**Epistemic Injustices in Psychiatric Research and Practice**

*Nottingham 20/7/22*

**1. Introduction.**

Developments in epistemic injustice studies since Fricker’s 2007 book. The original Frickerian framework is central to *epistemic injustice studies* (cf. Kidd, Medina, and Pohlhaus). But note:

1. critical refinement and elaboration of Fricker’s original account, by her and others.
2. identification of additional forms of EI (Dotson, Hookway, Tate).
3. appreciation of earlier studies of EI (Berenstein).

Some problematic tendencies in epistemic injustice studies:

1. over-generalised uses of ‘epistemic injustice’ to cover ‘anything bad epistemically’.
2. under-articulated accounts of EI.
3. defaulting to Frickerian framework without considering alternative possibilities.

 Carel and Kidd work on *pathocentric epistemic injustices* (focused on chronic somatic illness) and later gestures to psychiatric conditions (Crichton, Carel, Kidd).

**2. Applying epistemic injustice to psychiatry.**

Early work used a minimally-modified Frickerian framework:

1. Crichton, Carel, Kidd: persons with psychiatric conditions are *especially* vulnerable to EI. We noted *contributory factors*: (i) effects of psychiatric conditions, (ii) epistemic privileging of scientific evidence, (iii) entrenched negative stereotypes.
2. Scrutton: negative stereotyping and epistemic privileging: corrective strategies should include emphasising *first-person authority* concerning (i) the experience of psychiatric conditions and (ii) what is best for the person.
3. Kurs and Grinshpoon: awareness of EI in psychiatry ought to (a) alter concepts of care and (ii) appreciate the cross-contextual ubiquity of EI in clinical and social contexts.

General lessons:

1. Persons with psychiatric conditions are highly vulnerable to forms of EI.
2. Modelling these injustices requires *adapting* existing EI resources to the specific cases and contexts (eg sanist stereotypes).
3. Ameliorative responses *must* recognise and draw on the distinctive epistemic value of first-person testimonies of persons with psychiatric conditions. But we must clarify, carefully, *what* those contributions are (cf. Medina on ‘proportionality’).

 But this early work (i) did not engage specific psychiatric conditions or practices and (b) no real divergence from, or modification of, original Frickerian framework.

**3. Contemporary work on epistemic injustice and psychiatry.**

Later work got specific in two ways: (a) *psychiatric conditions* and (b) *psychiatric practices*.

**(A) Studies of specific psychiatric conditions.**

1. Kyratsous and Sanati: distorting stereotypes about *delusions* (eg as manipulative) could be offset by adopting more holistic conceptions of delusions. Also, their work on BPD.
2. Spencer and Carel: psychiatric conditions can be subject to *wrongful depathologisation*, eg OCD symptoms reduced to (nonpathological) personality traits. WD is in a grey area between *trivialisation* and *stigmatisation* – too ill to be free of stigma but not ill enough to be taken seriously.
3. Jackson: EI can arise from patronising attitudes/assumptions by neurotypical persons. Correcting these needs new conceptions of *empathy* (see Chapman and Carel).

 General lesson: an expanded *aetiology* of EI – more than negative stereotypes – eg deficient conceptions of delusions, wrongful depathologiation, and limited models of empathy. But too many specific psychiatric conditions are yet to receive proper study ☹

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

EI can be studied at the level of *psychiatric practices*. Compare to wider debate about strategies for promoting epistemic justice (Samaržija). Some emphasise individual-level changes, others privilege institutional changes (eg Anderson, Coady, Sherman).

* 1. Beuter: exclusion of patients from taxonomic decision-making in psychiatry represents a form of *pre-emptive testimonial injustice* (cf. Guidry-Grimes).

 Bad consequences: (a) exclusion of first-person knowledge that could correct *bad diagnostic criteria sets* and (b) narrowing the diversity of *values* informing psychiatric classificatory practices. (See, also, Spandler and Allen).

* 1. Miškulin: psychotherapeutic practice could be reformed to encourage epistemic justice. Strategies are (a) adopting a *virtue-epistemic* framing of psychotherapeutic practice and (b) critical awareness of the *epistemic biases* built into concepts of mental disorder.
	2. Weiste, Voutilainen, and Peräkylä: epistemic asymmetries in the psychotherapist-client relationship create EI. Strategies: to collaboratively construct (a) a mutually accepted evidence base and (b) mutually accepted description of the client’s experiences. Worry: this may be impossible in some cases (eg some delusions).

Methodological lessons:

1. We must adapt the generic EI resources to specific practices and contexts – psychiatric nosology, psychotherapy, etc. (but cf. Harcourt).
2. We must connect epistemic injustice studies with *specialist subdisciplines* (philosophy of science etc.) and *communities of concern* (patient activists, psychotherapists etc.)

**(C) Ameliorative projects.**

Everyone emphasises (i) collaboration, dialogue, and trust and (ii) the epistemic humility which helps clinicians engage seriously with concepts developed by service user communities, many of which explicitly conflict with scientific-medical understandings (eg Ho, Miller).

 From *individual* to *cultural* levels:

1. Newbigging and Ridley: Frickerian framework has liberatory potential for advocates of people using health and social care services – independent mental health advisory (IMHA) services as a kind of *epistemic justice advocacy*.

1. Todd: administration of mental health legislation in Scotland is corrupted by EIs rooted in use of bad heuristics relied on by mental health tribunal panels. The solution may involve properly-trained *Designated Medical Practitioners*.
2. Jackson: Americans with mental illnesses suffer EI due to (a) culture-level confusions about mental illnesses and (B) systemic failures to provide mental healthcare.

 *Sanism* can be appropriated as a conceptual and as a social resource for advancing epistemic justice (Gosselin, Leblanc and Kinsella, Peña-Guzmán *et al*).

 - compare with Allen on Foucault and EI.

General lessons: ameliorative projects must be:

1. *Collective* – service users, advocates, friends, communities.
2. *Structural* – (a) remove epistemically unjust features and (b) support the epistemic agency of persons with psychiatric conditions (Carver *et al*, Grim *et al*, Lee *et al*).
3. *Cultural*– a systematic transformation of how psychiatric health is conceptualised (stereotypes, preconceptions, media representation, conceptions of the aims and nature of psychiatry etc.)

 Implications: ameliorative projects can have specific and local goals or general and systemic goals and so are unavoidably and necessarily *political* (cf. Doan, Jongsma *et al*).

**4. Into the future.**

Understudied option: certain theoretical conceptions of the nature of psychiatric conditions can structurally generate EIs.

 Kidd and Carel: *naturalistic* accounts of health facilitate pathocentric EI, independently of the imperfections of how they manifest in practices and institutions.

 I think something similar is true of at least some psychiatric conditions. Consider the central claim of *phenomenological psychopathology*: psychiatric conditions are radical disruptions to the structure of human experience (eg Ratcliffe – but cf. Drożdżowicz).

 I think phenomenological psychopathology can sustain richer forms of EJ – by emphasising (a) the essential role for sensitivity to first-person testimony and experience, (b) the complexity of understanding structurally-different kinds of human experience, and (c) the complexities of articulating life-experiences which strain our epistemic and communicative capacities *because* they are characterised by disruptions to our ordinarily taken-for-granted ways of being. In some cases, what’s lost is the very *possibility of intelligibility* (Kusch on *linguistic death*, Ritunnano).

**IJK**

**Resource.**

Bibliography of work on epistemic injustice, illness, healthcare, and disability:

https://tinyurl.com/du3dfuts

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