mood, anxiety, tearfulness, or irritability. These symptoms must be severe enough to interfere with daily functioning, such as work, school, or interpersonal relationships (APA 2000, *DSM IV-TR*, 774).<sup>10</sup> The *DSM-IV-TR* lists PMDD under the appendix “Criteria sets and axes provided for further study,” but it also mentions it in the main text under “Depressive disorder not otherwise specified” with the psychiatric diagnostic code 311.<sup>11</sup> The claim that PMDD is a distinct clinical entity is grounded in the idea that we can empirically assess and measure abnormal biological processes resulting from hormonal and chemical changes in women immediately preceding their menses (Endicott et al. 1999; Endicott 2000). As PMDD is, by definition, about menstruation, focusing on the physiological changes occurring at the time of menstruation to the exclusion of the cultural perceptions about this process exacerbates the gap between the extent to which these biological processes “trigger” the cluster of symptoms labeled as PMDD and how the symptoms themselves are experienced and perceived in the lives of women. This part of the PMDD puzzle comes to the forefront when we consider the fact that the process of diagnosis for PMDD is dependent upon women’s subjective self-reporting of symptoms.

When weighing another set of evidence, there is equally good reason to take seriously the social constructionist claims that the contemporary American cultural representations and norms surrounding menstruation are internalized and become manifested as a cluster of symptoms. Social constructionists argue that, in a male-dominated society, women and other historically marginalized populations internalize the dominant standard, which, in turn, undermines their self-esteem and creates anxiety. The purported pathology, in this case PMDD, is not reflective of something “really” wrong with women, but rather it is a reaction to the social circumstances in

which she finds herself (Ussher 2004; Jimenez 1997; Rodin 1992). Consequently, there is evidence to support both kinds of modeling of the phenomena under description. Yet, both sides present the choice between models as a binary one; either PMDD is a distinct clinical entity, or it is the product of socialization.

To admit that women could become conditioned to respond biologically to oppressive social situations, particularly if these general sentiments are magnified by personal or professional stress, does not undermine the explanations given by either model. What this means is that we may need to have a different model that brings these two into conversation with one another, so we can see the bigger picture of how these different kinds of factors engage with one another and affect the lives of women who receive a medical label. In modeling the interactions among biological, psychological, and social variables as different kinds of looping effects, we can begin to get a firmer grasp on how such looping effects shape the social institution of medicine; we can track, for instance, how medical labels shift over time. Furthermore, we can also better track how nosological criteria of interactive kinds of labels might amplify first-order vulnerabilities in certain populations. Interactive kind modeling can capture the different variables at play in the diagnosis of PMDD, how these variables relate to one another within situated contexts, and compound the vulnerabilities that emerge as result.

### **PMDD as a category that compounds vulnerabilities**

By exclusively targeting women for diagnosis, PMDD further pathologizes women's functioning in a way that is not shared by men. Given the history of pathologizing women's bodies, PMDD as a category of mental illness raises an immediate red flag. Since its inclusion in the *DSM-III-R* as Late Luteal Phase Dysphoric Disorder, this category has been highly controversial because it singles out women and reinforces denigrating stereotypes of

menstruating women as irrational, overly emotional, and unstable. The label of mental illness, conjoined with these prevalent stereotypes, can affect women in numerous areas of life that threaten their well-being.

Women who are diagnosed with PMDD can have compromised legal standing in child custody and criminal cases. The label of mental illness alone can cast doubt on an individual's testimony or merits in court (Caplan 2004, 53). Moreover, in child "custody battles, it would not be unreasonable for an opponent to classify the mother as suffering from premenstrual dysphoric disorder," which could pose a threat to her case (Solomon 1995, 12). In the legal system, the diagnosis of PMDD could validate claims that a woman lacks the emotional stability or competence to fill certain roles, such as being a mother.

For similar reasons, a woman who receives this label could lose the ability to make medical decisions for herself. The diagnosis can be used to justify paternalistic claims that she be unburdened of the difficulty of making important decisions regarding treatment. Her ability to function as a self-determining agent can be threatened, also, when her other medical complaints and conditions are not paid their due attention. PMDD, as a condition associated with severe depressive behavior, can create a lens through which clinicians interpret all other medical claims that the woman makes (Thachuk 2011, 155).

This diagnosis can also thwart her as an end-setter. When a woman is labeled with a mental disorder that is beyond her control and renders her "irrational" or "unstable," this situation "gives rise to the argument that [she] must be denied important responsibilities outside the home since one can never predict when she will lose control of her ability to make rational decisions" (Rodin 1992, 55). In her professional and interpersonal encounters, she is at risk for being dismissed and distrusted whenever important tasks or duties need to be done. The PMDD

label could validate misperceptions that premenstrual women are incapable of productivity or level-headedness.

A core concern is that PMDD may threaten the self-conception of those diagnosed with it, as happens too often with other diagnoses of mental illness (Rose & Thornicroft 2010; Thornicroft et al. 2007; Hinshaw & Stier 2008; Corrigan 2004), still more with diagnoses that carry gendered connotations. She could experience lower self-esteem and self-doubt that directly result from the medical labeling. In an empirical study of how women diagnosed with PMS/PMDD respond to their femininity in light of these labels, it was found that “irritability, bloating, and the like are experienced as affective or physical signifiers that *they* have lost control, that *they* have failed as women” (Cosgrove & Riddle 2003, 49). There will be pressures for her to internalize the stigma and stereotypes that now appear to have backing from an official, influential authority. In her everyday interactions with others, her reliability, honesty, and performance might all be called into question from the outset, even if not explicitly stated. A woman labeled this way might feel freer to express her emotions when premenstrual (since emotionality is now considered expectable behavior), but this expression is consistently taken as suspect when “expressed under the guise of a PMS [or PMDD] outburst” (ibid. 51).

Given all of these considerations, the category of PMDD can compound the vulnerabilities of women by adding to the various hindrances to women’s well-being that are present in our society and by giving the hindrances apparent legitimacy. Although not all women diagnosed with PMDD will experience these barriers, it is our contention that many will, and these barriers make achieving a sufficient level of well-being more difficult in several areas of life. We do not mean to suggest that the diagnosis and treatment of PMDD are entirely detrimental, since some women will surely benefit from having their symptoms recognized and

ameliorated. However, this diagnosis cannot be treated like any other diagnosis; labeling women in this way must be taken with adequate care so as to mitigate the foreseeable harms associated with these additional barriers to well-being.

### **Conclusion and recommendations**

By thinking about labels within mental health and medicine as interactive kinds and how these interactive kinds give rise to compounded vulnerabilities, mental health professionals have a conceptual tool that can better evaluate how labels are reflective of the biological determinants and how the social determinants inform the interpretation of biological factors. Understanding the function of labels and their corresponding categories as interactive kinds opens up the possibility of understanding how different kinds of vulnerabilities intersect and how best to mitigate the harms caused by socially instituted vulnerabilities.

Such changes do not have to come in radical forms. From this shift in perspective, the health care community and professional governance bodies do not have to completely overhaul current practices to address and mitigate compounded vulnerabilities. For example, a socially responsible nosological system and diagnostic criteria might introduce category modification for labels that cannot clearly demonstrate biological indicators as the only trigger of disorder-related symptoms, particularly when historically marginalized or disadvantaged populations are targeted by the category and when the label itself plays into the historical stereotypes and prejudices against these groups. Another step in recognizing that health care providers play a crucial role in patient functioning is stressing the collaborative process of how a patient comes to achieve knowledge in the clinical encounter. The clinician is integral in fostering autonomy through competent, responsible inquiry (Kukla 2007). The health care community might consider altering the presentation of medical labels to ensure that the population they pertain to is aware of the

seriousness of receiving the label and what social supports are available to help mitigate some of these effects.

Finally, health care practitioners can better recognize vulnerabilities and foster well-being without drastically changing institutional structures. For example, we recommend incorporating diagnostic tools that provide contextually rich details, such as narrative-focused structured interviews, when patients present symptoms or seek treatment. Doing so will help ensure proper diagnosis and help identify intersecting social factors. There are significant advantages to an open-ended format, since it encourages patients/subjects to a) provide fuller and nuanced details of their experiences, b) explain what the symptoms mean to them as individuals, c) make distinctions that are significant for understanding their condition, and d) communicate comfortably about the circumstances of their lives (Cumming et al. 1994). Knowledge gained from these interactions will provide alternative or supplementary explanations for the cluster of symptoms, thus better ensuring long-term positive outcomes in treatment.

We have provided a conception of vulnerability that is narrowly applicable and that signals urgent moral need. Based on our account, an individual's vulnerability will reflect particularities of his/her situation, and it can contain multiple facets based on irreducible and interconnected dimensions of well-being. When systemic or institutional conditions intersect in a manner that creates additional barriers to the agent's ability to develop or achieve well-being, those situations compound the first-order vulnerability. We have argued that, in the case of mental health and medical labels that subject people or populations to compounded vulnerability, interactive kind modeling helpfully illuminates the interaction of biological and social factors that lead to classification, diagnosis, and treatment options. Interactive kind modeling directly bears on the question of compounded vulnerability because, when oppressive stereotypes enter

into medical diagnosis, they add barriers to well-being for those who are labeled with the disorder. The end result is the de jure or de facto targeting of historically marginalized populations and the compounding of vulnerabilities. Premenstrual Dysphoric Disorder serves as an example of an interactive kind that compounds the vulnerabilities of menstruating women; however, our analysis applies to a plethora of morally problematic medical categories.

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<http://engage.bioethics.georgetown.edu/mentalillness>.

### **Notes**

1. Iris Marion Young explains that marginalization “is perhaps the most dangerous form of oppression” because a “whole category of people is expelled from useful participation in social life” (1990, 53). Young’s explication is useful for understanding this concept, though it is not part of our project to give a comprehensive list of criteria for determining which groups throughout history have been marginalized.
2. We disagree with those who claim that social reactions and stigma alone are sufficient to bring about mental disorders. Nevertheless, we contend that stigma associated with certain diagnoses plays a significant role in a person’s ability to navigate the world successfully as an end-setter (see Rosenfield 1997, 661). Our view more closely aligns with the modified labeling theory put

forward by Bruce Link and colleagues, and we disagree with the stronger theory proposed by Thomas Scheff.

3. We are not taking the hard stance that *all* mental illnesses are best modeled as interactive kinds. There are clearly diagnostic categories within mental health that, even if they are interactive, are so in a *benign* sense (e.g., some somatic disorders). That is to say, there seem to be plenty of labels that do not reinforce vulnerability.

4. Non-human animals can also be vulnerable in bioethical contexts, though theories of well-being should be species-specific.

5. How one cashes out “urgent moral need” will depend on how one frames ethical obligations and responsibilities. We understand an urgent moral need to be one that has high priority in the balancing and weighing of obligations; it has this greater weight because of the type and level of moral harm that is likely if the need goes unmet (see Nussbaum 2000).

6. Powers and Faden reject ideal theories of the *right*, though they defend an ideal theory of the *good*, as is evidenced by their focus on flourishing. Additionally, on Powers and Faden’s account, we require more than the *capability* to pursue the different dimensions; we also need a certain level of success so as to *function* in these areas of life (Powers & Faden 2006, 37-41).

7. We can distinguish *actual* vulnerability and *susceptibility to* vulnerability; though, given our definition of “vulnerability,” our distinction would not map onto Kottow’s. We would say that someone is susceptible to vulnerability if he/she is *liable to enter* into a situation that threatens him/her as a holistic being. Someone is actually vulnerable if he/she *is* in that situation.

8. Similarly, being pregnant does not, in itself, push a woman below the minimum threshold on any dimension of well-being. If social institutions respond to pregnancy in ways that ultimately undermine the woman’s agency, then we would say that the *situation* renders her vulnerable.

9. Bruce Link, Jerrod Mirotznic, and Francis Cullen demonstrated through studies that stigma cannot be overcome through common coping methods, lending support to our contention that stigma forcefully hinders individuals' ability to attain a sufficient level of well-being (Link, Mirotznic, & Cullen 1991, 316). Therefore, stigma as a social barrier cannot be dismissed as some critics of labeling theory propose (see discussion in *ibid.* 400).

10. According to the *DSM-IV-TR*, a woman has Premenstrual Dysphoric Disorder if the week prior to her period, she experiences at least five of the following symptoms, one of which must be (1), (2), (3), or (4):

1. marked anxiety or tension
2. markedly depressed mood
3. marked affective lability
4. persistent and marked anger or irritability or increased interpersonal conflicts
5. decreased interest in usual activities
6. subjective sense of difficulty in concentrating
7. lethargy
8. marked change in appetite
9. hypersomnia or insomnia
10. a subjective sense of being overwhelmed
11. other physical symptoms

PMDD is distinguishable from PMS by the severity of these symptoms and the fact that they interfere with daily functioning (771-74).

11. The current Sub-Work Group for Premenstrual Dysphoric Disorder and the Mood Disorders Work Group are proposing the PMDD have an elevated status in the *DSM-V* and be placed in the main text under Mood Disorders. For more information on current proposals for PMDD, go to <<http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=484#>>.

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