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Epistemic injustice in psychiatric research and practice

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ABSTRACT

This paper offers an overview of the philosophical work on epistemic injustices as it relates to psychiatry. After describing the development of epistemic injustice studies, we survey the existing literature on its application to psychiatry. We describe how the concept of epistemic injustice has been taken up into a range of debates in philosophy of psychiatry, including the nature of psychiatric conditions, psychiatric practices and research, and ameliorative projects. The final section of the paper indicates future directions for philosophical research of epistemic injustices and psychiatry, concerning neurocognitive disorders, identity prejudices in psychiatric illness, concepts of epistemic privilege in psychiatry, and the prospects for combining phenomenological psychopathology and epistemic justice. We argue that much remains to be done in the conceptualization of these epistemic injustices and suggest that this future work should be multidisciplinary in character and sensitive to the phenomenology of psychiatric conditions.

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1. Introduction

Epistemic injustice has become a popular concept for scholars and activists concerned with the negative socio-epistemic experiences consistently reported by people with psychiatric conditions. An extensive set of conceptual resources already exist to describe experiences of being ignored, unfairly dismissed, “silenced” or otherwise epistemically harmed. Concepts such as stigma, sanism, and negative stereotyping are well-established within psychiatry and activist discourses. Philosophers of psychiatry and healthcare have recently begun to deploy the concept of epistemic injustice in relation to their own conceptual, epistemological, and practical interests. The quick uptake of the concept of epistemic injustice is partly due to those earlier concepts, many of which were themselves integral to the articulation of the new concept of epistemic injustice (see Kidd, Medina, and Pohlhaus,

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2017, Part III). However, epistemic injustice as a concept is distinctive; it is not simply a restatement, in a different vocabulary, of experiences and social processes already described by stigma and other concepts. We claim that the concept offers a distinct way of thinking about social and other injustices, in a way that uniquely articulates the injustice taking place in the epistemic domain. The concept of an epistemic injustice also offers new ways to think about issues in the epistemology of psychiatric research, the nature and practice of psychiatric practice, and phenomenological psychopathology.

The concept of *epistemic injustice* was coined by the philosopher Miranda Fricker. Her original statement of the concept was the landmark monograph, *Epistemic Injustice: Power and the Ethics of Knowing* (Fricker, 2007). Fricker describes her work as sitting at the intersection of ethics and epistemology, and the concept of epistemic injustice as capturing an injustice done to someone in their capacity as a knower, an epistemic agent. The two main kinds of epistemic injustice described in the book are *testimonial injustice*, where negative prejudice causes a hearer to deflate the credibility assigned to a speaker, and *hermeneutical injustice*, where a collective gap in hermeneutical resources prevents understanding some or all of the social experiences of certain groups (Fricker, 2007, chs. 1 and 7.). Fricker subsequently refined and elaborated her ideas in later publications, although the original Frickerian framework is what has come to be central to *epistemic injustice studies* (e.g., Fricker, 2017).

Since the 2007 book there have been three main developments in the philosophical literature. First, there has been critical refinement and elaboration of the original account. For example, an account of *structural testimonial injustice* was added to augment Fricker's account of agential testimonial injustice (Wanderer, 2017: section 3). Rebecca Mason distinguished hermeneutical injustices that involve the *absence of conceptual resources* from those involving a *collective refusal of uptake* of conceptual resources available in specific communities (Mason, 2011).

Second, scholars identified other *kinds* of epistemic injustice, other than those focused on by Fricker. Examples include what Kristie Dotson (2011) called *testimonial smothering*: a preemptive self-censoring of the content and expression of testimonies by speakers. Christopher Hookway (2010) identified another pair of preemptive epistemic injustices. *Informational prejudices* involve prejudices about what kinds of people will possess the sense of relevance necessary to being a worthwhile informant, while *participatory prejudice* prevents one from recognizing someone as a potential participant in a shared epistemic activity. Other scholars have described kinds of *contributory injustice* and *discursive injustice*; doubtless others exist (Kukla, 2014; Tate, 2019).

Alongside identifying other kinds of injustice, philosophers have also offered alternative accounts of the nature and normative status of epistemic

injustices. David Coady (2017) argues that Fricker's account presents the wrongs of epistemic injustice in *discriminative* terms – we unfairly and harmfully discriminate against certain epistemic agents (women, disabled persons, and so on). Coady proposes an alternative *distributive* account according to which the wrongs of epistemic injustice concern misdistribution of epistemic goods, such as credibility and intelligibility, in a social environment (compare Byskov, 2020). Dotson has argued that the real wrong of many epistemic injustices is that they are specific expressions of a wider phenomenon of *epistemic violence*, a concept introduced by Gyatri Spivak (1988). If the violent character of epistemic injustices is occluded, we may risk understating their full nature and significance (Dotson, 2011, pp. 237–242).

Another expansion was Pohlhaus (2012) account of *willful hermeneutical injustice*. She suggests that dominantly situated individuals need to take up currently local hermeneutical resources to grant them widespread epistemic force. Without uptake of these hermeneutical resources, marginalized individuals cannot successfully communicate their experience beyond their own communities. Pohlhaus Jr. argues that privileged social groups often need to “maintain their ignorance by refusing to recognize and by actively undermining any newly generated epistemic resource that attends to those parts of the world that they are vested in ignoring” (2012, p. 729). Turning away from marginalized groups' experiences in this way is an act of willful hermeneutical ignorance. Emmalon Davis (2018) suggests a further epistemic harm, which she dubs *epistemic appropriation*, in which marginalized knowers are harmed through the dissemination and intercommunal uptake of their epistemic resources, in ways that detach those resources from the knowers who created them. Moreover, such resources are utilized in dominant discourses in ways that disproportionately benefit the powerful.

A third important development in epistemic injustice studies has been the identification of earlier philosophical projects that aimed at understanding and rectifying epistemic injustices. These include pragmatism, phenomenology, and social epistemology. The broad phenomena of social injustice (which includes an epistemic dimension) have been recognized prior to Fricker's analyses, and the earlier projects often employed quite different vocabularies, as well as developing within different communities. Certainly, one can find examples within certain traditions in philosophy, religious studies and theology, heritage studies, and educational theory (see the chapters in Kidd et al., 2017, Parts III and V). Moreover, there is a multidisciplinary body of work – encompassing history, sociology, Disability studies, and Mad studies – which also analyses forms of what philosophers conceptualized as epistemic injustices (Morgan, 2021; Reaume, 2021). This sort of multidisciplinary approach is demonstrated by Mohammed Rashed's work, which draws on philosophy, history of

psychiatry, Mad studies, and Disability studies to offer a philosophical justification for “a broadening of our cultural repertoire as it pertains to madness beyond medical and psychological constructs and frameworks” (Rashed, 2019, xxxiii, see. esp. chapters. 1 and 11). Such pluralism is important for a further reason: our critical discourses about complex and contested phenomena should not be conducted using a single style of critical discourse (Rashed, 2020).

The upshot of these developments over the fifteen years since the publication of Fricker’s *Epistemic Injustice* has been a substantial enrichment of our resources for conceptualizing the nature, causes, wrongs, and effects of many kinds of epistemic injustice. These enriched resources are also being taken up by academics interested to put those concepts to work, often in the service of ameliorative and practical work in specific domains (see, e.g., the chapters in Sherman & Goguen, 2019).

Before we turn to examine epistemic injustice within psychiatry, we’d like to mention three problematic tendencies in epistemic injustice studies, or at least in certain sections of it. First, there is often a tendency to use the term “epistemic injustice” in an over-general way to cover “anything bad epistemically”. In many cases the epistemically bad thing really is an epistemic injustice, in which case the use of that term is entirely appropriate. In other cases, the epistemically bad thing certainly includes epistemically unjust elements, but also other sorts of epistemically bad elements, such as certain epistemic vices (Battaly 2017). In other cases, the epistemically bad thing isn’t really an epistemic injustice at all and describing it using that term disguises or distorts its actual nature. Fricker notes cases where a person has a credibility excess – such as presuming a man will be well-informed about car engines, when in fact he is ignorant – and argues that these would not class as testimonial injustices (Fricker, 2007p. 21; Medina, 2011). We might also consider cases where there is *intentional* downplaying or denial of someone’s testimonies – Fricker is explicit that epistemic injustice is necessarily unintentional (Fricker, 2017). If these intentional downgradings are not instances of epistemic injustice, they can still be instances of epistemic vices, such as the ones Jason Baehr (2010) labels *epistemic malevolence*. An epistemic vice is not an epistemic injustice, even if certain patterns of epistemically vicious behavior can encourage or sustain epistemic injustice.

Second, there is a tendency to rely on under-articulated accounts of epistemic injustice. Sometimes epistemic injustice is used without its associated theoretical machinery. This can include a neglect of relevant distinctions, such as the *primary* and *secondary* harms of epistemic injustices, where the primary harm could be characterized as “truncated subjectivity” (Pohlhaus, 2014) or “epistemic objectification” (McGlynn, 2021) or some combination of these. Not all uses of the concept require us to include all of

its associated theoretical machinery, of course, but in many cases the concept can only really do its work if that machinery is introduced.

A third tendency is scholars defaulting to the original Frickerian framework without considering either its subsequent amendment or the criticisms made of it, or without considering alternative possibilities. For instance, there is neglect of Fricker's two kinds of silencing (Fricker, 2007, §6.1) in favor of a default to the account of silencing developed by Langton and Hornsby (1998) – which, again, may suit certain cases, but not all.

We think that the diversity of resources available for epistemic injustice studies makes it a good time to use those resources to explore experiences of epistemic injustice within specific contexts and communities, or in relation to specific kinds of experience. We here focus on persons with psychiatric conditions. Indeed, one very energetic corner of epistemic injustice studies is that devoted to the study of epistemic injustice in healthcare contexts. That work began with two papers by Havi Carel and Ian James Kidd on the epistemic injustices experienced by persons with chronic somatic illness (Carel & Kidd, 2014; Kidd & Carel, 2016). In a subsequent paper coauthored with a psychiatrist, Paul Crichton, they suggested that the concept of an epistemic injustice may also be fruitfully used to better articulate some of the epistemically negative experiences commonly reported by those diagnosed with psychiatric conditions (Crichton et al., 2017). From that point onwards, a considerable literature quickly developed exploring epistemic injustices in psychiatry. Here we offer a survey and review of that literature. We outline its main themes and identify some of its current directions of enquiry, and finish by indicating neglected avenues of investigation.

2. Initial work applying epistemic injustice to psychiatry

The early work on epistemic injustice in relation to psychiatry relied on a minimally modified Frickerian framework. Crichton et al. (2017) offered a modest claim: that persons with psychiatric conditions are especially vulnerable to epistemic injustices. This claim is ambiguous. It could mean that those persons are more vulnerable to general kinds of epistemic injustice. It could mean that they are vulnerable in new or distinctive ways to epistemic injustice. It could mean that they are vulnerable to certain kinds of epistemic injustice which are unique or distinctive to them. Or it could mean some combination of these. Crichton, Carel, and Kidd seem to mean the first option: that persons with psychiatric conditions are *unusually* or *distinctively* vulnerable to testimonial injustice and to hermeneutical injustice in the sense described by Fricker. They identify three *contributory factors* that explain that enhanced vulnerability: (i) the effects of various psychiatric conditions on one's cognitive, mnemonic, and interpersonal abilities and one's capacity to conform to the socially standard kinds of

practical comportment, (ii) the epistemic privileging of scientific and medical evidence, language, and concepts in discourse about psychiatric health and illness, and (iii) entrenched negative stereotypes about psychiatric illness in general, or specific psychiatric conditions, reinforced by poor public understanding and problematic media and public representations of mental health.

The account by Crichton, Carel, and Kidd was further developed by Anastasia Scrutton, who highlighted the specific roles of negative stereotyping and the practices of epistemic privileging that might be feeding these epistemic injustices (Scrutton, 2017). Epistemic injustices can be enacted by agents, whether individual or collective, but they are also scaffolded and sustained by features of social and institutional environments. Scrutton argued that one important ameliorative response to the epistemic injustices experienced by those with psychiatric illnesses should be an emphasis – both moral and epistemic – on the first-person authority of those persons. Such authority is not a matter of rejecting the authority of healthcare practitioners: we need not adopt a monistic and agonistic conception of epistemic authority according to which one person or group must have it and there ought to be a struggle to seize it. Epistemic authority can be construed in the more collaborative sense of a group of persons coming together to attempt to pool their experiences, knowledge, and understanding – an ideal that can be modeled in different ways depending on the roles one assigns to trust, deference, respect, and other features of interpersonally structured epistemic agency (see, e.g., Dormandy, 2018; Zagzebski, 2012). The upshot of taking seriously first-person perspectives is a richer understanding of (a) the experience of psychiatric conditions and (b) what is best for the person, by their own lights, and according to their values and sense of the shape and direction of their life. Of course, taking seriously those experiences and value judgments need not entail uncritical acceptance or automatic deference. In cases of certain delusions, for instance, that would be unacceptable: imagine a person with Capgras Syndrome who insists sincerely that their loved ones have been replaced by imposters. But acceptance without criticism and deference without judgment are not our only options. The more interesting and difficult option is to scrutinize our presuppositions about the potential role that people could play in an understanding of their psychiatric conditions.

Initial work on epistemic injustice in psychiatry also began to probe the practical and clinical implications of acceptance of the phenomenon. In a paper on delusions, Rena Kurs and Alexander Grinshpoon argued that, if we take seriously experiences of epistemic injustice, at least these implications follow (Kurs & Grinshpoon, 2018). First, a rethinking of the concept of *care*, of what it means to care for a person who is now understood to be frustrated in their efforts to engage in shared testimonial and hermeneutical

practices. Some existing proposed reforms of mental health care could already spontaneously serve the goal of epistemic justice, but there are other cases where more deliberate efforts would have to be made. The second implication is greater appreciation, at least on the part of mental health practitioners, of the cross-contextual ubiquity of epistemic injustices. For those with psychiatric conditions, it is unlikely that these epistemic injustices only occur in healthcare environments, such as in a consulting room. Those injustices are more likely to be pervasive throughout the social world of the person, such that if one looks for them only in healthcare environments, one is not looking widely enough (Kurs & Grinshpoon, 2018). Of course, this will require a better understanding of the sorts of social structures and interpersonal contexts that might encourage epistemic injustices, and also of the distinctive kinds of epistemic injustice that are, or may be, relevant to different kinds of psychiatric conditions, and the actual epistemic capacities of the person reporting the injustices.

Finally, Kidd and Carel (2018, 2019) also suggested that epistemic injustice can be found within conceptual and theoretical formulations of psychiatry (and of medicine more generally), beyond its manifestation in interactions with persons with mental disorder. They suggest that certain *theoretical* conceptions of the nature of psychiatric conditions can structurally generate epistemic injustice and that specifically, naturalistic accounts of health facilitate epistemic injustice about illness and mental illness, independently of the epistemic injustice at the level of practices and institutions. What's epistemically unjust might not be only agents, communities, and institutions, but the theoretical conceptions of health that structure our responses to illness and mental disorder. Naturalistic conceptions of illness can entrench discriminative economies of credibility that define relevance, salience, and similar norms to a delimited range of knowledge, experiences, and methods. It can also be taken to be an exclusive way of describing ill health, to the exclusion of other vocabularies and testimonies. Finally, naturalistic conceptions of illness can render certain experiences and testimonies as "suspect", obscure items of epistemic ephemera, deprived of salience. Hence the entrenchment of naturalistic conceptions generates and exacerbates epistemic injustices within healthcare systems, including psychiatry.¹

We think that this initial work on epistemic injustice in psychiatry offers three general lessons. The first is that it is plausible that many persons with psychiatric conditions are highly vulnerable to epistemic injustice. The crucial conceptual questions are what kinds of epistemic injustice they are experiencing and how they relate to the more general kinds identified by Fricker and other scholars. The crucial empirical questions are what causes those epistemic injustices and how widespread they are, and which specific psychiatric conditions are associated with what kinds of epistemic injustice.

Epistemic injustices could vary along several dimensions including severity, frequency, and intensity and these should be investigated so we can eventually provide a more precise and detailed account of the phenomenon.

A second lesson is that modeling these injustices will mean that we must adapt existing resources taken from epistemic injustice studies, to make them better fit the specifics of psychiatric conditions (such as sanist stereotypes, preconceptions and prejudices related to specific psychiatric conditions, and so on). One can do a lot of good work using off-the-shelf analyses of epistemic injustice, but these were not developed with an eye to psychiatric conditions, so may need adapting or the creation of new concepts unique to psychiatry. We ought to continue to identify cases and types of epistemic injustice that are unique to psychiatry, for example, wrongful depathologization, a phenomenon identified and described by Spencer and Carel (2021), described in [section 3](#).

A third general lesson is that ameliorative responses must recognize and draw on the epistemic value of first-person testimonies of persons with psychiatric conditions, although there are complicated questions about the nature, scope, and authority of those testimonies. It seems that there is broad agreement on that lesson and those complications. José Medina is right to remind us that when we talk about taking seriously the epistemic contributions of a marginalized social group, we do in fact need to explain what those contributions are (Medina, 2012). This can be difficult for several reasons. Oppressive contexts are often designed not to accommodate or use certain kinds of epistemic contributions. At a cognitive level, marginalized groups may struggle to articulate their epistemic contributions because of psychological harm done to them (belittling, disbelieving, ignoring) or because of inherent features of those experiences; hermeneutical difficulties are not always and not necessarily the results of some epistemic injustice. At a structural level, marginalized groups may lack the hermeneutical resources to make such a contribution, either because no such resources exist (*hermeneutical injustice*) or because the relevant resources have been willfully suppressed (*willful hermeneutical ignorance*). Such problems are well-known. But we should still insist that, at a certain point, those who argue that certain individuals or groups have epistemic contributions to make should articulate what those contributions are. In some cases, a person might not have anything epistemically distinctive to offer, or what they have to offer is already present within a wider body of knowledge and understanding. Nevertheless, we can learn to engage in what Fricker refers to as “virtuous listening”, where one adopts “a more pro-active and socially aware kind of listening” that is open to epistemic contributions and expects them to be genuine and valuable (2007, p. 171; cf. Spencer (forthcoming)).

The initial work on epistemic injustice surveyed in this section left two areas for further work. First, it left a pressing need for more sustained studies of a wider range of psychiatric conditions and practices. Second, further work that diverges from or modifies the original Frickerian framework was yet to emerge. Subsequent work on epistemic injustices in psychiatry addressed both these areas.

3. Recent work on epistemic injustice and psychiatry

The initial work detailed in [section 2](#) inspired later studies by social epistemologists, philosophers of psychiatry, and philosophers of science, as well as mental health researchers, sociologists, and others. Such disciplinary diversification should be welcomed, since the broader range of expertise has allowed more careful studies of specific psychiatric conditions and specific scientific and healthcare practices. In this section we survey the work on specific conditions and practices.

(A) *Studies of specific psychiatric conditions*

The term “psychiatric condition” covers a diverse range of human experiences which vary in their symptomatology, etiology, treatment, phenomenology, and prognoses. Some such conditions are extremely well-studied. Some have entered, however imperfectly, into public awareness. Some are objects of energetic public campaigns and the subjects of major charities and government strategies. Others are obscure even to professionals (fetal alcohol spectrum disorder (FASD) is a prime example) or stigmatized and negatively stereotyped.² For all these reasons, progress in the study of epistemic injustices in relation to psychiatry must engage with experiences of specific psychiatric conditions.

The current literature includes studies of epistemic injustice in relation to a range of conditions. Some important examples include depression (Jackson, 2017), dementia (Jongsma et al., 2017; Young et al., 2019), borderline personality disorder (Kyratsous & Sanati, 2016; Watts, 2017), autism (Jongsma et al., 2017), psychosis (Sanati & Kyratsous, 2015), eating disorders (Voswinkell et al., 2021), **Premenstrual Dysphoric Disorder** (Gagné-Julien, 2021), and Obsessive-Compulsive Disorder (Spencer & Carel, 2021).³ While we lack the space here to cover all work on epistemic injustice in specific psychiatric conditions, we present three contributions to the literature.

Sanati and Kyratsous (2015) have investigated distorting stereotypes about delusions, like the assumption that persons with delusions are deeply manipulative, which tend to generate testimonial injustices. Of course, there are complications here, too: delusions can be monothematic or

polythematic and there is a range of recognized delusions but no widely accepted definition of delusion (Bortolotti, 2022, section 2). Kyratsous and Sanati propose a more holistic conception of delusions. For instance, a person with delusions may not experience continuous delusional episodes, and fixation on those might lead to a distorted picture of the overall social and epistemic functioning of that person (Sanati & Kyratsous, 2015), pp. 481-482ff). We should not assume that adopting holistic perspectives will always be to the advantage of the person with the delusion but adopting a holistic perspective will help us better appreciate the complexity of delusions and how they feature within a person's life.

A virtue of studying specific psychiatric conditions is that it can illuminate new ways that epistemic injustices can be generated, beyond those identified in the general literature. Spencer and Carel (2021) use a study of obsessive-compulsive disorder (OCD) to describe a phenomenon they call *wrongful depathologization*. Generally, *pathologisation* denotes treating a behavior as an aberration or defect. Many aspects of our behavior can be treated as pathological, and thus as *problems* to be conceived and intervened upon using the modalities of biomedical science (notoriously, homosexuality was conceived as such and hence became a psychiatric disorder, until it was rightfully depathologized). As Spencer and Carel argue, however, we can also *wrongfully depathologize* a condition. When we wrongly depathologize a condition, we fail to recognize its severity, since its pathological dimensions are omitted, reducing OCD to personality traits such as tidiness. Spencer and Carel propose that OCD is genuinely pathological and that appreciation of this is vital to its epistemically proper understanding.

When considering psychiatric conditions, a complex set of cases concern forms of neurodivergence. Jake Jackson (2017) has argued that there are forms of epistemic injustice experienced by neurodivergent persons that arise from patronizing attitudes and assumptions on the part of many neurotypical persons. Jackson argues that addressing the epistemic injustices experienced by the neurodivergent will require new conceptions of empathy (see also Chapman & Carel, 2022). However, empathy is complex and defined as a skill, a virtue, a capacity, or as an array of related attainments and abilities. Scholars distinguish “cognitive” and “affective” kinds of empathy and there are different proposals to root it in theory, simulation theory, and forms of existential phenomenology (Maibom, 2017). There are further complexities when considering what empathy requires in cases of psychiatric illness (see Ratcliffe, 2014). There is relatively little work on the relationship between empathy and epistemic injustice, and this connection awaits fuller articulation.

A general lesson of these studies of epistemic injustice in relation to specific psychiatric conditions is the need for an expanded etiology of those injustices. By *etiology*, we mean an explanatory account of the

conditions or causes that generate and sustain forms of epistemic injustice. Some familiar causes include negative stereotypes, the absence or marginalization of conceptual resources, implicit biases, and invidious practices of epistemic privileging. But other causes come into view when one looks carefully at specific psychiatric conditions – deficient conceptions of delusions, wrongful depathologization, patronizing attitudes, and limited conceptions of empathy alongside medicalization (Gagné-Julien, 2021; Wardrope, 2015). We suggest that other causes remain to be identified.

(B) Studies of epistemic injustices in psychiatric practice and research

Epistemic injustices are often enacted through specific kinds of interpersonal epistemic practices. These can include practices in research, classification, diagnosis, consultation, and treatment. Studying practices is vital for understanding the etiology of epistemic injustice and for effective ameliorative projects. If we can identify the practices which enact epistemic injustices, then we know where to direct our ameliorative energies. Of course, the focus on practices also relates to a wider debate about the best strategies for promoting epistemic justice (Samaržija & Cerovac, 2021). Some emphasize the importance of individual-level changes, such as the cultivation of the virtues of testimonial justice described by Fricker, investigation of other relevant virtues, training our communicative and perceptual sensibilities, or increasing our awareness, *qua* epistemic partners, of the risk of such injustice, to name but a few (see Fricker, 2007; ch. 4; Kwong, 2015; Marshall, 2004; Spencer, 2022). Other scholars either question the need for individual-level measures, or see them as counterproductive, because they distract us from the need for more substantive structural changes. Benjamin Sherman (2016) has argued against virtue-based solutions to problems of epistemic injustice (contrast with Kotsonis, 2022). Others argue that there may be a role for virtuous individuals along the lines suggested by Fricker, but also the interesting possibility that epistemic justice could itself be a virtue of social institutions (Anderson, 2012). One could also endorse individual-level changes but insist that there must be structural solutions, including active changes to social economies of credibility. Carel and Kidd (2021), for instance, have suggested recently that epistemically defective institutional cultures can be generated and sustained by a dynamic interaction of individual-level vices and institutional failings. They coin the term *institutional opacity*: an opaque institution is one whose mechanisms, norms, and arrangements are difficult to identify and understand, either accidentally or intentionally, in ways that thwart people's efforts to interact with it. They further suggest that opaque institutions are especially difficult for vulnerabilised individuals who come into contact with, and might depend on, the resources and services available through those institutions (for example,

health or social care). It is grievous for an opaque institution to fail those vulnerabilised individuals, who are already at severe epistemic disadvantage for a variety of reasons, ranging from having a learning disability or suffering poor mental health, to having had adverse childhood experiences and suffering from poverty and other forms of disadvantage. Of course, vulnerabilised individuals are highly represented amongst those with a psychiatric diagnosis, and as such are the very individuals served by mental health institutions. Carel and Kidd call for alertness to this potentially catastrophic encounter between an already vulnerabilised individual and an opaque institution and offer possible ameliorative strategies to reduce the risk (2021, section 5).

Within psychiatric science, there are a range of practices that could plausibly generate and sustain epistemic injustices. Anke Bueter (2019) has argued that the typical exclusion of patients from taxonomic work in psychiatry represents a form of *preemptive testimonial injustice* (compare Guidry-Grimes, 2022). These preemptive injustices occur prior to any interaction with the person or group who will suffer the injustice. Taxonomies matter, of course, since they organize our experience and understanding and, therefore, our policies and practices (Tekin, 2014). Moreover, taxonomies can become entrenched in powerful institutions, such as the influential American Psychiatric Association's Diagnostic and Statistical Manual, the DSM. The DSM is criticized on several counts, including for alleged deficiencies in how it tends to define and classify mental disorders (see Cooper, 2005; Murphy, 2015; Pickersgill, 2014; Schaffner and Tabb, 2015; Tabb, 2015; 2019; Zachar et al., 2014). Bueter's objection is that excluding patients from psychiatric classificatory decision-making has two epistemically bad consequences: (i) the exclusion of first-person knowledge will increase the risk of bad diagnostic criteria sets and (ii) a narrowing of the diversity of values informing psychiatric classificatory practices (see also Spandler & Allen, 2018). In these cases, the preemptive character of the testimonial injustice lies in the fact that service user communities are wrongly presumed, in advance and without fair appraisal, to lack relevant knowledge and expertise to contribute to classificatory practices. Moreover, there are many sources of those exclusions. Şerife Tekin (forthcoming, for instance, argues that the DSM-5 Task Force operates with deficient conception of objectivity which act to systematically understate the epistemic value of patient perspectives. To correct this, Tekin (in press) proposes a form of "Participatory Interactive Objectivity".

A second set of practices concern psychotherapy and other kinds of interpersonal practices. Inka Miškulin (2015, 2017) has argued that psychotherapeutic practice could be reformed to encourage epistemic justice. There are many kinds of psychotherapy and many ways they could be connected to epistemic justice. What she proposes are two individual-level

strategies to promote epistemic justice. One is a virtue-epistemic framing of good psychotherapeutic practice inspired by Fricker's original account, which aims to enhance the sensibilities of the psychotherapist. This is an interesting proposal because the virtue-epistemological framing of Fricker's original account is surprisingly neglected within the epistemic injustice studies literature (see Battaly, 2017). The second is to train psychotherapists to become more alert to the epistemic biases that are built into concepts of mental disorder with which they operate. Such biases perhaps cannot be eradicated, but they can be identified, and their effects mitigated or compensated for, through a kind of self-monitoring capacity that could perhaps be instilled during training.

A third approach is to consider what the psychiatric patient themselves could do to combat epistemic injustice in psychiatric healthcare. Medina argues that to challenge unjust epistemic practices, it is sometimes necessary to rebel against communicative norms; he calls this *hermeneutical resistance* (Medina, 2017, p. 48). An example of hermeneutical resistance in psychiatric healthcare may be the rejection of pathological terminology by the neurodiversity movement. In place of the terms "mentally disordered" or "mentally ill", the neurodiversity movement has developed alternative terminology such as "those with neurocognitive differences" and "neurominorities". In addition, the term "neuro-typical" is opted for in place of "normal" or "sane" (Chapman, 2019). This does not entail the removal or rejection of psychiatric diagnoses, which Chapman considers vital for the collective identity of different groups, e.g., those with autism (Chapman, 2020).⁴

Psychotherapy is also the concern of Weiste et al. (2016), who focus on epistemic asymmetries in psychotherapist-client relationships which could be a cause of epistemic injustices. Epistemic asymmetries are ineradicable features of our social-epistemic life: we consistently experience people with different kinds and degrees of knowledge and understanding, different epistemic abilities, and different epistemic projects. Asymmetries of this sort are essential to the division of labor in complex communities. However, epistemic asymmetries can become causes of epistemic injustice if they are coupled to social systems that privilege certain kinds of knowledge, ability, and understanding over others and then assign practical power and social authority on that basis. Medina, for instance, has emphasized the role of *credibility excess* in many cases of epistemic injustice, referring to "those who have an undeserved (or arbitrarily given) credibility excess [who] are judged comparatively more worthy of epistemic trust than other subjects, all things being equal" (Medina, 2011, p. 20).

Weiste et al. (2016) therefore propose two collaborative strategies for mitigating the problematic potential of asymmetries: we should aim to collectively construct (i) a mutually accepted evidence base for decisions

about diagnosis and treatment of psychiatric conditions and (ii) a mutually accepted description of the client's experiences. This call for a collaborative approach to the understanding of psychiatric conditions is welcome; however, much will depend on what counts as acceptable kinds of evidence and legitimate descriptions of such experiences. Moreover, there are serious challenges to the viability of these proposals: consider the case of delusions where it seems there are few prospects for the client and therapist to agree on a mutually acceptable description of the evidence and the facts, or cases of major depression, where part of the depressed person's predicament is their inability to describe their experiences. Such cases may indicate the limits of collaborative approaches, rather than prove their impossibility, and they ought to be tested carefully in practice. There will be complexities introduced by different contexts where evidence is feeding into specific decisions; consider, for instance, morally complex situations about suicide prevention (Kious & Battin, 2019).

There are also specific concerns about the tenability of such collaborative approaches when it comes to pediatric psychiatry, since children as a category complicate analyses of epistemic injustice, because of assumptions we make about their epistemic abilities and because they cannot be easily placed into existing epistemological frameworks (Burroughs & Tollefsen, 2016; Carel, Györffy, 2014). Finally, genuine collaboration can only be achieved if institutionalized biases about the distribution of epistemic authority has been redressed. We ought to be vigilant that so-called "collaboration" may just be a more palatable form of epistemic domination.

The study of specific psychiatric practices points to two general methodological lessons for future work. The first is that we must adapt generic epistemic injustice resources to specific practices and contexts – psychiatric nosology, for instance, or the practices of psychotherapy. Some critics question whether epistemic injustice could be adapted to these sorts of contexts, but we suggest we interpret their concerns as invitations to enquiry, rather than reasons to give up (Harcourt, 2012). A second lesson is that progress in the study of epistemic injustice in psychiatry will depend on closer engagement with specialist subdisciplines, such as philosophy of science or philosophy of psychiatry, with particular groups within psychiatry (such as children, the elderly, those with dementia, and so on) and with particular communities of concern, most obviously with patient activists and professional psychotherapists, but also other stakeholders, such as carers and health care regulators.

(C) Ameliorating epistemic injustice

Epistemic justice as a positive ideal is far less researched than epistemic injustice. The typical themes of the relatively few remarks on epistemic

justice are the need for dialogue, collaboration, and trust, and the exercise of epistemic humility (see Ho, 2011; Weidmann-Hügler & Monteverde, 2022). These suggestions are surely on the right track. However, we cannot make any serious progress in ameliorative projects without well-articulated accounts of (i) what epistemic justice is, (ii) our practices for pursuing it, (iii) our standards for measuring it, (iv) the resources and allies available in the pursuit of it, and (v) the obstacles in the way to achieving it. “Amelioration” as a term has recently become popular in areas of feminist and social philosophy, perhaps most associated with the work of Haslanger (2000). We mean something more general: amelioration simply refers to attempts to (a) study the current circumstances and lives of human beings so that one can (b) identify means of improving them. This is deliberately wide open. It can apply to human beings as such, or specific groups or communities. There are many possible ways of defining “improvement” in more or less specific and more-or-less theoretically-defined ways. It can be articulated in relation to various other concepts, such as solidarity (e.g., Pot, 2022). We leave the term wide open partly to avoid needlessly tying it to one specific account of amelioration and partly because there is simply too little work at the moment on the amelioration of epistemic injustices to say anything more concrete. We can, though, offer some general remarks.

Ameliorative projects aimed at epistemic justice can be located on a spectrum which runs from individual-level changes to radical cultural reforms. Newbigging and Ridley (2018) have argued that the original Frickerian framework can inform the development of a kind of *epistemic justice advocacy*. They suggest utilizing independent mental health advisory (IMHA) services as a vehicle for epistemic justice. By advocating for those who are vulnerable to epistemic injustices, IMHA services can help service users defend their testimonial credibility. After all, the task of advancing toward epistemic justice should not fall entirely on the shoulders of those who experience injustices. In a related proposal, Tom Todd (2021) has argued that the administration of mental health legislation in Scotland has become corrupted by epistemic injustices, rooted in use of bad heuristics relied on by mental health tribunal panels. Structural failings can perpetuate epistemic injustices, and, if so, then one should attempt reforms from within that system as well as from without. Todd proposes changes to the training of Designated Medical Practitioners to make them, in a sense, epistemic justice advocates. Like Newbigging and Ridley, this reflects a more collaborative and cooperative approach to the pursuit of epistemic justice, and one that presupposes that persons with psychiatric conditions will continue to be exposed to epistemic injustices within the systems intended to care for them.

We see a clear need for reform of practices and institutions in these local and specific contexts. Other writers, though, insist that such local

improvements can only be effective if they are accompanied by larger cultural changes. Jake Jackson (2019) argues that the real causes of epistemic injustices experienced by Americans with mental illnesses are culture-level confusions and misconceptions about mental illness and systematic failures to provide Americans with affordable, quality mental health care: the entire “life-world” of the US is apt to impose severe epistemic injustices on those with mental illness and then deprive them of the necessary kinds of empathy and care. Here one sees the complicated connections between epistemic injustice, political policy, and national cultures. This points to a neglected area of enquiry: the relationship of the concepts of epistemic justice and injustice to the concept of sanism, which could be appropriated as a resource for advancing epistemic justice (Gosselin, 2022; LeBlanc & Kinsella, 2016; Peña-Guzmán & Reynolds, 2019). A few scholars have explored the possibilities for cultural changes of this sort, including those who draw on the work of Michel Foucault (see Allen, 2017). Of course, the actual ameliorative power of any philosophical framework needs to be proven in practice: the fact that a philosophical tradition calls for radical social change does not guarantee that a particular approach can bring such change; creating social change is difficult and unpredictable and requires philosophy to engage with advocates, activists, policy makers and practitioners, in ways that can be successful. It also requires adoption of local, regional, national, and global perspectives (Bhakuni & Seye, 2021).

We think that there are four lessons for ameliorative projects withing psychiatry. First, we need to know precisely and in detail what we *mean* by epistemic justice. It surely is more than just the reduction of epistemic injustices. Second, ameliorative work must be *collective*, involving the collaborative efforts of service users, advocates, carers, family, friends, and communities of activists and scholars. But we must do more than just urge others to “listen” to the “voices” of the marginalized: there must be a clear idea of which voices ought to be listened to, and of what they are in fact saying, and why what they are saying matters, and how it could be translated into practical action. Third, ameliorative work will always have a *structural* dimension: trying to remove epistemically unjust features of the social world or enhancing conditions that support the epistemic agency of persons with psychiatric conditions (Carver et al., 2016; Grim et al., 2019; Lee et al., 2019). But for such work to be effective, it must be concrete. Radical proposals to build new institutions and systems must be accompanied by careful and realistic planning. Fourth, any serious and lasting movement toward epistemic justice must involve *cultural shifts*. Local improvements will remain fragile if they stand in tension with wider cultural realities. What is needed is a systematic transformation of how mental health is conceptualized, the stereotypes about people with psychiatric conditions, and in conceptions of psychiatry. This includes appraisals of

the moral agency of those with different psychiatric conditions, which is likely to require a range of particular analyses rather than a generalized theoretical account (Murphy & Washington, 2022). None of this is easy. All of it needs spelling out. All of it needs to be accompanied by concrete and realistic plans. It should also be sensitive to *emergent epistemic injustices*, those which are coming-to-be and taking specific shapes within particular social and institutional structures (Fletcher & Clarke, 2020). Patient activist groups and service user communities can play important roles here (Rashed, 2020). Ameliorative projects can have *specific* and *local* goals, or *general* and *systemic* goals, and can relate (or not) to wider social and political projects and are always unavoidably *political* (cf. Doan, 2018; Jongsma et al., 2017). In these cases, closer contact with disciplines outside of philosophy becomes imperative.

4. Future work

We end by indicating future directions for philosophical research of epistemic injustices in relation to psychiatric conditions, practice, and research.

(A) *Epistemic harms in neurocognitive disorders*

There is little current work on epistemic injustices as they might relate to neurocognitive disorders, such as Alzheimer's disease, traumatic brain injury, and Parkinson's disease. As well as the value of studying those specific disorders, there is specific philosophical value. For instance, one distinction missed by an overarching look at psychiatric disorder is that testimony plays a different role in the treatment and diagnosis of certain psychiatric illnesses compared to others (see Ritunnano, 2022). Certain psychiatric illnesses can only be diagnosed through testimony, as empirical investigation has thus far failed to identify a physiological disease process for them. In these cases, understanding the nature of a psychiatric illness is notably harder for both the patient and the healthcare professional as they can only access its symptoms through testimony. By contrast, neurocognitive disorders, such as dementia, amnesia, and disorders due to traumatic brain injury, can be diagnosed using neurological protocols.

Due to the different weight placed on testimony in each domain, the distinction between neurocognitive disorders and non-neurocognitive disorders is significant to an investigation into epistemic injustice. Although epistemic injustice may disrupt the testimony of patients with neurocognitive disorders, the underlying mechanisms may differ from those relating to psychiatric patients whose first-person reports are the sole means of diagnosis (Young et al., 2019; Dohmen, 2016). For instance, the patient's speech expression may be even more likely to be afforded a credibility deficit, as the

clinician may suppose that the neurological evidence “can do the talking” for the patient. More significantly, the person with neurocognitive disorder may be more vulnerable to hermeneutical injustice, as the clinician may assume that no contribution to the neurological interpretive framework is necessary from the patient (thus contributing to the creation of a hermeneutical lacuna). For this reason, an investigation into the contrasting epistemic operations in neurocognitive disorders compared to other psychiatric illnesses would provide greater insight into the different ways in which epistemic injustice can arise.

(B) Identity prejudices in psychiatric illness

Another area worthy of further investigation is the different kinds of identity prejudice that motivate epistemic injustice in psychiatric illness. Spencer and Carel (2021) raise this point in their discussion of the wrongful depathologization of certain psychiatric conditions through underlying *positive identity prejudices* that reduce certain psychiatric conditions to personality traits. Identity prejudices may cause epistemic injustice to manifest in disparate ways. Eating disorders and addictive disorders, for instance, are often perceived to be “caused by the patient”. Patients with alcohol dependence are more likely to be considered “difficult, annoying, less in need of admission, uncompliant, having a poor prognosis and more likely to be discharged from follow up” by healthcare professionals (Thornicroft, 2006, p. 94). This can feed a lack of sympathy which is reflected in studies of healthcare professionals’ attitudes toward patients with an eating disorder (Seah et al., 2017, p. 134). Such attitudes affect care, since patients are considered less deserving of medical attention and less likely to be listened to as attentively as other patients. In this instance, the credibility deficit that arises is not motivated by the perception that the ill person’s judgments are clouded by their condition, but by the misconception that their illness is a morally questionable choice – one reflective of selfishness, laziness, or hedonism (Pickard, 2017), while people with eating disorders are often considered similarly selfish, attention-seeking, and vain (Bannatyne & Stapleton, 2018). These are cases of credibility deficits caused by perceptions of bad moral character.

In such cases of wrongful moralization, we find overlapping identity prejudices at work that are parts of wider systems of discrimination, stigma, and exclusion. While the literature has focused on sanist identity prejudices that drive epistemic injustice in psychiatric illness, it would be worth exploring the intersection of sanism with sexism, racism, classism, ageism, ableism, homophobia, transphobia (and so on) that may equally drive epistemic injustice in psychiatric healthcare. This can also include kinds of pathophobic prejudice directed against those with somatic illnesses (Kidd,

2019). For instance, those diagnosed with dementia are likely to encounter overlapping identity prejudices directed toward both psychiatric illness and old age – 93% of those affected with dementia are over 75 (Young et al., 2019, p. 79; DSM-5, 2013, p. 612). Those with borderline personality disorder, where 75% of those diagnosed are women, are likely to encounter overlapping identity prejudices attached to both psychiatric illness and being a woman (DSM-5, 2013, p. 666). Indeed, a wealth of literature suggests that being a woman makes it more likely the patient’s testimony will be considered “manipulative” or “attention-seeking”, as these negative stereotypes are already directed toward women (Wirth-Cauchon, 2001).

In contrast, involuntary detention rates under the Mental Health Act “were higher for males (91.8 per 100,000 population) than females (84.4 per 100,000 population)” (Poupart & Foster, 2020). Regarding race, UK statistics show that in 2019–2020 Black people had the highest rates of involuntary detention and were ten times more likely to be involuntarily detained under the Mental Health act than a White person. Regarding the financially disadvantaged, people from the most deprived areas of England were around three and a half times more likely to be involuntarily detained, meaning they are considered “at risk of harm to themselves or others”, a judgment that likely reflects negative identity prejudices about working class men and violence (Harrison & Esqueda, 2001). Intersectional analysis should be a central methodological theme of future work on epistemic injustice and psychiatry.

(C) *Epistemic privilege in psychiatry*

The concept of *epistemic privilege* merits further investigation. We can distinguish *kinds* and *degrees* of epistemic privilege, the different *roles* which can be epistemically privileged, the epistemic dynamics of interactions between people with different roles, and the question of how to settle disputes. A patient may have privileged insight into their first-person experience of a psychiatric condition, but no privilege when it comes to ascertaining the possible neuro-biological correlates of that condition, which is again different from having a privileged role in determining the proper courses of treatment. Epistemic privilege is pluralistic and disputes about it cannot be settled easily. The term “healthcare professional” encompasses many different roles – nurses, case-workers, counselors, occupational therapists, psychiatrists, psychologists, social workers, and other specialisms in the allied health professions, which can be parts of explicit and implicit hierarchies, including kinds of legitimate and illegitimate epistemic privilege.

A key issue for epistemic privilege in psychiatry is that of involuntary hospitalization. Healthcare professionals who work with the involuntarily

detained are likely to hold a unique kind of epistemic authority over the patient detained. We do not suggest involuntary hospitalization is entirely detrimental to the person with psychiatric illness: the purpose is to protect the patient and those around them from harm. However, the disparity between the epistemic status of the clinician and the patient is likely to be heightened in this context. In modern mental health institutions, patients frequently compare their involuntary detainment to “being placed in jail” (Plahouras et al., 2020, p. 6) and people who are involuntarily hospitalized for eating disorders may perceive themselves to be “‘criminals’ who [...] ‘do their time’ and often become ‘repeat offenders’” (Bannatyne & Stapleton, 2018, p. 329). The clinician is perceived as the jailor, rewarding and punishing their behavior and holding the key to their freedom. Given this relationship, patients frequently report “not being listened to and not being heard” and feeling “out of control during their hospitalization due to not receiving sufficient information and not being involved in decisions” (Hooff & Goossensen, 2014, p. 431).

A vital aspect of the epistemic privilege bestowed upon the healthcare professional concerns their authority to disseminate knowledge regarding the patient’s diagnosis and treatment. By virtue of their epistemic authority, they possess a unique power to grant or conceal medical information. Given the routine use of non-disclosure practices in involuntary hospitalization, psychiatric patients in these settings are particularly vulnerable to what Kidd and Carel call “epistemic isolation”: “situations where a person or group lacks the knowledge of or means of access to, particular information” (Crichton et al., 2017, pp. 183–184). In the case of involuntary hospitalization, the patient often has epistemic isolation imposed upon them if the healthcare professional withholds vital information concerning the patient’s treatment plan, the nature of their illness or the very diagnosis. Through epistemic isolation, the psychiatric patient is forced to operate as an epistemic agent from the position of an imposed ignorance, where they are deprived of resources that are essential for communication.

Therefore, the unique epistemic authority of the healthcare professional in involuntary hospitalization entails (i) the power to occlude information (epistemic isolation), (ii) the power to either solicit or refuse testimony and (iii) the power to suspend typical epistemic norms of reciprocity. In this sense, a closer examination of epistemic practices within different roles and within different psychiatric environments would shed light on how epistemic authority can occur at different intensities within psychiatric healthcare.

It would also be worth examining the epistemic privilege afforded to family members and friends of the ill person within the psychiatric healthcare system. Young et al. (2019, p. 82) briefly gesture toward this in the case of dementia, where family members “are given primary rights and opportunity to influence policy and practice relating to dementia care”. A further

instance of epistemic privilege afforded to family members can be found in the work of Sanati and Kyratsous, who present the case of a psychosis patient, J.N., whose fears about her husband's infidelity were assumed to be the product of delusional jealousy (Sanati & Kyratsous, 2015, p. 482). Although it was revealed that her husband had been unfaithful, her justified emotional outbursts were perceived to be a symptom of her psychosis. However, the paper does not highlight the credibility excess attributed to J.N.'s husband, who further supported her diagnosis of delusional jealousy by telling the mental health professional, "this is how she behaves when she becomes ill" (Sanati & Kyratsous, 2015, p. 482). Despite J.N.'s claims that her husband wanted everyone to believe she was "crazy", they considered him a reliable informant (as both a "sane" person and a man). As such, they afforded him epistemic privilege regarding his wife's diagnosis, thus further perpetuating her credibility deficit. In regard to the aforementioned Mental Health Act, it would be worth examining the epistemic privilege bestowed upon designated family members through the "Nearest Relative" rule, which empowers a family member (who has not been chosen by the patient) with authority over the patient's care (see, *inter alia*, Johnston, 2007, Johnstone & Liddle, 2007, Owen et al., 2009; Peña and Bibler, 2016).

Future work on epistemic injustice in psychiatric healthcare should explore the epistemic privileges of the healthcare professionals and family members, carers and friends, who are sometimes afforded an unjust credibility excess over the person with the psychiatric condition.

(D) Phenomenological psychopathology and epistemic justice

It is essential to attend seriously to the phenomenology of psychiatric conditions: this is the task of phenomenological psychopathology. According to a widely-held claim, psychiatric conditions often involve radical changes to the structure of experience, meaning that people who experience, for instance, depression occupy a structurally different experiential world. A familiar theme of narratives of depression, for instance, is a sense that one is living in a different world, that one's prior world has "changed", or that something intangible but utterly vital has been "lost" (Ratcliffe (2015); (Svenaeus, 2011)). This is a way of understanding psychiatric conditions with potentially radical implications for how we think about epistemic injustices (for a contrary view see Drożdżowicz, 2021). If there are radical differences between our experiential worlds, what implications does this have for the very possibility of understanding someone else's experiences? To what extent is our sense of testimonial credibility – of what claims can be taken seriously – rooted in a sense of a shared world from which some people are estranged? To what extent do our existing hermeneutical practices and resources presuppose a common experiential world?

A phenomenologically sophisticated understanding of psychiatric conditions will challenge our epistemic norms and concepts, especially if one conceptualizes psychiatric disorders as global disruption of one's lifeworld, rather than a localized dysfunction, involving alterations to one's sense of self, social world, relationship to their environment, and experience of space and time, to name a few (Carel, 2016; Ratcliffe, 2008, 2012).

We suggest that phenomenological psychopathology can help develop and sustain richer forms of epistemic justice by emphasizing (a) the essential role of sensitivity to first-person testimony and experience, (b) the complexity of understanding structurally different kinds of human experience, and (c) the complexities of articulating experiences which strain our epistemic and communicative capacities because they are characterized by disruptions to our ordinarily taken-for-granted ways of being. In some cases, what's lost may be the very possibility of satisfactorily making and sharing sense of one's experiences. These psychiatric cases might therefore reveal epistemic injustices with radical kinds of depth and severity, ones currently unrecognized in the existing epistemic injustice studies literature.

(E) Summary

This paper has offered an overview of current philosophical work on epistemic injustice as it relates to psychiatry and outlined areas we believe worthy of further investigation. It should be clear that much remains to be done in the conceptualization of these injustices and the ways they are generated and sustained by psychiatric practices, social and cultural conditions, and by the disruptive realities of the psychiatric conditions themselves. Such work requires a closer contact with several areas of philosophy, like social epistemology, phenomenological psychopathology and philosophy of science. Much of that work would also naturally connect to wider academic discourses about psychiatry. It is our hope that philosophers can offer a lot to the articulation and analyses of the variety of forms of epistemic injustices as they relate to psychiatry – and in turn become enriched by contact with those other discourses. This work is both morally and practically important. Psychiatric conditions are already painful, disruptive, and difficult enough in themselves, without the added pains caused by epistemic injustices. Such work may help reduce the risk of epistemic injustice adding insult to injury to those already struggling with mental health.

Notes

1. We are partly inspired here by phenomenological criticisms of naturalism, for instance, Ratcliffe (2013) and Svenaeus (2022).

2. FASD is poorly understood and highly under-diagnosed around the world. While it is estimated to affect 6–17% of UK population, it remains obscure compared to ADHD and autism, both with much lower prevalence. See McQuire et al. (2018).
3. Many other forms of psychiatric illness have not yet been addressed in the field and would benefit from being examined through the lens of epistemic injustice. Such conditions include trauma and stressor-related disorders, anxiety disorders, dissociative disorders, elimination disorders, sleep-wake disorders, sexual dysfunction, substance-related and addictive disorders, and other neurodevelopmental disorders. Such projects would offer new ways of understanding the distinctive epistemic contours of these lives.
4. See also <https://www.psychologytoday.com/gb/blog/neurodiverse-age/202103/neuro-diversity-and-the-biopolitics-diagnosis> [accessed on 18 August 2022].

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