Diagnosis, misdiagnosis, and becoming better:

An investigation into epistemic injustice and mental health

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DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed: Martyn Sampson .... (candidate)

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Abstract

Epistemic injustice concerns a harm done to someone in their capacity as a *knower*, on the basis of attributing to them a credibility deficit. This can occur at the level of spoken communication, which is testimonial injustice: or in regards to the availability or otherwise of the conceptual tools needed to make meaning, which is hermeneutical injustice. Both kinds of injustice are especially active in the diagnosis and treatment of mental illness and disorder. This is because, in the absence of regular itemised scans and tests, determinations of value rest on the testimonies of patients and the persons presenting them. This dissertation consists of an extended investigation into mental health diagnosis and misdiagnosis by way of an interrogation of spoken and structurational biases and prejudices. It is my contention that by revealing, exploring and deconstructing highly questionable attributions of meaning, the voice of the patient can be heard in irrevocably clear terms. This is such that she is empowered to move forward positively in her journey towards health and wellbeing. My overall aim is to map the context of criticality that frames the patient, whom I term an *experient*, in that her experiences are potentially common to all. To the degree that she can in one way or another harness the hermeneutical and critical tools of philosophy she is also a *theoretical patient*. My main objective is to design an embryonic metric for measuring epistemic injustice. This is so experients and other interested parties can begin, in ordered-terms, to recognise when a wrong is taking place. Through a timely and accurate recognition of epistemic injustice, as it appears, the resources of healthcare economies may be employed with consistent efficiency and sensitivity. Suffering persons, in reflecting constructively on their identities, may become better, healing, growing, and proactively learning, in diverse ways.

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Introduction

Ways in: Phenomenology, epistemic injustice and the theoretical patient

> The things my mother’s illness taught me are the basis of this book. I learnt that mental illnesses are among the most awful a person can suffer. I still believe this, even after working on cancer wards and acute surgery units. There is something uniquely devastating about the way they can rob you of your sense of identity and self-worth.
> (Tom Burns, 2013, xvi)

Human identity, as a critical concept, is indubitably complex, and offers a helpful way into thinking philosophically about mental health and disorder. One means by which issues of identity are contested is race, inasmuch as this aspect of personal heritage can, through diverse social injustices, negatively press upon one’s mental health. In his psychoanalytic study on the role of race and racism in the consultation room, Narendra Kevel (2016) states that: “Identity is a complex tapestry. Offering a sense of integrity and continuity on one level, it is also hybrid in nature, creating disruption and multiplicity” (xvii). Focused, as they are, on how a person is and becomes, notions of identity are dynamic, yet context-bound. Keval continues: “As we move fluidly in our psychic identifications and geographically from one place to another so we are inextricably linked and connected. Such connections and hybridity offend the sensibilities of the racist imagination, which strives only to create myths of purity that only exist in our wishful thinking for absolute certainties" (xvii). The pernicious, violent effects of racism depend for their continuance on a need within racists to maintain a refusal to give and receive uptake in conversations and interactions. My argument is that this form of linguistic and semiotic obfuscation marks encounters not just between therapists and clients in some *therapeutic* settings: similar kinds of intellectual posturing pertain to a context all could potentially encounter, that of mental health diagnosis and treatment. It is my belief that the harmful effects of different intellectualisations can be comprehensively evaluated, tackled and dismembered, to prevent toxic prejudice within such settings.

Key to the maintenance of prejudice of numerous kinds is the role played by *belief*, specifically in terms of its formation and continuation. Eric Matthews (2007) considers how different beliefs are formed within and between mental health clinicians and patients, as they pursue integrative, holistic approaches to positive mental health. His suggestion is that: "rationality is not a matter only of logicality. Beliefs can be held to be irrational even if they are not self-contradictory – as when someone believes something in the face of a mass of obviously contrary evidence" (1). Belief-making is a culturally determined process that throws doubt on supposedly stable categories of sanity and insanity.

Perhaps a balanced position towards psychological concepts, constructs, events, and eventualities,[1] is one of interrogating closely their capacity to unsettle

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[1]. By the psychological event, I mean to refer to aspects of self-development that are both extraordinary and everyday, even mundane. On the one hand, in a recent investigation by Slavoj Žižek (2014), "an event at its purest and most minimal" is (2): "something shocking, out of joint, that appears to happen all of a sudden and interrupts the usual flow of things;

general, medicinally conventional subject-positions on the mind itself. Against "[t]he medical model" which (9), "so conceived sees psychiatry as a branch of *scientific* medicine" is the need to consider how the brain is a dynamically capacitating interpolation (9): "the philosophical view that the mind (or better, *psyche*) is a complex of cognitive techniques structured by meaning that, if deployed adequately, adapt the individual to the human life-world" (Gillett, 2009, 1). The extent to which the mind is an impression- and experience-making function that enables fitting adaptation to an environment is the focus of my study. Philosophy intersects with psychiatry, the medicalised appropriation of mental malady, because of its wide-ranging approach to human life and phenomena, the constitutive properties of ethics as a subject-discipline. As Thomas Schramme and Johannes Thorne state in *Psychiatry and Philosophy*

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something that emerges seemingly out of nowhere, without discernible causes, an appearance without solid being as its foundation" (2). Events can, within the series of concepts a person applies to herself, construct her identity, leading to widely transformational eventualities. By the same token, insofar as "an event is . . . *the effect that seems to exceed its causes*" (3), its meaning is isolated in space and time as: "that which opens up the gap that separates an effect from its causes" (3). An aspect of environmental conditionals, rather than an internal process within one's being, psychological events can be conceived in more sober terms. For Mitch J. Fryling and Linda J. Hayes (2011) such events are characterised by evolutions of the self, in that they are "historical" and "develop during the lifetime of the organism" (199). This is as connoted within senses of *organising* that accord with expressions of "specificity" (199), in that events, as commonplace occurrences, "are highly contextual" (199), instances of "integrated happenings" (199). A person's concept is, then, also constructed in and through linear time. Her future is directed by common destabilisations of everyday experiences, as articulated through moments of laughter and conversation, conflict, and argument.

(2004): “Psychiatry is a philosophical discipline. This might come as a surprising and even provocative claim. But it is obvious that in psychiatry many theoretical and practical issues have a philosophical connotation” (1). Psychiatry is, in essence, about the ratification of different kinds of regulations and procedures that are enshrined in law. Schramme and Thorne state: “What probably comes to mind first are ethical issues in the treatment of psychiatric patients. Confidentiality, informed consent and the criteria of competence, coercive treatment, the insanity defence, psychopathy and some other problems must be dealt with in medical ethics and law” (1). Insofar as philosophy can level constructive challenge upon what kinds of questions and treatment are tenable, its importance as a critical conversant that synthesises key themes is undeniable.

The philosophical topic best able to deal with issues of identity of both axiomatic and seismic proportions is epistemic injustice, recently defined by Miranda Fricker. In her seminal monograph *Epistemic Injustice: Power & the Ethics of Knowing* (2007), she explores the inherently social construction of context by way of diverse power relations. Fricker “home[s] in on two forms of epistemic injustice that are distinctively epistemic in kind, theorizing them as consisting, most fundamentally, in a wrong done to someone specifically in their capacity as a knower. I call them *testimonial injustice* and *hermeneutical injustice*” (1). Persons are epistemically wronged both in their spoken interactions and, preceding these, how they themselves are framed by society:

> Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker’s word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretive resources

> puts someone at an unfair disadvantage when it comes to making sense of their social experiences. (1)

Individuals, in their being victimised in such ways, suffer because they cannot access some of the key resources society can offer. One eventuality that is vitally important to my enquiry is the limited faith a person can place in herself. Fricker states: “When you find yourself in a situation in which you seem to be the only one to feel the dissonance between received understanding and your own intimated sense of a given experience, it tends to knock your faith in your own ability to make sense of the world, or at least the relevant region of the world” (163). To echo my epigraph by Tom Burns, a psychiatrist who saw his mother respond to psychiatric intervention, an individual is robbed of her means of validating her experience.

This actuality is especially wounding when its occurrence could concern, in the course of psychiatric treatment, the very faculty that is sense-making, a patient’s own mind.[2] In their potential to inflict a “literal loss of knowledge” (Fricker, *Power* 163), epistemic injustices: “may prevent one from gaining new

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[2]. It is a *de rigueur* point-of-operation that trust is a necessity between a patient and her clinician for her treatment to be functional, especially in the context of psychotherapy. In his introductory lecture “Psychoanalysis and Psychiatry” (1917 [1916-17]), Sigmund Freud signifies the imperative to respect patient autonomy by making trust foundational to the treatment process, remarking: “The human material on which we seek to learn, which lives, has its own will and needs its motives for co-operating in our work” (295). Attempting to exert measures of control on a patient during therapeutic interventions is counterproductive, if an aim is for her to emerge out of a chronic illness, integrally. Enabling her to find a sense of psychical wholeness, in a voluntary, not compulsory, manner, is the first priority of a therapist.

knowledge, and more generally . . . stop one gaining certain important epistemic virtues, such as intellectual courage" (163). In suffering losses of knowledge and capabilities, victims lose core abilities to address the existential conditions that disturb their situatedness. Fricker elaborates on what such a form of disturbance could mean in regards to "(more purely) epistemic harm" (47), in which: "the recipient of a one-off testimonial injustice may lose confidence in his belief, or in his justification for it, so that he ceases to satisfy the conditions for knowledge" (47). Should an individual be unable to find her confidence in the spectrum of circumstances by which this is normally established, she may doubt her insight into her environment.

She might, for example, question her awareness of the simplicity or complexity of her context, and come to wrong conclusions about its particular constitution, or no conclusion at all. It is also the case that: "alternatively, someone with a background experience of persistent testimonial injustice may lose confidence in her general intellectual abilities to such an extent that she is genuinely hindered in her educational or other intellectual development" (47-48). Due to repeated victimisation or systematic denigration by persons of importance, an individual can find herself unable to order and even formulate coherent thoughts. In such an undermining of belief, meaning-making, and confidence, there are significant potential effects: "[T]he implications . . . . are grim: not only is he repeatedly subject to the intrinsic epistemic insult that is the primary injustice, but where this persistent intellectual undermining causes him to lose confidence in his beliefs and/or his justification for them, he literally *loses knowledge*" (49). To *lose* knowledge at times when knowledge is most needed, for example, in defending oneself from an imminent or persistent threat, can entail confronting powerful situational vulnerabilities. They have the potential to topple an individual-subject when she might ordinarily stand strong.

This dissertation is an attempt to address key issues of epistemic injustice that affect sufferers of mental ill-health because of the situations in which they find themselves. The dimensions of their lived experiences mean that the balances of power between patients and medical clinicians are radically unequal. This is such that the defining feature of a patient's medical journey, her diagnosis, is subject to error and, sometimes, particular injustices specific to its own unique identity within the medical profession. The diagnosis can, therefore, in itself become a medicalised subject, construed and constructed in the course of each clinical encounter within professionalised healthcare economies of practice. My main question is: In what ways can different concepts of mental health and epistemic injustice converge in an applied sense, at the level of diagnosis?

According to Fricker, it is by way of collective gatherings that epistemic injustices are most effectively addressed because of the sense of validation that is therein attributed to victims. She states: “it takes group political action for social change. The primary ethical role for the virtue of hermeneutical justice, then, remains one of mitigating the negative impact of hermeneutical injustice on the speaker” (174-75). By empathising with a given predicament of wrong and inequality, by spoken words or acts of affirmation that widen circles of acceptance, new kinds of meaning are engendered. Fricker concludes: “From the point of view of social change, this may be but a drop in the ocean; still, from the point of view of the individual hearer's virtue, not to mention the individual speaker's experience of their exchange, it is justice enough” (175). Being listened to empathetically, even for a moment, can mean everything to a person who has been manifestly wronged, without fully comprehending how and why.

Paul Giladi (2020) writes that “[f]or Fricker, the best means of combatting testimonial injustice involves the Aristotelian notion of moral training, specifically the idea of training *testimonial sensibility*” (705). By opening consideration to elements of the range of dispositional influences specific to another personal circumstances, individual interlocutors become effective at hearing and recognising individual and social situational imbalances. Giladi continues: “listeners need to be trained well to develop *as far as possible* non-prejudicial attitudes about both their interlocutors (and themselves)” (705). This is such that subject-actors develop skills in knowing when to contribute to a social encounter, and when to withdraw sensitively or deflect attention. For Fricker: “[P]erhaps we should think of the ideal hearer as someone for whom correcting for familiar prejudices has become second nature, while the requisite alertness to the influence of less familiar prejudices remains a matter of ongoing active critical reflection” (*Power* 98). Listeners are to position themselves in such a way as to elicit key information correctly, and then arbitrate differing interests appropriately.

In doing so, there is potential within the subsequent exchange of subject positions for the presentation of positive solutions to long-standing problems. Fricker writes that: “What matters is that somehow or other one succeeds, reliably enough (through time and across a suitable span of prejudices), in correcting for prejudice in one’s credibility judgements. If one succeeds in that, then one has got the virtue of testimonial justice” (98).

Which is to say, it is possible for mutually agreeable outcomes to appear between opposing parties when each participant finds their interests positioned within a sinuous pattern of agreements.

A key feature of Fricker's stance upon listening well is for "the hearer" to develop "greater empathetic competency" (Giladi 705), since this facilitates both necessary trust and the making of "the *right* kind of credibility attribution judgement" (705). Where this appraisal also meets with a solid consideration of the dynamism particular to diverse accompanying "*social* phenomena" (705), two outcomes are especially possible, if not likely: a subject can find herself listened to in ways that validate her epistemic capacity as someone who has irrefutable personal and interpersonal value. Moreover, she is endowed with appropriate dignity as a functional participant in society, characterised, as she is, by values and significances important to her social, communal and political subjecthood.

The philosophers who have contributed to an understanding of role and function of illness in human development, inclusive of its conceptual limitations, often use the phenomenological tools and techniques. Whatever the strengths and weaknesses of these approaches, there is a notable lack of sustained investigation in regards to mental illness specifically. Valeria Malhotra Bentz and David Allan Rehorick (2008) emphasise the role played by phenomenological conceptualisations of the fluidity and contingency of human relations: "Phenomenology, the study of consciousness and its objects (phenomena), is a way of knowing which employs enriched and embodied awareness. Phenomenology directs us to the fullness of experience rather than a remote or pro forma accumulation of information and facts" (3). Individuals are conceived according to their shifting situations and developing *environs* of habitation.

Perceptions into human endeavour are “enhanced by the opening of vision resulting from immersion in the subject matter” (3). Relationships between investigator and subjects of study are defined in contradistinction: “to the traditional mode of observation or data gathering at a discrete distance” (3). In embracing “what the founder of phenomenology, Edmund Husserl . . . called the *things[-]in[-]themselves*” (3; Husserl, 1913, *Ideas*; 1954, *Crisis* 86), lines of investigation proceed that are rich in coherence, authenticity, and insight: the very qualities that are needed to create connections within and between persons whose faculties of feeling and reasoning are not only damaged, even impaired, but also suppressed.

In keeping with Maurice Merleau-Ponty (1945), who explores the embodied nature of human relatedness, apprehensions of the material world are manifested within and between one’s internal and external selves. Sense impressions are divided between their constituent parts, each of which: “arouses the expectation of more than it contains, and this elementary perception is therefore already charged with a *meaning*” (4). The activity of critical investigation derives from such acts of perception. The methodical deconstruction of wholes into their individual categories is illuminating on account of the relationships that are formed within and between subjects-of-analysis and investigators. “Analysis”, for Merleau-Ponty, “discovers in each quality meanings which resides in it” (5). Perceptions are visible and consequently meaningful inasmuch as they can be isolated from the physical states by which they are ordinarily structured.

L. A. Paul (2014) develops helpfully an investigative focus that rests on breaking down narrow binaries between mind and body. She is concerned with kinds of experience that constitute “*epistemic transformation*” (10), significant moments and events through which a subject's self-concept evolves: "Her knowledge of what something is like, and thus her subjective point of view, changes. With this new experience, she gains new abilities to cognitively entertain certain contents, she learns to understand things in a new way, and she may even gain new information" (10-11). Such moments invite foundational acts of self-questioning: "When faced with each of life's transformative choices, you must ask yourself: do I plunge into the unknown jungle of a new self? Or do I stay on the ship?" (123). To appraise oneself in such a revisionary manner is, perhaps, to conduct one's affairs according to the terms of reality: "A life lived rationally and authentically, then, as each big decision is encountered, involves deciding whether or how to make a discovery about who you will become" (178). To acquire a sense of self that has solid value is to examine with both fearlessness and eternal patience the corners of individual human personhood.

Havi Carel, in her ground-breaking book *Illness: The Cry of the Flesh* (2008, 2014, 2019), conducts a phenomenological enquiry specific to physical health. She confronts some of the limits and extremes of human physiology through her experiences of suffering from a severe lung condition, *lymphangioleiomyomatosis* (LAM). Carel suggests: "[t]here are two ways for us to respond to our mortality: authentically and inauthentically. We can choose to respond authentically to death, to live life with an appreciation of its finiteness" (123). By observing how events of any kind can develop and exert change, sometimes profoundly so, it is possible to engage meaningfully with moments of transience and intransience. They could manifest themselves in the liminal divides between professional and general valuations of physical and mental health, stratifications of meaning that may be questioned on every level.

Physicality can itself constitute psychical drama, pressing upon human *psychology* in ways that are both cruel and hopeful. This means: “[l]ife is a set of potential experiences, potential actions, and potential good and bad events. In itself, it bears no value. It is the condition of possibility of having experiences, the space within which experiences take place” (137). In appreciating space and time as of limited proportions, ill persons are forced to make occasionally difficult choices about how and why they conduct their affairs.

In her subsequent monograph, *Phenomenology of Illness* (2016), Carel considers elements of the manifold responsibilities physically ill persons face and place on the world: “The ability to care for oneself, but also the autonomy to make one’s way in the world, is seen as a fundamental feature of adult human life” (78). Being able to look after oneself is considered a capacity of the most fundamental kind. When this capability is impaired or disarmed, awkward questions may be asked both of and by the suffering subject. Those questions, in occurring across professional and lay domains could add up to epistemic injustices when:

> an ill person may be regarded as cognitively unreliable, emotionally compromised, existentially unstable, or otherwise epistemically unreliable in a way that renders their testimonies and interpretations suspect simply by virtue of their status as an ill person with little sensitivity to their actual condition and state of mind. (184)

A challenge for mentally ill persons could be that of making their account of their experiences believable in the face of a general absence of evidences from itemised scans.

My methodology is one of inhabiting as far as possible the conceptual contours of the suffering subject, as distinct from those of the psychiatric professional: that is, insofar as either can acquire practical validity on account of the fact that my research, in seeking to establish the investigative terms, is for now theoretical only. My subject is, consequently, herein known as a *theoretical patient*, or an *experient*, to give voice to general experiences of psychological dis-ease as identified throughout the critical literatures. Since her identification is one conceived in the critical literatures, her *identity* directly countenances the idea that: "illness . . . often understood as a physiological process . . . falls within the domain of medical science" (Carel, *Phenomenology* 1). While necessarily taking shape within medical terminologies and discourses, my subject-of-study, chronic mental ill-health, is *existentially* defined, inasmuch as its terms of enquiry derive from and challenge scientific-facticity. As "the experience of illness" in general is subject to "intense interest" (1), so *this* phenomenon, in lacking unquestionable identification, emerges from an aggregate of sources, discourses and conversations. Attention is therefore thrown on the subjecthood of the experient, that is, "their existential context" (Gillett 38), as much as, if not more so than, the supposed expertise of the clinician.

In her landmark essay "Epistemic injustice and mental illness" (2017), Anastasia Phillipa Scrutton invests especial attention in how the accounts of experients need to be given priority in clinical terms. One effect of doing so is to give their experiences fresh presence. By focusing on actual rather than supposed need, precious treatment resources can be applied efficiently. Persons with mental fragilities can exhibit global strengths that are ordinarily unrecognised. Someone with "motivated delusions is . . . both epistemically compromised, since she holds a belief that is both false and irrational, and also epistemically privileged, since she (and probably she alone) has a particular, if unconscious sort of insight into what is needed in order for her to survive a traumatic event" (353). By first validating the experient's testimony rather than deeming it disproportionately irrational, there is elicited a version of experience that has wide value: one that challenges rash obfuscations of patient-testimonies that are to all intents and purposes sound:

> In order for these injustices to be overcome and epistemic justice practiced, mental health professionals need to be cognizant of the ways in which experients are epistemically privileged – for example, in having unique knowledge of what their experiences are like and, in some cases, of what might be best for them. (353)

Experients have privileged access to their psychological experience, as well as elements of their biological constitution, providing validity to their individual and social situations.

It is naturally the case that for many healthcare professionals, persons with mental health difficulties are epistemically compromised, perhaps because of their constitution cognitive capacities or their existent behaviours. Joseph W. Houlders, Lisa Bortolotti and Matthew R. Broome (2021), investigate elements of this issue in terms of "epistemic agency": "the capacity to produce and share knowledge competently and authoritatively." The self-conceptions of different individuals, their ability to recognise and comprehend elements of their healthcare journeys, is complicated by their willingness to engage with practitioners and *vice versa*.

The relationships between patient and practitioner are directed in part by the details of a case history, constituting both potentialities and limitations in regards to “*epistemic* agency” (Houlders *et al*). A situational factor that is centrally constitutive of identity might reinforce or undermine a self-understanding of critical events. For Houlders *et al*: “The relationship between autobiographical narrative and agency” is especially “complicated when we start to think about felt possibilities for being competent and authoritative in producing and sharing knowledge. For instance, an autobiographical narrative could cast one as incapable of distinguishing the real from the imagined because one hears disembodied voices and has other unusual experiences.” Since “fearfulness and self-doubt” can emerge from such self-presentations, there may be good reason to not believe or trust an experient’s account of herself.

Equally, it is so that instances of cognitive dissonance or, should it appear for a connected reason, deceitfulness, could challenge a practitioner’s distrust. Houlders *et al* comment that “an autobiographical narrative could cast one as someone who has struggled in the past to discern what is real, but who has undertaken work to address this. Such a narrative may inspire feelings of hope.” Since epistemic injustice is inflected both by conscious social exchanges, and unconscious motivations that maintain diverse power imbalances, its appraisal is directed by the exigencies of the moment. As the sensation of hope is both lasting and fleeting, so its accompanying affectivity can engender confidence or constitutional dissonance. Houlders *et al* conclude that “[t]hese affective responses may alter one’s general sense of possibility for exercising epistemic agency.” Such hope is perhaps a vital factor in deciding how, when, where and why to conclude that an instance of epistemic injustice is at work or not.

For Richard Lakeman (2010), diagnosis is the central site in which the issues raised by the suppression of a patient’s voice intersect. In not considering how persons presenting mental distress may in part be reacting against narrow responses among clinicians, the very persons purporting to treat them, imbalances of power predominate: “An overconfident assertion of a psychiatric diagnosis or overzealous belief in biomedical explanations may also lead to hermeneutical injustice” (152). Extensive consideration of a patient’s journey that has led to a clinical encounter may be necessary but overlooked, and therefore could urgently need exploration.

Since she feels disempowered by individuals whose role is to deliver care, she may suffer injustice that is also, on multiple counts, abuse: “[A] person may accept the often uncritically espoused ‘biochemical imbalance’ explanation for their low mood and forgo the opportunity to explore what historical, social, or environment factors may actually have contributed to their ‘depression’” (152). The sense that an individual’s experience of illness may have been substantially affected by the structural constitution of a healthcare system in general is pursued and defined later by Kidd and Carel (2018). They identify “forms of *pathocentric* epistemic injustice: ones that target and track people who are, or are perceived as, chronically somatically ill” (“Naturalism,” 213). By conceiving an appropriate approach to medicalised codifications, terminologies and discursive structures, I shall engage with the possible conceptual-narratives and intellectual-apparatuses of experients on effective, affective, and empathic levels. My aim in employing this methodology is to map the context of criticality that frames the experient, the theoretical patient. This is so as to provide a platform for her voice to be heard in irrevocably clear terms.

My main objective is to make good on the observation by Carel and Ian James Kidd (2014) that: “epistemic injustice is a common, possibly pervasive, feature of healthcare” (“healthcare,” 538). It is therefore important to systematically define epistemic injustice to facilitate ease of recognition. Chapter One will delineate what helpful kinds of relation are in view of the philosophical issues under consideration. I am concerned especially with how the theoretical patient can be capacitated in crucial moments within and without the confines of the consultation room. Chapter Two will explore points of interest that can sometimes precede an initial clinical encounter, those being familial structurations, whose emotional disharmonies and dysregulation may destabilise mental health. Chapter Three will appraise and expand in the context of mental health the validity of a “*phenomenological toolkit*” designed by Carel to substantively aid clinical conversations about physical health (“Resource,” 96). Finally, in Chapter Four, I shall explore, particular to mental health diagnosis and treatment, Carel and Kidd’s invitation: “to establish a methodology or metric for measuring epistemic injustice . . . so that the vast body of anecdotal reportage can be developed into a substantive empirical basis” (539). Carel and Kidd’s further invitation “is then to determine the extent of epistemic injustice in healthcare” because their: “initial studies indicate that it is much more likely to be systematic and extensive, rather than local and minor” (“healthcare,” 539). I shall make summative comments upon what this extent could look like in my Conclusion, having developed a theoretical basis for a larger, applied investigation.

If, as Fricker suggests, “prejudice will tend to go most unchecked when it operates by way of stereotypical images” (*Power* 40), then such *imaginings* must be interrogated categorically. In doing so, a worthy endeavour is already underway, the address of how "our everyday moral discourse lacks a well-established understanding of the wrong that is done to someone when they are treated in *this* way" (40; emphasis added). Applying appropriate classifications, in the form of quality metrics, might facilitate correct approaches to clinical treatment, modelling ethical standards that have cogency and solidity in these senses: They may instil diverse forms of interdependence between experients and professionals who previously were without the necessary dialectical tools to mediate conversations away from measures of injustice and unfairness. Also, the person most vulnerable, and at risk, in such conversations, the experient, whose journey to the consultation room might have seemed unending, can an acquire *intra*subjective vitality.

Concomitantly, it is to be observed that developing metrics to measure epistemic injustice might simply reinforce existing unfairness and wrongs. If deriving from within a context that has not examined its own contextuality, they could serve simply to reflect the values, *mores* and concerns of biomedical science and the present bureaucratic healthcare economies. It is my hope that the experient's voice can emerge from within the darkness in which she may have, for a longer time, felt submerged. By equipping her with the capacity to speak from within and apart from forms and structures of meaning that appear to contain her best self, she might discover anew elements of her core being. She may come to know herself in the context of an operationally significant other, learning to generously value him and, most importantly, herself, perhaps for the first time.

Chapter One

Forms of relation and capacitation: How epistemic injustice and the theoretical subject can become

At the beginning of my enquiry proper, it is necessary to define some of my key terms and vocabulary. Epistemic injustice is defined by levels of individual, interpersonal and structural exclusion in regards to the extent to which a person is involved or excluded in a social encounter. Its focus, specifically, is on the levels of knowledge required to receive validity and bear effectiveness in the encounter. Setting out what kinds of epistemic injustice there are, Gail Pohlhaus, Jr. (2017) distinguishes between three levels of exclusion. She states that:

> [e]xamples of first-order exclusions include testimonial injustice, whereby knowers attribute less credibility to a knower's testimony due to an identity prejudice . . . and other sorts of exclusions from non-testimonial epistemic practices such as those involved in querying, conjecturing, and imagining, owing to deflated perceptions of competency. . . . ("Varieties," 19; Fricker, 2007, *Power* 28)

Credibility, in this context, concerns the extent to which an individual's account of an incident or event is believed. Should her identity as a potential knower be subject to negative value in not presenting characteristics that demonstrate social or political acceptability, she is subject to negative-identity prejudicial stereotyping: her identity is defined not by qualities that present her reality as a dynamic functional agent.

Instead, she is judged to be of lesser worth, framed by the values of a group who control the requisite epistemic resources that are necessary to access some social spheres. As Pohlhaus, Jr. puts it, “an epistemic agent is unfairly prevented from participating fully within epistemic systems owing to an unfair distribution of epistemic power due to unwarranted credibility deficits and assessments of competency” (“Varieties,” 19-20). An individual’s general potential and fate within a specific circle is determined by economies of power that she cannot shape, or even access.

In contrast to first-order exclusions, which rest on communicational exchanges that are largely *transactional*, it is the case that second-order exclusions apply to aspects of the *structural* constitution of a social context: “Second-order epistemic exclusions require more than ensuring equitable participation in epistemic systems. In such cases, there is something wrong with the epistemic system itself: it is insufficient in a way that leads it to function less well with regard to certain experiences or aspects of the world as experienced by certain persons” (20). A person’s experience and history as a social agent of importance and scope, capable of making an impact in an apprehension of collective origins and general complexity, is overlooked.

She is not deemed to merit access to the apparatus that enable the sharing of knowledge, the hermeneutical resources that define identity on numerous levels. Pohlhaus, Jr. writes that “what Dotson calls ‘testimonial smothering’ would fall in this category. Testimonial smothering occurs when one ‘perceives one’s immediate audience as unwilling or unable to gain the appropriate uptake of proffered testimony’ and so must truncate one’s testimony” (20; Dotson, 2011, “Tracking,” 244). Individuals are denied a resonant voice socially and, in this denial, are unable to hear and listen to both others and themselves in the forming of self.

Finally, there are third-order exclusions, marked by instances where systemic inadequacies in knowledge mean that an established set of resources in itself works against a given spectrum of identity features. Pohlhaus, Jr. writes that "[t]hird-order epistemic exclusions are exclusions that occur when an epistemic system is functioning properly and is sufficiently developed, but the system itself is altogether inadequate to a particular epistemic task" ("Varieties," 20; Dotson, 2014, "Conceptualising," 129-31). Injustice in systems whose functionality depends, in part, on maintaining numerous threads of conversation that compete for dominance, are especially oppressive. The subject who is subjugated is, in effect, also systematically victimised.

To overcome the wide, sometimes acute unfairness embedded within a specific system, also called structural deficits, requires a strong effort on the part of persons wishing to mount a challenge. For Pohlhaus, Jr.:

> [t]hese sorts of exclusions require third-order change, or the ability to think what a given epistemic system does not allow one to think, revealing the system itself to be not just insufficient (and so remediable by adding and adjusting) but rather *inadequate* to certain epistemic tasks (and so in need of a new epistemic system)." ("Varieties," 20)

Change, as conceived in this context, is defined by a targeted attempt to deconstruct, break-down and diminish structures of thought, speech and action that exert overwhelming force on vulnerable persons.

In terms of testimonial injustice, in which an individual is engaged in a communicational exchange that presents diverse, conflicting levels of accessibility, control over spoken-content can naturally vary. Jeremy Wanderer (2017) describes a specific interaction between Speaker and Hearer. As well as being "accorded insufficient credibility by a Hearer due to a prejudicial stereotype held by the Hearer" (28), it is the case that the Speaker herself is marginalised. The Hearer may link "a salient aspect of the Speaker's social identity to a disparaging attribute, as a result of which the Hearer accords to the Speaker less credibility than she deserves" (28). Testimonial injustice, in being characterised by critical incidents among acting participants, presents first-order exclusions. Where its constitution is marked by faults in an epistemic system that predispose some participants to unfair treatment, its characterisation can also assume the idea of structural testimonial injustice, second-order exclusions.

In this instance, negative-identity prejudicial stereotypes are characterised by imbalances and unevenness in the distribution of social resources, such as differently stratified education- and work-opportunities. Wanderer presents an example of structural testimonial injustice in an account provided by: "Elizabeth Anderson, in which a Hearer accords insufficient credibility to the Speaker's say-so on a matter that requires an educated judgement, and the Hearer's primary reason for according a low level of credibility is the Speaker's use of non-standard grammar in formulating their judgement" (33; Anderson, 2012). In this case, the presentation of the Speaker as someone who has not acquired habits of speech that present her as educated in a specific way, lowers her perceived credentials.

The injustice at work here, one indicative of what educational opportunities might be available to certain groups, is less transactional than structural because its enactment stems from deep-rooted prejudices. The Hearer formulates judgements about the Speaker on the basis of details on speech that in themselves speak into perceptions about the lives of both persons. Those perceptions might naturally change in the course of time, and the speed of the change, as well as its nature, can determine the success of a conversational encounter. Wanderer writes, “[a]ssuming the Hearer is not drawing on a prejudicial stereotype that is resistant to counter-evidence in making his credibility judgment, then it is possible that the Hearer is following a sound epistemic procedure that could even be justified to (and perhaps shared by) the Speaker herself” (34). The Speaker is herself subject to imbalances in social ordering, meaning her inability to level fair perceptions stems from her character and upbringing, rather than her behavioural choices. Wanderer concludes that “[t]he injustice here is thus not transactional but structural, viz. the unfair distribution of certain epistemic goods within the society” (34). Within spoken-interactions are therefore present elements of meaning that are the product of social deficits: those deficits are not necessarily derived from the powers of discernment within and between Hearer and Speaker. Instead they are characteristic of the complex imbrications within and between different social encounters.

Third-order exclusions are typical of hermeneutical injustice, in which factors particular to testimonial injustice shift in emphasis into aspects of singularly structural meaning. By this, I mean that the interpretative resources necessary for general personal progress relate directly to different capacities unique to enhancement of self. Those powers of discernment are hermeneutical resources because they determine accessibility in attributing and accepting meaning. For José Medina (2017), “[h]ermeneutical harms should not be minimized or underestimated, for the interpretative capacities of expressing oneself and being understood are basic human capacities. Meaning-making and meaning-sharing are crucial aspects of a dignified human life" ("Varieties," 41). Since meaning-giving and meaning-rejecting can in their very enactment form substantial elements of the self, "[h]ermeneutical injuries can go very deep, indeed to the very core of one's humanity" (41). Miranda Fricker, who pioneers the concepts of testimonial injustice and hermeneutical injustice, therefore "asked: 'Is hermeneutical injustice sometimes so damaging that it cramps the very development of self'?" (41; Fricker, 163). The injury exerted by hermeneutical injustices is principally one that rests on who holds capacity in bestowing meaning, and the extent to which they are aware of doing so.

Medina comments on the central issues at stake in handling central interpretative powers: "When it comes to hermeneutical harms and injustices, the question is not simply whether or not there are expressive and interpretative resources available for meaning-making and meaning-sharing, but how those resources are used, by whom, and in what ways" ("Varieties," 43). It is "by asking more and more specific questions" (43), to interrogate what the phenomena, contexts and dynamics of a situation are, that hostile forces exerting profound control can diminish.

This can facilitate space for the possibility of hermeneutical justice, a practice of meaning-making of increasing levels of openness and equity that create degrees of cohesions, not fragmentation. Medina comments that "Fricker has recognized the importance of 'localized hermeneutical practices'" (43; Fricker, 2016, "Preservation,"163), and, given the possibility for their abuse, rather than benign use, "has called attention to agential elements in the production of hermeneutical injustices" (Medina, "Varieties," 43). Frequency in instances of "patterns of testimonial injustice can contribute to the production and perpetuation of hermeneutical injustice" because the former can endenger the latter (43). It is in stimulating the incubation conditions advantageous to one group over another that a particular set of interests predominates. This means "the shared pool of concepts and interpretive tropes that we use to make generally share-able sense of our social experiences" can lead another to suffer ill effects (Fricker, "Preservation," 163; qtd. in Wanderer 43). They include those of hermeneutical marginalisation, in which members of a group come to have increasingly less grasp of the controlling factors that are generative of positive social change. It is on the circumstantial change that is possible for *experients* of mental health that I shall focus.

It is vital to consider the theoretical patient in authentic ways if she is at risk of falling subject to epistemic justice, testimonial or hermeneutical. Insofar as she is of sound mind, she is to be deemed capacitous, capable of making decisions about her health treatment that have legal legitimacy.[1] The case

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[1]. It is to be observed that individuals incapable of such are extremely vulnerable to epistemic injustice. They include children, whose parents or guardians may not necessarily have benign intent, and persons whose intellectual or mental states may not carry efficacy in some decision-making contexts. In asking "How do we listen to children?" (1256), Havi Carel and Gita Györffy (2014) point out there is existent a tendency to overlook the significance of the "developmentally shifting needs" of children (1257). It is incumbent on healthcare professionals to "continuously question the validity of the patient's and carer's testimonies and the diagnosis itself" (1257). This is because neither may be expressing an accurate account of their experiences: one on account of a possible lack of status and credibility, the other because of their own reasons or agendas.

remains that some forms of discourse and argument are resistant to attributions of authenticity. Individually, interpersonally and structurally, the experient is dealt epistemic injustices that manifest themselves in overt and covert ways. The aim of this chapter is to account for the multiple concerns that are engendered throughout constructive forms of relation and capacitation. My objective is to assess the extent to which experients can resist developing unhelpful relationships, regular and clinical, to reframe different interactions in her favour and therefore acquire vital validation. My principal question is, what kind of conceptual framework needs to be set in place to give the patient a defined and empowered voice in a clinical setting?

A central point of reference in conceptualising mental ill-health and disorder according to individual, interpersonal and, especially, structural factors is *Madness and Civilization: A History of Insanity in the Age of Reason* (1961) by

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While these states-of-affairs might seem to undermine the tenor of my enquiry that mentally unwell individuals should be able to acquire a voice in treatment, two points are underlined. My methodology, in being one of coming to identify with a suffering subject, means I wish to create a specific conceptual space for her. Making room for her to express herself as coherently as possible, at as early a stage in the treatment process as is tenable, is important to limiting negative outcomes. In having different personal capabilities and strengths within reach, she stands a chance of suffering less on account of possible stigma, prejudices or linguistically-framed violence. Secondly, and within this principle, where she does fall subject to specific ill-treatment, she should, insofar as is possible, be provided with space in which to find useful footholds. To be capacitated, as I mean it, is therefore to have not just jurisdiction within which to make decisions of legal consequence. To have capacitation is also to exert reasonable influence upon persons who could exact decisions-by-proxy.

Michel Foucault. Mental illness, in this text, is categorised according to Enlightenment distinctions between the rational and irrational, expressions of reason and unreason that are culturally constructed within their discursive frameworks. For David Cooper (1989), “Foucault makes it quite clear that the invention of madness as a disease is in fact nothing less than a peculiar disease of our civilization. We choose to conjure up this disease in order to evade a certain moment of our existence—the moment of disturbance” (viii). By externalising *into others* psychical acts whose impacts upon one’s own self are too distressing to confront, internal pain is evaded and displaced: “Others are elected to live out the chaos that we refuse to confront in ourselves” (viii). Such projections, forms of psychological violence that both cause and elicit harm, mean that different diagnoses are not necessarily what they appear to be. In the case of schizophrenia: “the major form of madness in our age . . . people do not in fact go mad, but are driven mad by others who are driven into the position of driving them mad by a peculiar convergence of social pressures” (viii).[2] However

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[2]. In his recent study on the cultural and biomedical intersections in the conception and treatment of schizophrenia, Nathan Filer (2019) describes instructively aspects of its scientific formulation. He quotes from his conversation with the psychologist Dr Lucy Johnstone: “We’d talked about how people with a diagnosis of schizophrenia are often very sensitive, picking up on interpersonal vibes and feeling things very deeply” (148). Individuals diagnosed with schizophrenia could possess emotional and feeling sensibilities that are finely-tuned, easily provoked in times of duress and conflict. This provocation of the emotional- and feeling-self need not be to the detriment of the experient: “To her mind, the mistake geneticists too often make is to conceptualise this as a biological vulnerability to illness rather than a temperamental factor, which in the right circumstances could be a real advantage” (148). Experients, in having acute sensitivity to moments of aggression and

passive-aggression, may know when to seek exit from a threatening situation. Dr Joanna Moncrieff, “a consultant psychiatrist and a founding member of the Critical Psychiatry Network” (148), asks two leading questions: “How do we identify what makes it difficult for people with these particular characteristics to function in our society? And might there be ways of organising society that would make it easier for them?’” (149). Sufferers of schizophrenia could play humane societal roles, exuding benefits far beyond the confines of their present identifications as marginal subjects.

It may be that in practice this could mean one of two possibilities: the first being an attempt to have a person adopt a set of prescribed social norms in regards to behaviour and presentation. In Foucault’s terms, this would be typical of “the loss involved in the relegation of the wildly charismatic or inspirational area of our experience to the desperate region of pseudo-medical categorisation from which clinical psychiatry has strong” (Cooper ix). Equally, persons with a diagnosis of schizophrenia could be encouraged to enact radical social change that diametrically opposes attempts to vitiate the vitality of individual and interpersonal experience. If, for Cooper, “evaluating the social meaning of madness” is strongly contested within and between different traditions of clinical psychiatry (ix), the former is more likely. Given the multiple obstacles to overcome, experients may struggle to mount sufficient challenge to a prevailing clinical and social orders.

Filer develops his perspectives by also pointing out that a person with “so-called schizophrenia” could have “higher . . . dopamine levels” (198, 199), increasing “the salience things around you will seem to have” (199). Should dopamine levels rise because of different events and happenings, then levels of cortisol, a hormone induced during times of stress, could also rise. This can be to the detriment of the experient, whose state-of-mind could be perpetually alert should she have been raised in a difficult familial environment. Filer interviews Dr Philip Corlett, an expert “on the neuroscience of hallucinations” and based at the Yale School of Medicine (219), who has studied individuals who have been subject to such conditioning. Observing how “rates of *psychosis*” (222; my emphasis), as sometimes found in *schizophrenia*, are “higher . . . in people who have suffered trauma” (222), he contends: “‘If your model of the world through development is that you can’t even intentional or unintentional such inflictions of injury are, their origins are nonetheless identifiable, as familial dynamics coalesce and focus on “certain selected individuals” (viii). Such social mediations can be discerned as “intelligible—through various mystifying and confusing manoeuvres” (viii), and are, in residing within the structurations that determine meaning, distinct hermeneutical injustices.

Foucault argues that the prime means through which injuries occur is language because of its capacity to occupy any region of enquiry: “*Language is the first and last structure of madness*, its constituent form; on language are based all the cycles in which madness articulates its nature” (*Madness* 94). Since individuals come to know the significance of mind and body under its scrutiny, language can exert powers that are determining at the levels of speech and meaning. Madness, as a specifically social phenomenon that divides and unites communities according to their individual stratifications, has a functional value that is concomitantly absent of ethical import. For Foucault, by way of its ubiquity in individual and communal contexts: “madness is always absent, in a perpetual retreat where it is inaccessible, without phenomenal or positive character; and yet it is present and perfectly visible in the single evidence of the madman” (101). Madness, as a categorisation of experience that is continually perplexing, demands a strictly rationalistic treatment in terms of critical apprehension

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rely on your parents to take care of you . . . then that’s a shortcut to massive amounts of uncertainty about other individuals and situations’” (222-23). It would seem that philosophically, scientifically and anecdotally, the case is strong that a difficult home-life could, through its organisation of social (and even clinical) pressures, sometimes lead directly to mental trauma.

precisely because of its capacity to trouble moral standards. Foucault writes: "*a rational hold over madness is always possible and necessary, to the very degree that madness is non-reason*" (101). For me, the voice of the theoretical patient is best heard on a scale of intelligibility that reaches across, within and between reason, unreason and non-reason. Inasmuch as each questions, respectively, how she is seen, heard and understood, and, in different respects, rejected on the same counts, those responsible for her care are accountable.

Foucault's perspectives are largely representative of the issues individuals can encounter during third-order exclusions, marked as they are, by ruptures in hermeneutical meaning on medical-institutional, linguistic-theoretical and moral-cultural levels. First- and second-order exclusions are apparent in individuals' attempts to secure validity of their individual experience, and measures of social acceptance within this as they pursue the best meanings of forming constructive relationships. The forms of relation that are required to provide an accurate description and application of the key ethical concerns in terms of different epistemic injustices reach across diverse heuristics. On the one hand, interpersonal relations between experients and clinicians build one upon another in a linear sense. If one kind of epistemic injustice is particular to the undermining of the integrity of vocative address, the infliction of "a *credibility deficit*" (Fricker, 2007, *Power* 17), the other targets intelligibility: "The second form of epistemic injustice is *hermeneutical*, where a speaker is rendered incapable of making sense of her own social experiences, and of having them understood by others, owing to a persistent gap in epistemic resources rooted in group-based hermeneutical marginalization" (Doan, 2017, 184-85). Injustices, on these bases, are normative in residing in unfairnesses and wrongs that can be both individual or structural in orientation. One person's struggle to be believed in voicing their symptomology might, for another, manifest in an inability to begin to occupy a space of validation.

But injustice need not necessarily form an intelligible pattern of give and take in terms of harm done, whether visible or invisible. Andrew Peet (2017) focuses on interpretation itself as of central importance in applying Fricker's tools. Her distinctions between the "*testimonial*" and the "hermeneutical" can actually reside in injustices of their own constitution (Fricker, *Power* 17, 148). Where testimonial injustice refers to how a subject-participant is deprived of the opportunity to receive validation of her account of experience, hermeneutical injustice has a different emphasis. This concerns her inability to make sense of her *experiences* in the first place because she or the perpetrator of the injustice lacks the necessary conceptual tools and apparatus. Other individuals might *understand* their experience soundly: they may simply be unable to share its detail and nuances with persons who lack the right concepts, meaning it is the rare exception, rather than a common instance to find "exceptional testimonial justice being practised by individuals operating in poor hermeneutical environments" (Todd, 2021, 87). Against "Fricker's 'adjust upward' heuristic" (Peet 3441), in which perceiving the meaning of another's words and actions is an inherently interpersonal endeavour, is placed the need to confront how "interpretation is multifaceted and non-scalar" (3441). This means that discerning differences and indifferences between victim and perpetrator needs to account for how those qualities themselves change from moment-to-moment. For Peet "[a] heuristic [device] such as 'evoke more evidence in interpretation' . . . . seems more appropriate" (3441). It is in the lived actions, reactions and redactions between person-to-person or person-to-group accounts that substantive interpretative work is enacted and completed.

The caveat to these activities is that conclusions are not arrived at easily or quickly: “heuristics along these lines differ from Fricker’s heuristic in an important way – they are far more cognitively demanding” (3341). The quantitative and qualitative application necessary is problematic precisely because the issues that come to be identified are not generally readily discernible. Peet concludes: “Thus, application of the heuristic will be, in some ways, detrimental to the audience, and may also be detrimental to speakers” (3441). Whatever Peet’s criticisms about the demands placed on a victim because of her ill treatment, she can, if her resources are solid enough, attain a linguistic mastery and competence. The effectiveness of those resources naturally pends on the extent to which she is neither psychologically discomfited nor mentally impaired.

While one “variety” of testimonial epistemic injustice is “transactional” (Wanderer 34), sitting within “the self-understanding of the maltreatment by . . . practitioners themselves” (34), other kinds of more insidious. Credibility-distorting biases and stereotypes can manifest in unjust interpersonal testimonial practices, that is, deciding who can speak and when, meaning individuals sometimes have limited choice over their behavioural responses. When individuals’ internal states displace their conscious perceptual judgements and outward presentation, they are subject to “structural testimonial injustices . . . not internal to the perspective of the participants in the practice themselves” (34). Moreover, while it is naturally important to take “seriously the participant’s self-understanding of the social practice of testimony" (35), however slanted, deficits in self-awareness can continually present themselves.

This is because "not every explanation of an instance of testimonial injustice need appeal to both structural and transactional varieties" (35). Another instance of testimonial injustice, "testimonial betrayal" (38), can occupy the potentially troubled waters of relational intimacy in which "socially-situated agents" stand "not just . . . in varying forms of power relations with one another, but they also stand in varying relations of intimacy and acquaintance with each other" (38). In moments when betrayal between persons also "takes the form of rejection" (38), transactional encounters can assume the uncertain qualities specific to intimate relational bonds, where what is not said can be as expressive as what is voiced. Affected agents, who may feel rejected, stand to suffer not only crumpled testimonial confidence, in finding their significance as speakers shunted aside in favour of an apparently important other. They may also feel crushed as individuals pointedly or generally rejected on account of another individual or group's preferences for a seemingly arbitrary set of personal qualities.

Identifications and subsequent addresses of epistemic injustice, within Peet's framework, are valuable insofar as they make a lasting difference upon all parties involved in a series of interactions. Listening actively, with an intent to reveal the complex seemings and substances of tough actualities, may be both enlightening and cathartic. In the context of mental health specifically, one measure of accomplishing these tasks is that of alleviating the suffering caused by the pain of being epistemically silenced. Wesley Buckwalter (2018) examines how *silencing* is a kind of violence that arises from contested valuations about who or what is valuable in a given circumstance. He defines silencing as “the act of interfering with or preventing others from speaking, communicating, or being heard” (294). Since to make oneself known and understood is to be placed in relations of knowing, “silencing can be a symptom of epistemic harm” (295). In not having their testimonies properly heard, a speaker may be pre-judged by listeners, “lead[ing] them to reject their testimony, which causes silencing to occur. As a result of incorrectly identifying the knowledge that a speaker has, the listener might dismiss the speaker’s evidence, undermine or reject their credibility, refuse to listen to them over others, or stop communicating with them entirely” (295). Over time, a speaker could find herself ostracised completely because she becomes excluded from communities of knowing that she would otherwise be part of “causing certain mental state representations of knowledge. In other words, the impact that antecedent acts of silencing have on speakers and listeners can lead us to subsequently deny knowledge to them; and, in some cases, this can potentially deprive individuals or communities of knowledge itself” (295). It is crucial that experients of mental disorder are not silenced during important clinical encounters, especially those that could lead to diagnoses.

To find oneself in a position of solipsism is to be in a situation of not being able to convey the information necessary to make a correct diagnosis. Institutionally, an individual may encounter first- and second-order exclusions in finding herself denied the opportunity to speak, and or having her account truncated or abridged. Culturally, she may suffer third-order exclusions through exclusion from consideration of elements of the language and grammar that denote credibility, in her subjection to negative prejudicial stereotypes. Theoretically, she may suffer such exclusions in lacking the hermeneutical resources required to formulate meaning, and then the opportunity to participate in a hermeneutical practice that is central to the distribution of key tools and facilities. Whereas hermeneutical injustice, the product of third-order exclusions, is denoted by elements of structural imbalance, testimonial injustice, in this instance, is quite different. In exhibiting individual-, interpersonal- and structural-features, its presentation offers both opportunities to effect change and, if invisible in key times, such as during diagnostic assessments, reasons to feel defeated. Individuals may find themselves placed in wrong behavioural categories, or attributed erroneous psychological characteristics. They are, therefore, vulnerable to misdiagnoses in meeting inaccurate categorisations of symptoms, or wrong diagnoses in having incorrect diagnostic models placed upon their presentations of self.

Epistemic injustice therefore occurs on numerous levels, psychosocial, medical and philosophical: “Silencing may . . . literally affect what is known or what it is true to say about another’s knowledge. . . . [T]he conditions brought about through silencing can potentially manipulate the conversational standard whereby knowledge statements come out false, or actually make it harder to have knowledge itself” (Buckwalter 305-06). Unless individuals are attributed validation in a proactive way, they may become psychically lost in healthcare economies and society, even unto themselves. They are subject to testimonial injustice that in its manifold multiplicity prevents them from acquiring individual self-knowledge, interpersonal skill and dexterity and, through long-sustained occurrence, manifests in structural obfuscation-of-self. Silencing is one of many forms of testimonial injustice. Its effects are sometimes complemented and cemented by testimonial injustices whereby individuals can speak so as to substantively contribute to a dialogue: but their sense, meaning or information is distorted or truncated. In regards to “epistemic injustice . . . in psychiatric services . . . *contributory injustice* . . . occurs when a marginalised group cannot contribute their perspective and experience because their contribution is systematically dismissed by a privileged group, leading to epistemic loss” (Drożdżowicz, 2021, 2; Dotson, 2012, “Cautionary,” 31). This can be “important” where its inverse, an epistemically sound consideration of patients’ views, can mean treatment approaches are tailored to their “needs to effectively enable the expression of experiences” (Drożdżowicz, 4). Patients can acquire time, space and visibility that they were previously denied.

Their existential incapacitation could mean their psychological trauma goes unrecognised, so creating hidden communities of subjects who are also hidden from one another. As Buckwalter puts it: “silencing and knowledge representation may go hand in hand in an ongoing cycle, . . . which, in turn, results in and promotes more acts of silencing” (306). Preventing “cyclical epistemic injustice” should be a crucial prerogative of not only healthcare professionals (306), but also informal communities of care, such as families and friends. Enabling an experient to become their full self, growing through phases of suffering, eventually to a point in which they attain “*self-actualization*” (Maslow, 1943, 382), also means actively deconstructing epistemic injustice because: “[u]ltimately, Fricker contends, such injustice(s) are profound in their effect, such that ‘a person may be, quite literally, prevented from becoming who they are’” (Bostwick and Hequembourg, 2014, 490; Fricker, *Power* 5). To have an experient discover how she has agential-capacity outside of a restricting set of standards that reside without her day-to-day routine, is to endow her with value ontologically.

She assumes a particular kind of dignity, “one that is related to ideas about the value or worth of a being” (Humphreys, 2016, 143). By “put[ting] oneself in the circumstances or position of another being, or understanding the sufferings of another being” one can empathise with how her persona and presence are prorogued (159). This is an act which, on account of the need to adopt a disposition of empathic enquiry into another’s circumstances and situation: “requires using the imagination to some lesser or greater extent” (159). Epistemic injustice becomes so in an environment in which the suppression of an experient’s voice and version of reality is the norm. The experient might be depressed in her being literally de-pressed as a valuable and functioning member of society. Pohlhaus, Jr. (2014) suggests that an especially damaging kind of harm that results from testimonial injustice is truncated subjectivity. An individual is denied efficacy as a person capable of positive individuation, suffering instead from “*being relegated to the role of epistemic other, being treated as though the range of one’s subject capacities is merely derivative of another’s*” (“Discerning,” 107; qtd. in Carel and Kidd, 2017; “medicine,” 343). “Any contribution” that she might make to the epistemic identity and functionality of an individual or interpersonal context “is summarily denied epistemic support and uptake by dominant members of the community” (Pohlhaus Jr., “Discerning,” 107). The consequence is that she can neither make informed choices about her treatment, nor direct vital features of its delivery, possibly increasing the severity of a series of symptoms or lack of self-esteem.

Of course, it may sometimes be appropriate to deny some epistemic agents a voice, where their intentions are to all intents and purposes far from benign. The promotion of malicious ideologies, harmful versions-of-reality and skewing of important facts can de-value and even collectively de-press not only a person, but entire sections of a population. In regards to the need to expose "disinformation as false" in the COVID-19 pandemic, Wasim Khaled and Naushad UzZaman (2021) remark that: "False information thrives precisely because it resounds with preconceived ideas and human desires, whether unknowingly consumed or deliberately employed as a political stunt" (324). Attempts to make plain individual, interpersonal and structural constructions of false meaning is imperative to prevent "harm" to a society's "citizens, ecomonies and way of life" (324). In terms of mental healthcare, this means equipping an experient with skills to listen well and articulate herself lucidly in the face of illness and inhibiting forms of treatment.

She can become better by having her voice heard by appropriate persons, and her suffering rendered visible. Her role and function in the context of presenting herself in efficacious terms is not dissimilar from the concept of the "absent referent" advanced by Carol Adams (2010, 13). Its function, in the case of meat-eating, is to separate "'the meat eater from the animals and the animal from the end product'" (13; qtd. in Humphreys and Watson, 2019, 181). For Adams, an ethics of representation, as based on making known that which is denied the potential to be seen and heard, is one of bringing about a solid presence of thought and idea: "'The function of the absent referent is to keep our "meat" separated from any idea that she or he was once an animal . . . to keep something from being seen as having been someone'" (qtd. in Humphreys and

Watson 181). Similar to the imperative need to challenge forms of discrimination that operate beneath ordinary awareness, is that of reifying oneself as a subject-participant in the exchange of goods and values. As “[c]arnism[,] . . . the belief system that conditions us to eat certain animals” has an “invisibility [that] accounts for why choices appear not be choices” (Joy 19), so counter-actions are possible. In re-orienting her awareness, however incrementally, the experient can make constructive choices that begin with reframing and assuming alternative beliefs. The experient, in identifying herself within a set of terms that overcomes the prejudices levelled presented within another, can attain a resonance and currency that are constitutionally enabling. She might therefore access the range of resources society may offer, and acquire a cohesiveness of self in her interpersonal identification, and in her experience of her own subjectivity.

She could even develop a critical apprehension of her status as a person within the domains of eternal vigilance, as conceived according to her most firmly held beliefs. They might include those particular to a religious or spiritual disposition, even as it is possible that religious convictions could amplify epistemic injustices. In her chapter on *Numbers* in *The Queer Bible Commentary* (2006), a volume which serves to point “the way . . . into a fuller recognition of the significance of sex and sexual desire” (Long 17), Sue Levi Elwell asks: “How do we read these tales that both lift up and flatten the solitary voice that calls for justice or fairness or compassion?” (106). The search for alternative ways of framing religious tradition, in the context of LGBTQ+ persons, resonates with explorations of epistemic injustice specifically. Some persons, while tolerating religious interests, may not necessarily afford them epistemic respect. It is, nonetheless, essential that diverse interests receive the attention they deserve if an individual is to be treated as an actor of rich and complex potential. This might be especially present in her version of religion precisely because of its difference with prevailing norms within and without a tradition.

Her religious disposition could be, for example, one resonant with a theistic sense of *God*, conceived by way of established dogma: or a deity that is conceived within her own sense what *He* or *She* could be and do, for good or ill, for her or those significant to her. Ian James Kidd (2015) suggests that suffering is on multiple counts educative, even transformative, precisely because ill persons are exposed to versions of society that are normally hidden. He writes: “My claim is that reflective experiences of suffering can effect a fundamental transformation of a person’s experience of and engagement with the world, and, indeed, with God” (292). Even though one’s personal apprehension of divine figures is sometimes an individual matter that is nevertheless important in times of collective duress, the value of a religious belief-system can contribute to general communal well-being. Whether the figure-of-interest is Jesus, Buddha, Muhammad, or another, he (or she) can serve the experient in profoundly helpful ways if his (or her) teachings are specifically instructive. Should the figure of the divine, as conceived in history, ever ground (*again*), *He* or *She* might first come to identify with the concerns particular to those suffering the tough actualities of epistemic injustice. Which is to say, on *our* common, corporeal conception of *Earth*, He or She might do well to first become the theoretical patient. Religious persons and authorities, in occupying the theory and practice of healthcare delivery as it is, could learn lessons that are widely applicable without.

It is, perhaps, by way of different transformations, phenomenological and other, that it is possible to find ways into evaluating the significance of common opportunities. Trying new doors and discovering new relationships can become the norm not only for people with the privilege of good health. Those for whom sickness is a core part of their lived experiences can meet social challenges by apprehending the degree to which prejudices are composed of commonplace cultural features. In her investigation into stigma and mental health, Angela Thackuk (2011) writes that: “The word *stigma* comes from ancient Greece, and was initially used in reference to signs or symbols physically cut into or burned onto the bodies of those deemed to be of an inferior status. It was a marking of one’s tarnished and flawed character” (140-41). Stigma has a performative quality in the sense that its attribution stems from limited and limiting economies of fixation about social roles and functions. In contemporary economies of significations, tattooing of persons and marking of animals has a similar role. For Rebekah Humphreys and Kate Watson (2019) “marking and scarification can function as a representation and reflection of the perceived value of certain beings, particularly of nonhuman beings and women, and of their status in society; a value and status ‘inscribed by culture and counterinscribed by individuals’” (170-71; DeMello, 2000, 9). Thackuk continues in a similar vein, in suggesting that some forms of stigma can exact different interpretative demands: “Today, stigma is more often attached to one’s social standing, personality traits, or psychological makeup” (141). By recognising how social actors play a central role in attributing labels, such as mental health diagnoses, and by challenging their soundness, experients can become powerful interpreters of events.

Not only might an experient be misdiagnosed or wrongly diagnosed; the critical constitutionality of a label might itself be inaccurate, and subject to change. Misplaced attributions of value to notions of race, gender or sexuality can sometimes collapse conceptions of mental health that have remained of pointed significance. Thackuk writes: “For women, whose epistemic status is still tainted by the residual effects of historical accounts of ‘the female kind’ as essentially irrational and overly sentimental, psychiatric diagnosis further threatens their consideration as trustworthy and valued informants” (155). Systems of sexism, chauvinism and patriarchy have combined to mean women are sometimes disbelieved in the consulting room, perpetuating the effects of abuse they suffer: “Consider the fact that many women with serious mental illnesses have been abused, and their vulnerability to violence increases as their health deteriorates. . . . Despite this, a woman’s reports of abuse are often viewed “through the coloured lens of her diagnosis” (155; Harris, 1997, xii; qtd. in Morrow, 2002, 7). The stigma invoked by gendered diagnoses, one form of pernicious prejudice, points towards the imperative to heed, on micro- and micro-levels, “Goffman’s advice and reintroduce ‘a language of relationships’” (Thackuk 157; Goffman, 1963, *Stigma* 3). By reframing stigmas about mental health treatment and diagnosis as matters of relational dynamism, human subjecthood can acquire a different status.

Similar to how the stigma of AIDS became “‘a question of power, inequality and exclusion’” (Parker and Aggleton, 2003, 21; qtd. in Bergstresser, 2011, 227), “so mental health–related stigma” is subject to wholesale revision (227): not rendered “a problem of individual pathology” (227). Within such acts of reimagining, contexts of conditioning are fundamentally altered so that *con*-texts of all kinds *become* anew. As individuals and communities interact in and through *text*, however conceived, so text, presented as language, in itself serves as a site by which meaning is created and rejected.

The experient, in pursuing forms of relation that are synchronic and diachronic, such that she can revise, sometimes radically, the epistemes that have determined her social standing, discovers self-empowerment. In positioning herself as a figure of solid significance within her own circles of influence, she can also develop a capacitous role in the clinical consultation process. This positionality has philosophical importance inasmuch as the experiences unique to her may constitute conditionings that shape the course of different terms of enquiry, consonant and disconsonant. The theoretical patient therefore renders the terms of philosophical investigation as themselves contingent upon the rawness of tone particular to acute suffering.

For Kidd and Havi Carel (2019), it is within long-term illness that knowing oneself and another presents a drama of critique whereby framing experiences and conducting oneself within them intersect. Kidd and Carel cite the “special complexity in cases of chronic illness” (“Practice,” 214), in which: “Amid turmoil of diagnosis, concerns about treatment choices, anxiety about prognosis, and the often-profound changes to previous life, a new urgency inflects our epistemic needs – to speak, be listened to, understood, and to attain a degree of cognitive command over our practical and existential situation” (214). In embracing elements of her pathography, the features of her condition that are communally and collectively resonant, the theoretical patient can institute her own kinds of change: forms of affect special to her sensibility as a person whose powers of insight are sharpened by threshold experiences.

The will to convey her affectivity by way of meaning created in and through its shaping within different kinds of interdependence and *intra*-dependence serves to reinforce her defensive capacities. They can be mediated philosophically by way of an awareness of the construction of intent in conversations inside and outside medicalised contexts. In availing herself of which of her behaviours are noticeable in clinical settings, the theoretical patient might address them specifically. Through strategic sharing of information, she can prevent *or mitigate* intrusions of unhelpful bias and prejudice. Kidd and Carel observe that: "[a]s formerly stable structures of meaning destabilise, the world ceases to be 'a space of salient possibilities', reliably reflective of one's goals and purposes. It is [']no longer ["]a safe context [. . .] that offers opportunities for activity but [becomes] something one is at the mercy of"[']" (221; Ratcliffe, 2008, *Feelings* 113, 121, 115). In attempting to reposition what her goal and purpose is, in view of what counts as knowledge, the theoretical patient might exert herself sensitively on specific circles of influence.

They include those that could determine her future, for example, through diagnoses that have positive or negative *gravitas*. Through such attempts to impose meaning where the imposition would seem impossible, she might overcome the effects of the worse forms of patient-treatment, the undermining of self. This is inclusive of that effected by reductive notions of what ill-health is, whereby: "[u]nderstood outside the strictures of clinical medicine, illness is experienced as [']a ["]breakdown of meaning", a harsh disclosure of the truth that "meaning and intelligibility depend on consistent patterns of embodiment" that no longer – and, poignantly and painfully, may never again – obtain[']" (Kidd and Carel, "Practice," 221; Carel, 2016, *Phenomenology* 14, 15). Against the possibility of existential despair, elicited by a pervasive lack of critical awareness, is placed the hope of internal comprehension, the growth of self within other *selves*.

The development of oneself in a global sense is that of learning to appreciate and handle personal histories, especially one's own, within their individual historiographies. Perceiving where, when and why a sequence of events is meaningful, and who and what is important within its happenings is instrumental on several counts. Factoring into phenomenal occurrences the quality of how a person is led to realise her psychological and physiological limitations engenders an awareness of what consciousness is at critical moments. Appreciating injustice personally, in one-to-one relations, can facilitate a wider appreciation of its global importance, those qualities which make its imaginative reach hermeneutically epistemic.

As a person is led away from and back towards herself in times of trauma, she comes to confront: "the ways of conceptualising disease that we have contingently inherited – ones that come to inscribe a set of pathophobic prejudices, stereotypes, and preconceptions" (Kidd and Carel, "Practice," 233). For Carel, the "*pathophobic* . . . attitudes towards illness . . . characterized by fearing illness and wishing to avoid it at all costs . . . often turn to denial of illness, and to rejection of the illness experience as potentially valuable and worthy of study" (*Phenomenology* 12). A more constructive approach to ill-health, especially mental illness, where experiences of suffering could be chronic, is to explore and expose its pathophobic manifestations in all their guises: "Identifying these requires us to go 'all the way down', into the deep socio-epistemic structures of our biomedical and healthcare systems, and 'all the way back' through the contingent histories that shaped them" (Kidd and Carel, "Practice," 233). Subjecting illness to an examination of its diverse *strata*, abstract, applied and cross-sectional, facilitates equity whose healing effects are near-universal:

“Such genealogical projects, familiar from other critical discourses, are often directed toward the achievement of epistemic justice” (233). Addressing injustice epistemically is, in the very same moment of its definition, to *do* justice. The exposure of a wrong, in this context, is also the voicing of new meaning, that belonging to individuals whose presence was invisible, and now has agency and efficacy.

In her pursuit of forms of relations that are capacitous and, in clinical encounters, mutually capacitating, the theoretical patient needs to take into account a number of important factors. This is especially so in the case of nosology, the classification of diseases according to groupings of symptoms, as identified biomedically, and inter-relational characteristics, whose classification is in itself inter-relational. Paul Crichton, Carel and Kidd identify some of the key factors in their seminal article “Epistemic injustice in psychiatry” (2017). They focus on some of the prejudices experients encounter in medical encounters, in which, due to wide stigmas, there is in circulation a “common prejudicial stereotype of patient unreliability” (65). The authors concede that stereotypes are naturally important to grasp quickly the features of personal relationships: “We rely on stereotypes as heuristic aids in making credibility judgements because they are often empirically reliable generalisations” (65). Employing stereotypes is especially problematic when they are relied on unquestioningly.

When stereotypes “are resistant to counter evidence, owing to what philosopher Miranda Fricker calls an ‘ethically bad affective investment’” (65; Fricker, *Power* 35), they impose on vulnerable persons interpretative violence. This acts to dispel the potency of their voice and quells the quality of their presences. For Crichton *et al* the “kinds of stereotypes” that exert such effects are those “that may lead to epistemic injustice” (65). Its manifestation includes: “detrimental effects on individual psychiatric patients, but also on the funding of psychiatric services and the public perception of mental disorder” (65-66). An alternative means of apprehending moments critical to clinical outcomes is for healthcare professionals and experients to seek out moments in which patient-expertise is prioritised.

Crichton *et al* point to the solidity of patient accounts when mediated through a sufficiently mindful consideration of their insight into the terms of reference that structure their experiences: “We are sufficiently aware of the existence of people’s unconscious desires and beliefs to know that they can be mistaken about their own desires and beliefs, but it is also the case that they have exclusive access to many of their desires and beliefs” (66). In appropriating interactions that would ordinarily be met with measures of scepticism, degrees of uncertainty that could sometimes render an experient’s narrative less valid, alternative beliefs are created. Crichton *et al* write: “In the interests of epistemic justice, physicians should accept what people with mental disorders say about these matters as true unless there is good reason not to” (66). Through communities of confidence and competence, in which mutual sharing of key information takes place, there can occur effective and efficient meeting of the complex needs of patients.

Such an address of needs naturally needs to be balanced against practical considerations about what to accept or reject in a testimony. A delusion whose presentation is in acute or chronic terms harmful to well-being, such as some manifestations of the Capgras delusion, naturally needs to handled sensitively. Sufferers of the Capgras delusion experience “[t]he belief that one or more familiars have been replaced by imposters" (Ratcliffe, *Feelings* 139), and this belief can be "resistant to change" (143). Other features of a delusional condition might raise flags about a patient's existential living circumstances, highlighting possible safeguarding concerns, amongst other issues. Or a patient may give voice to aspects of their feeling-states that could demand empathy, not critical judgement. Such expressions of feeling may fall within a conversational flow without challenge if this enables an efficient, respectful, validating form of patient-care.

One tool for enabling this means of address is the use of: "'Schwartz rounds', which allow health professionals to focus on the existential, ethical and personal aspects of a medical case, [and which] are growing in popularity in the UK" (69). The Point of Care Foundation state that they "provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare." Focusing, as they do, on general aspects of patient health treatment and the relationships between staff, "[t]he purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care." The concerns of Schwartz rounds intersect with Matthew Ratcliffe's enquiries into the phenomenological status of patients, that is, their lived experiences as suffering persons.

In *Feelings of Being: Phenomenology, Psychiatry and the Sense of Reality* (2008), Ratcliffe offers "a phenomenological account of bodily feelings, which shows how they can be both *feelings of bodily states* and at the same time *ways of experiencing things outside of the body*" (1). Experients of mental ill-health, in the context of general approaches to her care, such as Schwartz rounds, is to be treated as individuals with insightful knowledge, however specifically non-clinical. Since “[e]xistential feelings are central to the structure of all human experience” (2), they potentially speak into crucial aspects of extreme experience, such as some forms of illness. Such a consideration is a way of extending empathy which, for Ratcliffe (2015), “involves being open to varying degrees and kinds of interpersonal difference, rather than attempting to eliminate those differences by experiencing what the other person experience in the same way that she does” (*Experiences* 230). In structuring the experience of caring for patients in such a way as to elicit interest from diverse persons, there is posited a way of challenging third-order exclusions. They appear in the structurations-of-meaning that can evacuate the voice of the patient, in terms of her lived experience, if first- and second-order exclusions are not already at work: exclusions which trouble or diminish her presentational state.

Conceiving the patient as an integrative unit whose functioning is of unending complexity is one means of facilitating a powerfully imaginative approach that combines effective insight and affective generosity. It is “[b]y listening carefully to what patients tell them, [that] doctors can make a conscious effort to imagine how things seem from the patient’s perspective” (69). Apprehension of symptoms can meet with comprehension of targeted medical expertise, applied know-how, when imaginations are engaged across, between and throughout interminably painful journeyings. Crichton *et al* conclude: “Prejudices against people with mental disorders . . . go unchecked because they operate below the radar of the conscious scrutiny of our own beliefs” (70). By reshaping the contents of “[‘]the [“]collective social imagination”[’]” conversation-by-conversation (70; Fricker, *Power* 15), step-by-step, and phase-by-phase, it is possible to re-frame dialogical exchanges in dialectical terms that may evolve incrementally and exponentially.

Re-imagining the terrain of mental health diagnosis and treatment means conceiving mental disorder through appropriate investigative lenses. Perceptions of what mental disorder is are inherently subjective, resting as much on the vicissitudes of deviance as biopsychosocial diagnostics. In her investigation of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (American Psychiatric Association [APA], 1980, 1987, 1994, 2000), Rachel Cooper (2005) observes the degree to which mental ill-health is relative: “The best thing to say about cases where it seems that a condition is good for some people but not for others is that one and the same condition can be pathological for one person but not for another” (*Classifying* 26). One person’s agonising malady is for another a gift that benefits his or her life circumstances.

Cooper suggests “that we should think about diseases in a way analogous to the way in which we think about weeds. A plant is only a weed if it is not wanted. Thus a daisy can be a weed in one garden but a flower in another, depending on whether or not it is a good thing in a particular garden” (26). While Cooper also observes that “the distinctions between kinds of plants generally considered weeds are fixed by the nature of the world” (45), her central points are valuable. Whether or not a person is deemed unwell, and how her health is categorised, appropriated and improved, will rest in large part upon collections of perceptions in the consultation room. An autistic savant’s profound gifting with numbers and detailed information is, in the perceptions of her carer or guardian, inflected by a mix of awe, pride and burdensome perplexity. A schizophrenic’s *voices* could be creative resources that fuel a personal project, or debilitatingly injurious. The mania of someone with bipolar disorder could be by turns a well of creativity or unsufferably exhausting.

In its attempt to summarise what psychological complaints are mental disorder specifically, the *DSM* invokes strong contentions about what “mental” and “dis-order” can be. Either is ordered and dis-ordered within the order, and occasionally chaotic formulations and reformulations, of human constructedness. Devin Singh and Walter Sinnott-Armstrong explore the present *DSM* in use, the fifth edition (2013) (*DSM-5*), by remarking that: “It will be easy to criticize any definition by showing that it fails to satisfy some interest of someone. The real question, however, is whether some alternative definition could do a better job of satisfying all of the relevant interests and groups” (8). *DSM-5* aspires to attain levels of scientific validity and social malleability “by combining specificity with flexibility” (10). However useful those terms can be, inflected, as they are by an attempt to instil confidence, their counter-positions mean that rendering them exact is vexatious.

The definition of mental disorder begins: “‘A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning’” (APA, *DSM-5* 20; qtd. in Singh and Sinnot-Armstrong, 2015, 10). It is assumed that reasonable kinds of behaviour are observable in most persons, such that variances of sufficiently visible manifestation can be classed as abnormal on regular systematic scales of classification. In having scientific corroboration across diverse fields of medical specialities, the opening to the definition seems reasonable in tone and content.

The definition continues: "'Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder'" (APA, *DSM-5* 20; qtd. in Singh and Sinnot-Armstrong, 2015, 10). Most events of a key nature in the course of a person's life should not have the effect of causing her disposition to morbidly change. That some happenings can have devastating effects seems not unreasonable and, to a degree, to be expected.

It is the final point of the definition that is key to my argument. The manual observes, within happenings that might be expected to cause individuals to become uneasy in their behaviour, commonplace phenomena that take place on a daily, if not hourly basis: "'Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described'" (APA, *DSM-5* 20; qtd. in Singh and Sinnot-Armstrong, 2015, 10). While deviance, however constructed, is naturally sometimes conceived within the terms of distinctively physical pathology, it need not, if ever, necessarily become a disturbance of psychopathology. If the former is an aspect of limit experiences, key moments that exert smaller or lesser degrees of personal change,[3] the latter constitutes biologically-inflected morbidities. They

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[3]. The limit experience, as I am invoking the term, derives from the difference identified by Foucault (1991) between "'[t]he phenomenologist's experience'" and that of post-structuralists ("Born," 31; qtd. in Jay, 1995, 158). Their approaches to *experiencing* phenomena sometimes run counter to those described in phenomenological theory. If the latter "is basically a way of organizing perception (*regard réflexif*) of any aspect of daily, lived

need not converge with regular patterns of behaviour where their playing-out can be handled in conventional means, as they can on occasions like births, deaths and relationship break-down.

Singh and Sinnott-Armstrong would seem to agree with my scepticism that a mental disorder has a co-efficient relationship with normative conceptions of order. Remarking that “some deviations may be abnormal, but relatively neutral in their impact such as a person with eccentricities” (11), they conclude upon the behavioural relativism implicit in *DSM-5* “[o]n this interpretation, the term ‘disturbance’ explains why certain conditions are called ‘dis-orders.’ They disturb the normal or expected order, and they do so in a way that is bad, so they are not just alternative orders or eccentricities” (11). It is the case what is *good* or *bad* is subject to as many norms as the norms that define normativity itself. One person’s disorder in an environment of order is for another an important and necessary dis-ordering of order. The terms at stake are so ubiquitous as to themselves be *dis*ordered.

A way of addressing the perturbations within the terminology is to consider how the rigours of order occupy the chaos of lives seriously devastated, even dismantled by mental illness. This means placing attention on the communities

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experience in its transitory form” (Foucault, “Born,” 31), the former presents some of the limitations and acuities of human physicality: “[Friedrich] Nietzsche, [George] Bataille, and [Maurice] Blanchot, on the contrary, try through experience to reach that point of life which lies as close as possible to the impossibility of living, which lies at the limit or extreme” (31). While limit experience, as described here, refers to the gathering of “the maximum amount of intensity and impossibility at the same time” (31), my use of the term is placed more soberly. To account for changes in oneself that are unpredictable, yet no less significant in their impact, I am referring to any moment that is more or less self-defining.

that cope with varying prevalences of imbalanced behaviours that would require heavy investment should mental and physical health share equal status. Rena Kurs and Alexander Grinspoon (2018) point to the vital role played by experients and carers coping with the effects of different mental health conditions: “Citizenship is important for people with mental disorders, yet it remains a largely overlooked concept within psychiatric and mental health practice” (343). Individuals affected by mental illness are also affected by imbalances in public perceptions that resemble elements of mental disorder, the perceptions stemming from illusions that all is well.

Those illusions raise concerning questions about who is a societal actor and who is deemed superfluous to the running of *society*: “Even though mental health service users have legal status as citizens, owed to the aforementioned stereotypes there are often concerns about service users’ trustworthiness and doubts about their levels of insight that impact on their status as full citizens” (Kurs and Grinspoon, 2018, 343). Since persons with diagnoses are in some ways ostracised, important insights, necessary to the running of an integrated economy of medical treatment, are lost: “Having been hermeneutically marginalized . . . mental health service users are often not regarded as having anything substantive to say, and therefore the standpoints of stigmatized groups are not taken seriously” (343). Knowledge that would have been valuable clinically, in its being other to accepted forms of comprehension, is displaced. This displacement demands acknowledgment because its occurrence also constitutes a tragic loss to the stock of knowledge particular to the common good.

The theoretical patient has a vital role to play, converting credibility deficits into epistemological currencies that rebalance knowledge deficits. In grasping firmly those parts of the therapeutic processes that are available to her, however near or remote from her immediate reach, she can begin to regain crucial agency. She might thereby overcome some of the prejudices attached to her innate characteristics, specific to her appearance and identity, and become a central agent in the delivery of care.

This embrace of subjecthood, an acting-out from within contexts of limiting ideological content so as to *act* confidently in times of crucial importance bears marks of irrevocably constructive intent. Within and without the consultation room, the theoretical patient can exorcise the derogatory effects of reductive interpolations, and from within her excisions of burdensome freight, interpolate discursive exchanges herself. Crichton *et al* observe that: "[s]ince being able to give information to others is essential to social life and agential action, testimonial injustice harms those who experience it" (66). To play on the title of a recent volume by Barker *et al*, *Harms and Wrongs in Epistemic Practice* (2018), experients can, through their relational innovations, re-vise theoretical valuations. They might exert independence of thought that could seem to pose a distinct epistemological threat: in this case, transmuting the critical work of one subject-of-study, into another, a project of their own devising, that being *Virtues and Goods in Epistemic Being and Becoming*.

The conceptual framework that needs to be set in place to give the theoretical patient a defined and empowered voice in a clinical setting consists of the following points. Firstly, it is necessary to acknowledge the extent to which diagnosis of mental disorder could affect small and large-scale applications of resources that society can offer. In serving as both a clinical marker through which they could be distributed, and as a criteria for notions of regular and deviant behaviour, the definition can embody: “two important realities that have largely been ignored in the DSM-5 debates. First, many (most?) people relate to psychiatric diagnosis—perhaps particularly so when they have a diagnosis themselves—in ways that are contextually variable, ambivalent and labile” (Callard, 2014, 527-28). Subjects of psychiatric intervention can be willing or unwilling participants in the care process because of how they are treated in everyday-general and medical-specialist senses. It is the case that: “[s]econd, the effects of and responses to psychiatric diagnosis are profoundly *uneven*: they depend on what the actual diagnosis is; who receives it; at what point in her life; whether it is her first or her sixth psychiatric diagnosis; what the particularities of the healthcare systems of the region/country in which she lives are” (528). A patient, as she stands presently, and as theorised herein, has circumstances that require judicious handling, internal, in terms of her subjectivity, and external, in regards to her subjecthood. Since there are “*other* axes of identification or ascription . . . that influence how she is seen by others and/or sees herself” (528; emphasis added), her sights and *sightings* need to be precise.

One key mental health condition that exemplified principles of mutual openness, accountability and acceptability in biopsychosocial senses is presented by schizophrenia, “the most devastating disorder seen by psychiatrists” (Chung *et al*, 2007, 1): and one that “[w]e do not *really* understand” (1). In her extended exploration of its importance as a combined medical and cultural benchmark of unsound psychopathology, Angela Woods (2011) observes that: “schizophrenia has, since its identification, been consistently viewed as the proper object of a scientific psychiatry anxious to alleviate one of the most severe forms of human suffering, as well as secure and maintain its position as preeminent authority on mental health" (57). The condition, laden with a long history of diagnostic variations, acquired through a spectrum of applied and theoretical psychiatric diagnostics and diversities, is, in many ways, loaded with mystery. Perhaps, as a result, its treatment has varying success rates: "comprising a significant percentage, if not the majority, of long-term psychiatric cases, people diagnosed as suffering from schizophrenia are also at the 'core of psychiatric business'" (57; Healy, 2002, 329). Conceived, as they were, as persons of behaviours in need of restraint, rather than individuals responding to their living conditions as best they could, experients have been actively marginalised.

This was until when "[t]he antipsychiatry movements of the 1960s and 1970s marked a decisive turning point in the history of representing schizophrenia: it reconceptualized in subject terms psychiatry's sublime object" (Woods 124). Patient-subjects were re-conceived as their conditions were reimagined, meaning "schizophrenic symptomatology is not baffling, bizarre, or otherwise unfathomable, but on the contrary rich in meaning" (124). In having stories to tell that were (and *are*) widely instructive, experients of the condition met degrees of acceptance and rationalisation, as distinct from abjectly objectifying restraining measures, conceptualising: "the person as an embodied subject bound by history, geography, and social class; a person whose 'madness' was fundamentally social in character, and therefore had to be understood in the context of the family, the welfare state, the total institution or patriarchal Western culture at large" (124).[4] Individuals found themselves in the

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[4]. How schizophrenia is portrayed in the media plays an important role in its placement in the public imagination. Observing how in media-representations, "people with schizophrenia

are unpredictable and violent" because of media reporting (69), Crichton *et al* point out that: "Changes are . . . required in the social and political arena" (70), especially where this concerns news reporting. Media reports that tie mental illness to crime, particularly violent crime, can severely impact public perceptions of experients. A careful, if not systematic appraisal of media representations is required to prevent the skewing of the public imagination: "Media editors should reduce the stigmatisation of psychiatric patients in media reports, especially if epistemic failure (such as reliance on negative stereotypes) can be a cause of moral failure (such as treating persons with mental disorders in an unfairly hostile or suspicious manner)" (70). If conceptions of mental illness are variable and, to an extent, relative, it is perhaps the case that deviance and crime are even more subject to mis-representation. Attending to a balancing of their portrayals, where possible, could exact helpful changes in public treatment of experients, in general.

Miloš Forman's film adaptation (1975) of Ken Kesey's novel about a psychiatric institution, *One Flew Over the Cuckoo's Nest* (1962), epitomises with bluntness different media portrayals of mental illness. R. P. McMurphy, played by Jack Nicholson: "seems to have found in a manufactured psychiatric diagnosis a pretext to flee his confinement on a work farm" (Lambe, 2019, 303). He continually challenges the authority of Nurse Ratched, played by Louise Fletcher, who responds with her own measures of defiance. McMurphy, in part because of "[t]he very ambiguity of his mental state" (303), ultimately fails in his attempts to provoke the other patients. In losing his life to one of them, not before he has lost his soul to electroconvulsive therapy (ECT), the film's success is conflicted by an ethics of representation.

On the one hand, the film presents: "psychiatry's seemingly proximate past—as represented by our very parents and grandparents" (318). One worrying concern of this is the indeterminacy about: "just how prevalent electroshock was in 1975, how tortuous asylum conditions were, or how abusive psychiatrists may have been" (318). Amidst the intrigue presented by the film's drama is its raising of the possibility of widespread abuses of authority. The need to give proper attention to what is conveyed about the value of different treatments of mental disorder includes the contention that it is necessary to confront: "not new position of issuers, rather than subjects of, directions for *treatment*, in the loosest of senses: "'Rescuing', as it were, the schizophrenic patient from the relatively closed world of the clinic or the asylum, antipsychiatric discourse re-framed 'the schizophrenic' as a figure now capable of sustaining multiple and sometimes contradictory *symbolic* roles" (124). Experients, in exhibiting ways of thinking that were multifactorial in an illuminary way, begot a new kind of political-cultural insight: "[C]ultural theorists have been compelled, whether directly or indirectly, to negotiate schizophrenia's status as sublime within psychiatric and psychoanalytic discourse, to stake a claim if not at the level of clinical theory then certainly at the level of psychological metatheory" (224). No longer subjects of alienating, sometimes cruel psychiatric interventions, schizophrenics occupied a special status, *giving*, as embodiments of imaginative perception, as much as they *received* from institutionally-backed medical procedures.

Using the exemplar presented by the recent history of schizophrenia, experients can resist developing unhelpful relationships, regular and clinical, by assuming roles of imaginative potential, wherever their importances. For example, an experient might develop aspects of her domestic conditions in creative ways that aid her psychiatric vulnerabilities. In doing so, she might learn lessons, however small in seeming, that she can bring to a therapist to instigate useful instruction for going forwards. She may thereby form her own pedagogies or andragogical apparatus that can reframe different clinical interactions towards her favour, and away from the threats of compartmentalisation, as sometimes

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only for our understanding of psychiatry's past, but, perhaps more consequentially . . . its present and future" (318). McMurphy's story is in one way or another a modern-day narrative, presenting, as it does, lessons that must continue to be learned.

invoked. In refusing to be institutionalised, she can acquire vital validation that is enabling of her individual flourishing as a person desiring of growth and autonomy. The forms of relation and capacitation that are most effective are, arguably, those that arise from within an experient's own self-concept. Epistemic injustice becomes so out of the violence exerted by the suppression and objectification of the suffering-subject, in that she is robbed of necessary agential control. This is manifested in each order of exclusion, presenting in individual, interpersonal and structural forms. The theoretical subject can become unified within and without as an organic whole by preventing wrongful behaviours and activities, individual, social, or organisational, that disturb and granulate her integrity. She may in turn secure a status as a solid unit of *infinite* potentiality.

Chapter Two

Telling truth and telling detail: The role of narrative in framing mental health and epistemic injustice

Central to the dynamic between a therapist and his patient, whom I conceive as *theoretical*, are the skills of speaking and listening in context-informed, structured ways. The structurations that determine the shape and nature of the exchanges are composed of qualities that are unique to the professional and the *experient*. They might, at a given point in time, include factors specific to social circles, familial interactions, issues particular to employment, and small or large-scale senses of group belonging. These might, in turn, take their essences from issues of race, gender, sexuality and social class, amongst other concerns.

It is my contention that by attending to the complexities of structure in clinical *environs*, general or particular, it is possible to elicit interactional *minutiae* that are broadly instructive. Epistemic injustices as phenomena that manifest themselves in the spoken word may, within and between its domains, reveal hermeneutical qualities whose detail is organisationally or institutionally telling. My aim in this chapter is to examine elements of the story an experient might tell if she finds herself in the consultation room. My objective is to critique the role played by narrative, as drawn from a diverse range of sources, in aiding her development, recovery and healing. One of my main questions is: What forms of relation are centrally and, at the end of a medical interaction, finally, important to "becoming well" and "getting better", within the criteria of a diagnosis? Since health and well-being are relative concepts, sometimes achieved in the face of ideologically-loaded approaches to medicine, inclusive of epistemically unjust forms of clinical treatment, I shall also ask: To what extent are notions of healing themselves interpolations?

Concepts of mental health and epistemic injustice intersect at the level of narrative in ways that are both self-evident and nuanced. Jennifer Radden, in *The Philosophy of Psychiatry: A Companion* (2004), observes the axiomatic relationship between radically exploratory philosophical narratives and the tumultuous trauma caused by mental ill-health: “It has become something of a truism to point out that philosophy can learn as much or more from states of mental disorder as it contributes to our understanding of those states” (7). Philosophy, in posing enquiries that seek to clarify investigative terms and unearth findings normally resistant to the elicitations of everyday conversation, plays a disassembling role like that of illness. Radden continues:

> Nowhere is this more apparent than in the symptom descriptions that constitute psychopathology – the vivid, strange, and puzzling phenomenology of delusion, dissociation, and compulsion and the ruptures between thought and desire, willing and doing, mood and belief that are revealed through fine-grained clinical description. (7-8)

Through its incisions into the core tenets and principles that organise value-systems, especially “traditional Western values” (10), mental disorder destabilises fundamental controls against which individuals measure their subjecthood.

Radden points towards some of the features of common interaction that identify aspects of the self as significant in times of emotional or psychological fragility: “Rational autonomy and competence, responsibility and unified personhood are some of the qualities that make us human. . . . By eroding those attributes that are most importantly definitive of personhood itself, mental disorder places its sufferers at risk of stigma, discrimination, ill treatment, and neglect” (10). Since a core feature of mutual communication, regular or conceptual, is that one’s intents and purposes are rendered intelligible, rationality is foundational to sociality. Definitive, as it is, of how and why a circumstance or occasion is important, conventionally or philosophically, regularity in communication is a pervasive feature of discursive dialogue. This is so whether a crucial situation is of common occurrence and epistemically just, or of an opposing, critically flawed disposition, in deriving from interpersonal dis-ease and constitutional distemper.

As a phenomenon of wide-ranging complexity, inflecting, as it does, most aspects of daily life, including legal impositions, culture serves as a means through which to mitigate epistemic injustices. On the one hand, cultural expressions are a force for good, challenging social unfairnesses whenever they appear, by way of the sharing of an established repertoire of gestures and kindnesses. For Rebecca J. Hester (2016): “cultural competence has been celebrated as the curricular response to a variety of political and social challenges in healthcare” (541). Such challenges touch on the pressure points of my enquiry, as focused on some of the protected characteristics that would normally warrant even-handedness in times of contestation and dispute.

Hester elaborates upon what such moments of contention could consist of: “These challenges include the persistence of race- and ethnicity-based health disparities, breakdowns in communication between the patient and provider, and issues of cultural difference around delivery and acceptance of healthcare" (541). Stories of the fragmentation, even demolition of self-identity are all too common in accounts of psychological distress. Laypersons and medical professionals can issue potent challenges to this effect, levelling ideals in their mutual roles and occupations by attaining competency, even mastery of: "'a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations'" (541; Cross *et al*, 1989). Practising the judicious handling of cultural currencies, as found in the patterns of uptake engendered in and through lived moments of physical and psychical social exchange, facilitates communicational ease: "cultural competence is meant to engender increased sensitivity, humility and awareness with regard to cultural diversity in the clinical context" (Hester 541). Issues that could otherwise present as troublesome are displaced by an embracing of diversity in its full spectrum of difference: "Such diversity encompasses a broad spectrum of issues including health beliefs, the racial make-up of both patient and provider, linguistic access, gender and class disparities, as well as patient compliance and treatment" (541). Composed, as a patient community is, by a collection of epistemes, units of knowledge, that enable harmonies of needs and interests, professional competence is a vital aspiration in healthcare.

The episteme, as I am invoking the term, originates with Michel Foucault (1966), for whom "[i]n any given culture and at any given moment, there is always only one *episteme* that defines the conditions of possibility of all knowledge, whether expressed in a theory or silently invested in a practice" (*Order* 183). The episteme that defines *this* moment is an opportunity in which to interrogate, granulate and render accessible to marginalised subjects elements of the discomfiting features of clinical psychiatric practice. This is even as elements of such a practice may be resistant to categorisation because its core features are foundationally situated in biomedical norms. For Caroline A. Jones (2000), Foucault’s concept of the episteme could seem situated in such norms to such an extent that its operative use is limited. Jones writes that “[t]he Foucauldian episteme may seem to have aspects of frame or worldview about it” (499) that would seem to fixate an episteme to a given context. “[B]ut”, she also writes, “Foucault would have it used to characterize a thoroughly historical situation (closer to the way modernism and postmodernism are conceived) that is nonetheless in constant flux” (499). Insofar as the inverse of the fixation of a discursive marker is also the embodiment of ripe possibilities for change, the Foucauldian episteme is, for me, an incisive concept.

For Hester, the epistemes created by professional medical training and induction affect much of the course of a patient’s healthcare journey: “As an episteme, competence in medicine brings together anxieties about scientific and professional expertise, prestige and authority” (545). Competency affects not only one-to-one interactions between a doctor and an experient, but also the cultural capital through which she approaches the medical establishment: “It is shaped both by clinical priorities based on biomedical knowledge and by the neoliberal imperatives of standardisation, metrics, measurements, accountability, efficiency and expertise, standards which themselves have taken on a kind of scientific authority in a market-based healthcare economy” (545). In proceeding from a nationally- and internationally-determined economic environment, itself a live entity that is culturing and enculturated, healthcare services present their own unique challenges to the theoretical patient. The extent to which she can find synchrony in her experiential path rests on her capacity to identify and then organise particular aspects of its make-up to her advantage. She must develop her cultural-medical competency if she is to design a narrative that is uniquely self-serving, one based on an absorption and use of key linguistic markers.

Hester summarises the dynamic at work as follows: “In so far as it requires the translation of the other into the idioms and epistemes of medical professionals (such as is proposed by health literacy), the linguistic and cultural translation of the patient is, in fact, an appropriation of the other” (551). The theoretical patient can prevent ill treatment towards herself as a person already in a vulnerable position by appropriating the otherness of her predicament, however divisive and individuating. For example, a person who appears to present to friends and family faltering mental health that eventuates in hospitalisation could take ownership of her experience in key ways. She might reach out to patients and hospital staff by making gestures of connection, such as intimations of friendship, that serve to both transcend and salve her fractured mental-state. In *othering* those aspects of institutional care delivery that are themselves attempts to other, such as diagnoses that bear stigma or shame, she may invert key terms of reference. By turning that which would seem singularly despairing into a positive that in its othering is personally refreshing and organisationally rejuvenating, she can upend an incapacitating series of negatives. Her work, in some ways mirroring that of the professional clinician, can resist the features of institutionalism that could, in their unchecked continuation, universally fixate unhelpful prejudices and beliefs.

One way of developing an orientation of perception that can challenge persistent kinds of spoken and unspoken imbalances in healthcare is by creatively appropriating the significances of key interpersonal relationships. For Miranda Fricker (2010), actively cultivating the imagination is a means through which individuals can begin to take ownership of their individual circumstances. Responding to some of the philosophers critical of her conceptualisation of epistemic injustice, she points to the agency that its defining and addressing can invoke in subject-participants.

One criticism of testimonial and hermeneutical injustices is that their identification can occupy critical parameters that extend far beyond a person's intentional awareness. In residing within the respective workings of spoken and unspoken consciousnesses, it might seem that: "we need to ask how far identity prejudice tends to result from ignorance and deficient rationality, and how far from non-rational processes" ("Replies," 167). Fricker's response is consonant with my approach to epistemic injustice and mental health, in that the terms of her enquiry necessarily extend beyond themselves at any given point because: "[o]f course there's always room for further exploration of the various unconscious motives and impulses that can skew credibility judgement, producing a testimonial injustice in so far as they introduce prejudice" (167). To explore the unconscious in the context of unjust approaches towards, and appropriations of, psychological ill-health is to make explicit and systematise a foundational aspect of Fricker's work. In placing a narrative framework on an aspect of personhood that would seem to resist the act of narrating, the expression of a fractured self, restorative work can occur.

Firstly, versions of mental health are made apparent that were previously allusive insofar as victims and perpetuators of epistemic injustice can mutually support one another in righting fundamental wrongs. Not believing an experient's account of a situation of importance simply because she appears to fulfil the criteria of a racist, sexist or homophobic stereotype is heinously victimising. In turning this scenario into one that is epistemically just, the experient and her clinician can enhance therapeutic practices in that moment, for an individual good. Moreover, going forward, it is possible the lessons learned in practice can co-alesce, so setting continuously improving precedents. They include those that seem to sideline epistemic injustice itself in the belief that the concept lacks situational specificity. This is simply to compound and perpetuate another form of epistemic injustice, that being its denial based on the misplaced, naive hope that social improvement can occur through good-will.[1]

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[1]. The *good will* is a concept with which Immanuel Kant opens *Groundwork of the Metaphysics of Morals* (1786), whose First Section begins: "It is impossible to think of anything at all in the world, or indeed even beyond it, that could be taken to be good without limitation, except a GOOD WILL" (15). Allen Wood (2003), in his analysis of Kant's concept, suggests that its role in the moral development of a group or individual stems from a dialectically-informed morality standpoint, noting: "Readers of the *Groundwork* sometimes think it is crucial to deciding whether a person has a good will to know what the same person would have done under different circumstances or with a different structure of incentives" (481). A series of personal or collective actions takes its prime meaning from the significance of a moral conflict in the lives of persons to this extent: they must be able to agree on how and why a moment in time, conceived within and between important events, is necessary to personal or group development.

The *good will*, in its informing of individual and collective agency, is a character not dissimilar from Will Hunting in the film *Good Will Hunting* (1997), directed by Gus Van Sant.

The hope that *hope* itself will somehow function in a benign way, without the need for active intervention, points to another criticism of Fricker's work. Fricker observes Linda Martín Alcoff's (2010) observation about the extent to which her investigations into different forms of prejudice are unhelpful on account of their very identification of prejudice. This would seem to change, even skew the terms of prejudices themselves, so rendering imbalanced the specific identification of the subject of a wrong. For Alcoff, Fricker's conception of hermeneutical injustice, a concept premised on gradually identifying prejudices that escape the attentions of most people: "'changes in the terms by which we bring experiences under a description[, which] can affect the actual things themselves'" (Fricker, "Replies," 168; Alcoff 136). Fricker is quick to acknowledge

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Will, played by Matt Damon, struggles to gain traction as a young adult in an economically deprived neighbourhood in Boston, Massachusetts. He needs to repair a conflicted sense of attachment by way of therapeutic and vocational means in order to sustain meaningful relationships with friends and intimates. This moral drama, shaped by the contingencies of a difficult living-environment, as much as the ethical underpinnings that shape and determine a particular *morality*, is helpful to my enquiry.

Will's wanderings and ill-fated attempts to grasp hold of his *story* are, in their relative discomposure and discomfiture, similar to Kant's *embrace* of experience. Apprehended in its full range and diversity, according to a prism of generally and specifically significant values and meanings, this is incisive since, as Wood comments: "the 'good will' is not a *kind of person*, but rather a way of willing" (481). By enjoying interpersonal relationships on the premise that they can, at any time, develop from one-to-one to one-to-two or more, is also to be alert to possible socially-unjust vagaries. As one can feel discomforted or discombobulated by chance events that occur outside a firmly-conceived values-structure, so that structure is itself employed to identify inter-relational and structural communicational deficits.

that perceptions of experiences are changed by their very noticing, but this is not to dismiss the main factuality of an unpleasant series of events.

A “man” who is “‘bullied’ in the workplace by a female boss” experiences distress that is tangibly the case (Fricker, “Replies,” 168). This is even before workplace bullying, so conceived, found itself placed in the “collective hermeneutical resource” (168). Making such an act of workplace bullying subject to organised disciplinary action is not to amplify nor devalue the harm that takes place in a working environment. Nor is this to obviate the necessity of considering how structural injustice occurs in large collectives of individuals or groups. I concur with Fricker that: “[o]ur collective resources for social interpretation are not a fixed set of meanings, but rather a hive of hermeneutical potential, only some of which is communicatively realized at any given time” (168-69). In considering how the theoretical patient finds herself in a closed circuit of self-perpetuating negative energies, attention falls on the need to break the current: a flow of divisive energy whose circulation is powerful inasmuch as epistemic injustices, whether of *first-*, *second-* or *third-order exclusions* (Pohlhaus, Jr., 2017, “Varieties,” 19-21), can involve working hard to maintain a state-of-affairs. This is such as to ensure some potentials, whether general or specific, are never realised, so they cannot come to be. It is because, not in spite of the fact that “unequal relations of power cause some needs to stay unmet for longer than others” (169), that a humane touch is needed in some psychiatric interventions.

Shannon Sullivan (2017) supports my interpretation of Fricker in the sense that focusing on epistemic injustice as principally a transactional endeavour is helpful on several counts. Firstly, it is vital to focus medical attentions specifically so as to prioritise the need to conserve precious care resources. For Sullivan:

“Without naming it as such, Fricker operates with a banking model of knowledge that implicitly relies on a representational epistemology. As pieces of information, knowledge is an accurate representation of the world that can be deposited to and withdrawn from a common account” (207). By appraising the experiences of the theoretical patient primarily according to their prime actualities, not attributions of value imposed pre-judgmentally, she herself can articulate what is clinically important information.

Fricker (2007) describes the *toing-and-froing* specific to an exchange model of meaning by differentiating between testimonial and hermeneutical injustices. While the former is especially typical of individual and interpersonal encounters, the latter is particularly evident in structural credibility deficits: “We might say that testimonial injustice is caused by prejudice in the economy of credibility; and that hermeneutical injustice is caused by structural prejudice in the economy of collective hermeneutical resources” (*Power* 1). The experient must negotiate the different epistemic injustices skilfully, and one key to doing so is to relate well to her principal healthcare practitioners. In enabling her authentic voice to resonate in clinical terms, *clinicians* can target their attentions on appropriate diagnostic procedures and humane possible treatments.

The *bank of knowledge* becomes less an objective entity in which to make deposits and withdrawals, than a live metaphor of invigorating use-value. Knowledge itself, in its different critical interactions, can transition in its importance, becoming, according to necessity, forms of knowing that alter and shift, actualising or displacing value. *Knowing*, in this capacity, is to beget, sequester and reject the very idea of knowledge, as its significance declines or expands according to the terms of changeful, *changing* relationships: “Knowing . .

. is the activity either of developing accurate representations to deposit to the bank or of withdrawing knowledge from it that others have contributed" (207). Epistemology, in intersecting with phenomenology as a category of knowledge that questions the very essence of what knowledge can be, is radically capacious.

Foucault's work on the exercise of power and the construction of power-relations is especially germane to my explorations of the work and limitations of different epistemes. Their articulation by individuals at opportune times endangers bonds and ties that, insofar as they present in discernible ways, are telling of connections between forms of justice and injustice. This is especially so with regards to those *forms* that are specifically epistemic. Foucault (2000) comments on the role of reason in the construction of thought patterns by exploring the role and function of reason itself, stating that:

> the central issues of philosophy and critical thought since the eighteenth century has always been, still is, and will, I hope, remain the question: What is this Reason that we use? What are its historical effects? What are its limits, and what are its dangers? ("Space," 358; qtd. in Allen 187)

To practice philosophy is to engage in the risks particular to exploratory investigation that can sometimes serve to undo, even unhinge, parts of the self that are ordinarily cohesive. In this regard, Foucault asks: "How can we exist as rational beings, fortunately committed to practicing a rationality that is unfortunately crisscrossed by intrinsic dangers?" ("Space," 358). In the vein of Foucault's inquiry into the units that form bodies of knowledge, and the patterns of rationality that accompany them, Amy Allen (2017) comments on how relations of diverse kinds form.

If individuals pursue bonds that are specific to their conscious awareness, connections that have more or less capacitating interpersonal resonances, structural elements of self-presentation appear across personal- and collective-ties. Allen states that “[f]or Foucault, the dangers and historical effects of forms of rationality consist primarily in their entanglements with relations of social power, relations that subject individuals in both senses of the term: constitute them as subjects in and through their subjection to prevailing regimes of ‘power/knowledge’” (187). According to Allen, for Foucault, to be a subject to be active in the construction of power-relations, and to be subject to status-connecting forms of power: *forms* that in their very enactment come to facilitate individual and collective activity.

Power, as an actor in individual, interpersonal and structural formations-of-self, is therefore an enabling force, generating the chains-of-effect necessary for work, while being generative of *affective* work itself. Allen writes that Foucault “combines a constitutive conception of power – that is, a conception of how power works to constitute subjects and to them to their identities – with an agential conception – that is, a conception of how power is exercised by agents to constrain or act upon the actions of other agents” (188). Allen states that “[t]he classic statement of Foucault’s constitutive conception of power” appears in his *History of Sexuality* (1978): “[T]he multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them" (92). If "power, for Foucault, is neither an institution nor a structure nor an innate capacity of individuals" (Allen 188), its continual contestation in multiple epistemic injustices, testimonial and hermeneutical, is instructive. Subjects, who in their limited knowledge of a situational-dynamic, find themselves subjugated, can, in learning and even mastering communicational codes, come to apply their own vocabularies and grammars. Power then becomes "the name that one attributes to a complex strategical situation in a particular society" (Foucault, *History* 93); a situation that in its contingent formation, affords opportunities to continually become anew.

To find herself rightly, fittingly and judiciously accommodated in different kinds of experience, the theoretical patient needs to act appropriately amongst competing philosophical discourses. Key to her attaining functionality in her social and intellectual dispositions is the imperative to develop, and then actively employ, insight to apprehend how she could find herself victimised. In one sense, her reaction to an exchange that is demeaning, whether aggressively or passive-aggressively so, could be to act out feelings of hurt. To an expression of condescension that is motivated by prejudice, an experient may react in ways that seek to fill the credibility deficit, by asserting her status. Fricker terms the reactive characteristics particular to some presentation of individual behaviour "expressive styles" (*Power* 160), which can themselves fall subject to epistemic injustices.

Forms of "hermeneutical marginalisation" can engender "practices whereby certain expressive styles come to be recognised as rational and contextually appropriate" (160-61). Due to such marginalising practices, some "[i]ll persons . . . report that they are forced to adopt an epistemically marginal role in consultative exercises" (Carel and Kidd, "medicine," 342). Despite making efforts to voice their experience in ways they find sincerely fitting, they may find themselves labelled "'difficult'[,] . . . 'clingers', 'incommunicatives', or 'self-destructive'" (342). Rachel McKinnon (2017) writes that: "a normal response to this testimonial injustice is to become *more* emotional (e.g., angry, frustrated, etc.)" (169). But, reacting to an aggressor in a way that either vitiates or imposes dominance could simply serve to amplify the effects of the injustice, by compounding a negative impression. The experient's "subsequent emotionality is treated as a *further* reason to discount the speaker's testimony. And so on: it's a positive feedback loop. Testimonial injustice tends to cause victims to become emotional, which is often used as a reason to further victimize them" (169). To one form of negative affect is added another, creating a toxic situation in which the combined relationships between effect and affect spiral, to potentially devastating consequences.

An experient may withdraw into silence, which is poisonous in its own way, exerting pressure in her not to speak for fear her situation could become worse. By falling subject to "*testimonial quieting*: the speaker suffers such a severe credibility deficit that it's as if they never spoke at all" (169). In finding herself forced into silence, after and despite her protestations, she suffers one of the worst expressions of epistemic injustice, gaslighting, in which "a disadvantaged person . . . reports an injustice to . . . an 'ally'", who, in turn, "doesn't afford her testimony appropriate epistemic weight" and: "responds by raising doubts viz. the speaker's perceptual (and perhaps reasoning) abilities" (171). In the context of mental health diagnosis, treatment and prognosis, such a state of situational relations can be especially damaging. This is not least because in having their trust in their own experiences, rational abilities and sense of the world systematically eroded, they cease to function as an effective epistemic agent.

Paul Crichton, Havi Carel and Ian James Kidd (2017) make similar observations, describing how some psychiatric patients might never achieve a coherent categorisation nosologically. They comment: “psychiatric patients who have experience of psychiatric services become reluctant to disclose psychotic symptoms because they know it might make them more likely to be diagnosed with a psychotic illness, and in some cases detained in hospital and medicated against their will” (66). Patients might sometimes not visit a specialist for fear their state of health will be mishandled. One form of this mishandling could be that a false version of their symptomology is integrated in a diagnostic-model or care plan. Premised on their unusual feelings or behaviours that might or might not be part of their condition, the actual mental state of the patient could be misconceived or misappropriated: “If they nonetheless disclose such symptoms, then psychiatrists might conclude that the symptoms are more severe in the sense that the patients are unable to inhibit their expression and/or that their executive function is also impaired” (66). It would seem that when an experient is most in need of urgent help, she is most vulnerable to finding herself victimised by the very persons who should aid.

The sense of time that organises the experience of suffering of the theoretical patient is, on the basis of her vulnerability, of a different synchrony to that normally apprehended. In contrast to a way of being that is subject to a continuous series of moments, she is forced to constantly look back and ahead to orient herself. In her judging of how best to respond to benign influences and malign actors, her concept of the temporal is occasionally asynchronous, at other moments diachronic. This sense of shifting back-and-forth, internally and externally, is not dissimilar to Jean-Paul Sartre's (1943) problematising of the temporal: "Temporality is evidently an organized structure. The three so-called 'elements' of time, past, present, and future, should not be considered as a collection of 'givens' for us to sum up—for example, as an infinite series of 'nows' in which some are not yet and others are no longer" (130). Against the idea that a patient-narrative can be plotted as a sequence of steps whose following is ordered by causes, sub-causes and prime expressions-of-intent, appears an alternative theorisation: one centralised in the psychic dissipation invoked by exertions of destructiveness and incoherency, sometimes applied environmentally by outside forces, other times arising from within the experient's own mind.

In its subjection to chronic conditions that have evolved, as well as the effects of persons whose intent initially seemed benign, an experient's mental state could crumble. Then one *thing*, now another, her psychological well-being is both liable to fracture and continual re-making, such that senses of immanence are no longer relevant to her self-concept. Temporality, for her, does not appear in an expected form: "but rather as the structured moments of an original synthesis. Otherwise we will immediately meet with this paradox: the past is no longer; the future is not yet; as for the instantaneous present, everyone knows that this does not exist at all but is the limit of an infinite division, like a point without dimension" (130). A phenomenon that, in an ideal form, is regulated by calendar periods of more or less detail, time, in periods of illness, especially psychological irregularity, is itself a destabilising actor. He or she must be managed by the experient in ways that serve her, not a deviant or malfunctioning *other*.

For many individuals, the family unit, whatever its formation, is part of how they maintain their lifestyles, and its disruption can exert severe negative effects on their psychologies. Inasmuch as familial structures sometimes take the form of psychically fraught machinations that, through perplexing dialectical entanglements, disrupt well-being, they illustrate the workings of numerous kinds of epistemic injustice. Fricker (2017) comments on the differences between functional and dysfunctional families: “The real difference between a happy family and an unhappy one is that the happy family has found a way to cope with its tensions and difficulties, at least not letting them eclipse family life, whereas the unhappy one has not” (“Evolving,” 57). While one collective of “immediates” and intimates is unified by a combined purpose that is internally settling, another is marked by fragmentation that is telling of wider issues.[2]

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[2]. While it is the case that “immediate” is not a noun, the expression is helpful to the ideas I am wishing to convey. I am interested in how friends, family, and associates, like work-colleagues, can have an impact on the mental health of an individual, in more or less equal measure, context-depending. The historian Linda W. Ronsensweig (2005) notes that the 17th century Pilgrim pastor John Robinson observes: “‘Grandfathers are more affectionate towards their children’s children, than to their immediates’” (62). Using the term in the sense of psychical inter-relationships between persons who might not be family-related, the psychotherapeutic-practitioners Stanley W. Standal and Raymond J. Corsini (1959) state that: “[t]hese personalities extrapolate their difficulties, projecting them upon their immediates, both in personal life and in business” (*Search* 166; *Archive* 166). Consistent

Fricker suggests that it is from this difference that epistemic injustice can take its patterns of meaning: “[T]he difference between a functional epistemic practice and a dysfunctional one is that the functional practice contains certain counter-pressures or mechanisms by which to stave off anti-veridical forces of various kinds, such as prejudice, for example” (57). If happiness is a sign of order in *chaos* that neutralises the threatening effects of antagonising forms of conflict, its inverse is harmful in far-reaching ways. In diametrical opposition to the possibility of conditions that nurture flourishing kinds of growth are the sometimes chronic, other times acute effects of diverse *dis*-orders, presenting subtly or forcibly. Their continuance amplifies chaotic states to the point that an epistemically just version of events, one characterised by reasonable narrative coherence, is elusive, if not impossible.

Family units can damage an individual in many ways and I shall focus on two: firstly, the extent to which an emotionally fragile person could be disbelieved and invalidated in the face of evidence that she is desperately troubled or poorly. Secondly, I shall explore how family units themselves can create the conditions for mental illness. Following my commentary, I shall make summative comments that answer my leading questions.

A person presenting with psychological disturbance might, even amongst those perceived to be closest to her, find herself subject to globalising credibility deficits. Outside a given grouping, an experient could suffer “[o]ne widespread prejudice, which Fricker (2007) called *identity prejudice*, . . . the prejudice that attaches to a person because of his or her social identity” (Kurs and Grinshpoon,

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with these senses of *immediate*, my invocation of the term is predicated upon social and structural inter-relations, as much as ties of blood, bond, and kinship.

2018, 339). However, should there be a grouping within a *grouping*, which, in some cases, could take the form of *cliques* within families, an experient could find herself without adequate social support. Since “[s]ocial identity is an individual’s sense of who he or she is, based on group membership” (339), when an experient’s core belonging is dispelled, she can be isolated existentially. This makes her vulnerable to the threats of epistemic quieting and gaslighting even before they can arise as phenomena in her social world, compounding her isolation and anxiety. Where gaslighting is an exertion of epistemic harm premised on the manipulation of factuality, epistemic quieting is the active prevention of such manipulation subsequently coming to *light*.

Once the actuality of her illness presents, she “may suffer identity prejudice as a ‘mentally ill person’ whose credibility as a knower is thus subdued, because as a person with a mental disorder he or she is considered bizarre or unreliable or dangerous” (339). In having forms of distancing and disconnection projected onto her, she is face-to-face with the realisation that she is considered in terms normally reserved for members of an *outside*-group. She must, therefore, revise her standing amongst those who were once intimates, as she attempts to re-gain her footing in a new series of *environs*: potentially alien conditions that in their very *worldliness* could themselves be disorienting.

One consequence of no longer receiving validation within her family, is that she cannot make choices that have its support. In being outside an organically-organised *whole* that was once regulative and cohesive, experients, especially minors, are deprived of the ability to make efficacious choices: “The testimony of people who use mental health services is considered suspect because their capacities to make decisions are taken to be diminished. In this way, their choices and even their treatment preferences might be seen to be incoherent, illogical, or lacking credibility" (339). Once functioning inside a unit on which society, especially Western society, is founded, and now pushed outside its terms, the experient suffers emotional, practical and institutionally-supported losses.

To be specific in how such a dynamic could work in practice, an experient might, in a psychotic state, suffer from delusions whose potential to offer insight into her psychical world is overlooked. In prioritising the testimony of a family member over the experient, important features of her condition may go unobserved: "Dismissal of patients' beliefs as delusions might cover up the truth, such as the premature dismissal of claims of abuse, which might be mistakenly interpreted as persecutory delusions" (340). If a significant other might hope not to have the full meaning of a delusion observed, it is the case, too, that clinicians could wish to narrow an interpretation.

Even as "epistemically privileged caregivers tend to disregard the psychiatric patients' perspectives, which are subordinated to the authority of the professionals" (340), the experient's account needs to take centre-stage. Since medical opinions can sometimes displace those elicited in patient accounts, for example, because of racial, gender-specific, sexual or classist prejudices, the testimonies of experients could be unfairly dismissed: "despite the fact that the patients are those who have undergone the experience of the disorder" (340). In view of the risks of overlooking how an experient could be suffering in ways not confined solely to her internal state, Abdi Sanati and Michalis Kyratsous (2015) observe: "It is important for clinicians to be aware of the phenomenon of epistemic injustice in order to avoid [']negative outcomes[']" (Kurs and

Grinshpoon 340; Sanati and Kyratsous 484). One example thereof could be that of mistaking an experient's presentation of feelings of fear, paranoia and persecution as delusions, when, actually, an *immediate* might be psychologically abusing her. This could manifest itself in subtle ways that operate beneath the surface of a conversation in an institutionally significant context, such as the clinical consultation room.

José Medina (2017) cites some of the minute attacks on individuals that are not readily observed because their significance and impact develop over long periods of time. These acts are termed microaggressions because they are delicate in expression, yet highly specific in intent:

> skeptical stares; looking confused, puzzled, or unable to follow; constantly interrupting or questioning one's meaning, are some of the subtle (sometimes not so subtle) communicative intimidations and micro-aggressions that can silence people or implicitly encourage them to limit their speech or take a discursive detour. ("Varieties," 46; forthcoming, 14)

Some forms of maltreatment are diluted to the degree that they are more or less invisible to another, whatever her professional expertise. Lauren Freeman and Heath Stewart (2019) observe the presence of microaggressions "[i]n medical contexts . . . when physicians and other healthcare providers view themselves as experts over patients' bodies in problematic ways" ("Epistemic," 123). As physicians "prioritize their own technical expertise, professional habits, and the deeper epistemological structures of healthcare systems" (123), patients can be ignored or discredited as insightful participants in clinical processes. Being subject to "multiple epistemic microaggressions" is (127), potentially, highly damaging because of their systematic impact on the expression of self. Not addressing their existence and, indeed, even allowing them to play out, can leave the experient in unsufferable psychological pain that could manifest itself in severe mental disturbance.

By the same token, it is to be recognised that despite their subjection to numerous forms of injustice, determined socially, culturally or clinically, experients can have special insight. While clinicians might seem to “have the advantage of being able to evaluate patient testimonies and to decide which are important” (Kurs and Grinspoon 341), experients have their own *specialisms*, in that: “those who have certain experiences are the actual epistemically privileged, meaning that those who are marginalized are in a position in terms of understanding ‘how the world works’” (341). It is to the subject of the specialist knowledge of the theoretical patient, as conceived within the context of a family unit, that I shall now turn.

An experient of mental-disorder, sometimes crudely called insanity, has passed through a series of experiences that mean she has an unparalleled insight into some elements of the human condition. My claim is naturally complicated by the fact that mental disorders are complex and heterogenous experiences, meaning one person’s behavioural-norms are for another evidence of acute or chronic dysregulation. Foucault (1961) remarks on transitions in perceptions of what is considered rational and irrational behaviour, inclusive of different forms of cultural and organisational appropriation, stating that in “European culture at the end of the Middle Ages . . . [m]adness and the madman become major figures, in their ambiguity” (*Madness* 11). It is less to the characterisations of mental disorder that I am alluding, nor to the attribution of lessons learned from ill-health. They would be typical of cultural and even clinical "[e]hortations to think positively—to see the glass half fall, even when it lies shattered on the floor" (Ehrenreich, 2009, 45). I am wishing to refer to the insight suffering bestows as a prism through which to observe surrounding behaviour that may have become customarily familiar. What once appeared to constitute norms in terms of habituations or relations with another, individual, social, or organisational, comes to be seen afresh as odd, strange, uncanny, or wrong. While testimonial injustice might become readily apparent because of incongruous social interactions, registering the effects of a singularly hermeneutical injustice may take more time as it presents itself subtly.

In their work on some of the poisonous relations that might shape her journey into, and back out of, mental illness, Hannah R. Farber and Daniel J. Siegel (2011) allude to her perceptiveness: "It is said that if individuals do not acknowledge the madness of their own environment, then they may go mad themselves. Likewise, if people place in the front of their mind that their environment is crazy, then they can maintain their own sanity in the face of the madness" (59). Setting aside the generality of these remarks, there are, within, important insights.

Experients can, by working on their awareness of the strengths and weaknesses of their habitations, develop skills that equip them for smooth passage, in related contexts, going forwards. One such set of skills includes the problem-solving techniques required to neutralise the toxic aggressions of immediates, such as *poisonous* words and behaviours from parents, friends or associates. In choosing what she can say in a given situation, and what meaning is consequently imposed or removed within its parameters, experients may retain measure and hope, however partial.

She might, within her means, choose to recognise, comprehend and appropriate conventional developmental narratives, especially those that pertain to medicalising notions of wholeness, completeness and healing. Judith V. Jordan (2011) observes that: “The traditional developmental narrative that suggests we start out dependent and needy and move toward autonomy and independence does all of us a disservice” (149). While aspiring to feel autonomous is to be commended, this ambition lays undue emphasis on the principles embodied by the idea of upbringing.

Some individuals may, of course, have led happy childhoods and have come to develop, with relatively little incident, into rounded adults. Other children and adults encounter extreme difficulties, often not of their making, however much a set of parental values might suggest so. An unwillingness to question the veracity of value-sets constitutes an ill appraisal not only of development experiences. It also means scant attention is paid to how persons become who they are by pursuing *bona fide* or serendipitous opportunities, as well as the vagaries of happenchance.

Jordan comments helpfully on the viewpoint that human developmental narratives necessarily proceed within unproblematised conceptions of psychological well-being: “It exaggerates the attainment of certainty, control, autonomy, and invulnerability, and it downgrades the value of emotional response, creating unattainable standards for how an adult should function” (149). By removing agency from the child in times where it should be attributed, she is denied important recognition for the role she could have played in her *progression* and *development*. An artificially created set of attributes and a falsely-conceived series of standards are projected onto her, which could be reinforced by the diagnostic narrative of a clinician. Jordan continues: “[b]ecause these standards for human ‘maturity’ are impossible to attain, they make us enormously vulnerable to shame” (149). Jordan’s belief is that persons should not receive undue burdens from contrived forms of value, as imposed on them from outside the norms of their personal integrities.

This imposition of value, manifesting itself in feelings such as personal shame, is inclusive of a false critique of those very standards. Referring to the toxicities imbibed from parents and guardians, Jordan comments: “One must be careful in using the term *poisonous parenting* not to abdicate societal responsibility in setting up unrealistic expectations for parents and children or in turning a blind eye to oppressive values that unfairly target marginalized groups” (149). Since any individual can form attachments that, if unscrutinised, can cause unbearable torments, caution in word and action is key. Taking “a critical eye toward the culture that fosters destructive relationships” is a generic requirement for safe conduct amongst experients (149).

Critiquing oneself and another with due sensitivity, caution, and reflectiveness can mean upending criticism in its very idea, inclusive of that which makes the critical itself effective. For Jennifer I. Durham (2011), in her approaches towards unhelpful immediate-relatives, placing effective metaphorical structures on relations and inter-relations, is an uppermost priority: “Addressing poisonous parenting should not be done without considering the nature of poison. Plainly stated, poison is a substance that is harmful to an organism. It is important to note that what makes the substance harmful is variable” (163). A poison has a self-evident effect on an organism, diminishing its strength and potency. Its effects can also be gradual, appearing as the toxin is slowly ingested: “It can be something developed in nature that once exposed to an organism immediately and quickly begins impeding functions that support life. It can do this slowly and cause impairment over time” (163). One might also be poisoned by consuming excessive amounts of a substance that might, in more modest amounts, deliver benefits, such as alcohol (Rogers and Pilgrim, 2021, 138; Buettner and Skemp, 2016, 319). To the degree that a poison is recognised as such, there is always the potential to gain control over whether and how one is exposed:

> Like alcohol, a substance may be relatively harmless in low dosages but can evolve into poison when experienced in greater quantities or before an organism is mature enough to diffuse it properly. It can also be something that has been created for a benevolent purpose but when taken incorrectly becomes harmful or lethal. (163)

It is precisely because a substance can have a dual-value that individuals may struggle to limit their exposure to its harm.

A relationship that once had nurturing value can, through the same means by which its supportiveness took effect, create emotional disharmonies that manifest in physiological and psychological dysregulation. To the extent that she can acquire a sensitivity towards the operational viability of the relationship, the experient may exert measures of control: concomitantly, she is at risk of ongoing victimisation if the sense of control is in itself instilling of poisonous exchanges of thought and emotion.

For Donald J. Olund (2011), the complex vulnerability exercised by relationships on which a person has come to depend are evidenced in families where religion has a strong, potentially unhealthy presence. Olund notes the power of some Biblical verses, such as Proverbs 22:6: "'Train up a child in the way he should go, and when he gets old he will not depart from it'" (*Holy Bible*; qtd. in Olund 177). In their belief that a religious upbringing can safely direct a child, parents can omit to recognise how some religious *beliefs* are shaped ideologically. Since a belief might be interpolated and internalised gradually, both a child, her parents and even her religious ministers could be misguided, sharing dogmas that are actually dangerous.

This problem, within an organised belief-system, can also emerge with devastating impact in the family unit. Once the adult child has developed rigorous consciousness of the destructiveness of the belief, several fundamental questions arise: "Will the adult child continue to ingest what makes him sick? Or is his fate already sealed, as the proverb seems to indicate; 'when he gets old he will not depart from it'? Furthermore, what becomes of the parent–child relationship?" (178). In the worst case scenario, the child may come to totally devalue her own identity in place of a collective religiosity, perceiving herself to be valueless, without agential capability.

Equally, she can, within the very same terms by which she has lacked agential control, come to retain an efficacious autonomy. By seeking to reclaim aspects of her personhood, she may also exert positive effects on the very persons through whom her identity was suppressed. Terry Hargrave (2011) observes that: "Almost all poisonous parents are people just like the victims they exploited. They are not evil but are rather victims themselves. Victims did not deserve their abuse but are lovable and well deserving of safety" (206). Experients for whom a belittling, disempowering, or demeaning family environment is the norm, can, in applying themselves to specific manifestations of abuse, reverse its effects. They may develop an holistic, integrative-oriented self-understanding that facilitates enactments of targeted forms of altruism.

This approach, one marked by interventions that are individual and interpersonal in their focus on person-to-person encounters, and structural in addressing long-term issues, could even address intragenerational trauma. For Herrenkohl *et al* (2008), intervening in familial or other group-collective dynamics in ways that are planned and subject to focused, specific considerations of structure are especially helpful. Herrenkohl *et al* comment on the possibility of developing long-term progress among children who have been exposed to domestic violence and other abuse within and even across generations (93). In regards to the question of "[w]hether resilience in child victims of violence exposure can be promoted through planned interventions" they state that (94-95): "data do show that the prevention of adolescent problems is possible when programs attend systematically and comprehensively to risk and protective factors across domains of influence, including the family and surrounding community" (95). Persons with the capability to effect targeted change potentially have the capability to exact lasting benefits. They might serve as a way of accessing and addressing otherwise invisible social structurations, which could address epistemic injustice of both a testimonial and hermeneutical nature.

To the degree that their application of *this* new skill is cohesive, its impact is also universally healing: "When victims understand, they relate to their own humanity as well as the humanity of the victimizer. They acknowledge that if they grew up and were victims of the poisonous parent's past, development, and history, they might not have done any better than the poisonous parent" (206). By perceiving how their conflicting emotional states can, through self-application, be harnessed to repair areas of fracture, feelings of distaste or hatred projected onto them lose their painful impact: "When this type of understanding takes place, victims do not feel the bite of the painful emotions associated with this hate and lack of worth" (206). Hargrave characterises the activity involved as necessarily *restorative*, demanding, as it does, a choice to occupy an alternative space of psychical signification from that previously inhabited.

Individuals make a choice to forgive as they perceive tangible steps forward that they may conceivably take. These could take the form of commitments to actions and gestures that seek to salve that which causes pain: "When one crosses over into the category of *restoration*, the work of forgiveness usually goes in the direction of correction and transformation of the victimizer from destructive patterns toward loving and trustworthy action" (206). A place of both salvific healing and dramatic perturbation, the family is a site conflicting with, and conflicted in, the mentality of the theoretical patient. Its participants can make a case for rapture over rupture, despite the evidence that for many, its main sites of activity serve as a way into *Hell*, not *Heaven*. Familial structurations, physiological and psychosocial, can act to cure *psychological* sickness, even as they could create, incubate and perpetuate the conditions of its occurrence.

The forms of relation that are centrally important for the theoretical patient to "become well" during a period of mental ill-health are those that directly support her best interests. Stemming, as they might, from her home-life, it is vital that any part her immediate relations or intimates could take in aiding her development are professionally scrutinised. Such an examination of purpose and intention must extend, in a mutual fashion, to the clinical services themselves. This act of inter-examining must, of necessity, and to every extent that is achievable, also become *intra*-examining, by involving the patient in the following manner.

Firstly, the principles by way a person can address the toxic effects of poisonous familial relationships can be applied to encounters with clinicians in parallel ways. In recognising how a system of belief develops, assessing how this manifests itself emotionally, and then contemplating how to steer a way through mixed behavioural responses, experients develop self-agency. While an experient of poisonous parents might be unlucky to find herself treated by a toxic professional, it is important to recognise that toxins, like illnesses themselves, occupy gradients. Just as one person's mental illness might, for another, be a normal state-of-mind, so the relationship between doctor and patient can take forms that are surprising, sometimes shocking.

Hargrave observes that should the child of a victimising parent wish to pursue relational activity that is genuinely restorative, she must do more than "the work of salvage" because "this category of forgiveness demands interaction" (207). While some mentally ill persons display morbidities that mean almost any person-to-person interaction is limited, if not impossible, the principles at work in Hargrave's formulation still apply. As she gradually attains degrees of health and wellness, the patient can exercise measures of due caution and thoughtfulness, which are to be actively built into her care plan.

Part by part, she may seal, dress and heal wounded trust, important, as it is, that with a clinical professional or an immediate, she delivers: "the work of forgiveness . . . to ensure that there is reason to believe that the relationship actually can become loving and trustworthy" (207). Through the facilitation of accessible ways out, at each stage of a clinical or medical encounter, especially one in which an immediate is present, she can find safe space. This means if morally questionable staff or "the poisonous parents had not changed, the victims could reasonably extricate themselves with minimal trauma and with the knowledge that the victimizing parents [or staff] had not changed enough to trust" (207). As the key individuals come to prove to be reliable, maybe "loving and trustworthy, the victims would continue to relate in more and more complex ways to see if the relationship could recover a sense of love and trustworthiness to the point of losing dysfunction" (207). As slow, incremental and laborious as this work could prove, for all persons, it is perhaps the only way for lasting healing to take place.

It is in and through complex relations that the most effective results can occur, bonding that which had been loosed, to form a new, solid structure: one whose wholeness is durable for longer. In concluding each phase and part of a treatment process in a way that capitalises on that which went before, the theoretical patient can "get better" on her own terms. By taking hold of her diagnosis, as stultifying, dynamic or broad-ranging as it might seem, she can take ownership of her life course in ways that work for her.

In the face of the ideologically-pressurised work that inflects the medical and religious establishments, even staple Western institutions like the nuclear-family, normative notions of wellness are violently contested. As Barbara Ehrenreich concludes in her polemic *Smile or Die: How Positive Thinking Fooled America & The World* (2009), "[h]appiness is not, of course, guaranteed even to those who are affluent, successful, and well loved. But that happiness is not the inevitable outcome of happy circumstances does not mean we can find it by journeying inward to revise our thoughts and feelings" (206). It is precisely because of a too-ready acceptance of easy answers to complex problems that testimonial and hermeneutical injustices are able to be continually generated and *re*-generated. Ehrenreich states boldly, "[t]he threats we face are real and can be vanquished only by shaking off the self-absorption and taking action in the world" (206). Notions of healing, sometimes categorically objective, other times indomitably subjective, are, in their *subjection* to the variable comportments of professionals, lay-persons, and even loved ones, interpolated at will. Inasmuch as those very same notions are owned and then rejected by competing interested parties, they are themselves interpolations, undermined by counter-pressures outside the practice of reasonable epistemic accountability.

Chapter Three

The toolkit: On addressing the degree to which epistemic injustice can displace theory and practice

Epistemic injustice, as examined in my enquiry, takes two main forms, testimonial and hermeneutical. The former concerns what an *experient* says during interpersonal interactions that leads to an assessment of the state of her mental health, culminating in assessment, diagnosis, and, potentially, *misdiagnosis*. The latter concerns what she does not, or cannot, say during interpersonal relations because the conceptual tools and apparatuses are not in place. For example, she may lack a knowledge of the required terminology, or be physically incapacitated, and therefore literally unable to access the required spaces. Whereas one kind is temporal, occurring across synchronous moments in time, the latter is structural, and may therefore occur within and without the confines of key occasions. My belief is that both synchronic and diachronic inter-relations can act as opportunities in which to address epistemic injustice, bringing about dynamic forms of treatment, even healing.

It is naturally so that some, if not many expressions of epistemic injustice concern less interpersonal or moral failings of individual persons, than the *storms-and-stresses* of regular activity. Generally difficult day-to-day living circumstances and suboptimal working conditions, especially in sectors that are underfunding or under-resourced, can create pressures that necessitate a reliance on negative stereotypes and prejudices. In *Asylums* (1961), a *classic* sociological investigation into the *sociodynamics* of psychiatric hospitals, Erving Goffman observes the "the degrading conditions" that "belie many of the self-stories that are presented by patients" (142; qtd. in Cockerham 241). These conditions can manifest in layers of distrust, which multiplies among different inflictions of maltreatment. Goffman writes that: "there is not always sufficient patient solidarity to prevent patient discrediting patient, just as there is not always a sufficient number of 'professionalized' attendants to prevent attendant discrediting patient" (Goffman, *Asylums* 142). William C. Cockerham (2021) notes that patients are prone to manipulation by hospital staff, who may use generally, if not specifically, deceitful techniques to force her into a particular mould.

This is such as to discredit a patient's self-narrative in order to desensitise her knowledge-capacities to re-form, and sometimes do violence to, her interpretative abilities. Cockerham writes that "[s]omtimes the staff will even deliberately discredit a patient's story so that the patient will be encouraged to adopt the hospital's view of himself or herself" (241). The reason for exerting such force on the patient in terms of her self-concept is so that she will "accept the treatment that is prescribed" (241): a transaction that she pursues on multiple levels because her release "is dependent upon the staff's assessment of how well . . . she conforms to the staff's expectations" (241). While Goffman's study is historic, particular to a context significantly different from today,[1] its insights

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[1]. Goffman completed his research "[f]rom Autumn 1959 to the end of 1957" while "a visiting member of the Laboratory of Socio-environmental Studies of the National Institute of Mental Health in Bethseda, Maryland" (*Asylums* 7). He "did some brief studies of ward behaviour", and, also, "a year's field work at St Elizabeth's Hospital, Washington, D.C." (7). He focused on

remain important, in that “medical sociologists and others interested in the treatment of mental patients have expressed concern about the effects of the mental hospital as a total institution on the attitudes and self-concepts of the inmates” (241). Their concerns are principally those of “the effect of prolonged living in a state of enforced dependency” (241). In terms of epistemic injustice, an equally important concern is the effects of spoken and unspoken meaning on patient and staff perceptions regarding the lived experience of mental disorder.

Mental health practitioners, as characterised by Goffman, or within the present-day, might sometimes exhibit resistance to treatment approaches that are widely accommodative of patient-experience, perceptions of their total need. I suggest that it is the case that accommodating diverse perspectives on what holism is can benefit both patients and healthcare practices.

One important way into a holistic sense of how the theoretical patient may be treated is to employ phenomenological tools that explore, expand and specifically address her illness narrative. My aim in this chapter is to apply to the field of mental health treatment a “*phenomenological toolkit*” designed by Havi Carel, principally for the treatment of physical ill-health (2012, “Resource,” 96; Carel and Kidd, 2014, “healthcare,” 529). My objective is to appraise its value in the context of a range of story-telling tools, synthesising key elements of physical and mental health treatment. This is so as to democratise its function and, in a

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describing “the patient’s situation faithfully”, which, he admits, “is necessarily to present a partisan view” (8). Since (at the time) “almost all professional literature on mental patients [was] written from the point of view of the psychiatrist”, “the imbalance” could be seen as justified (8). In terms of the discourse of epistemic injustice, it would seem he is contributing to the establishment of the *voice* of the patient on both *vocative* and *structural* levels.

central respect, create parities of esteem between diverse professional practices that may displace conventional theory and practice. My main question, asked on the basis of the current state of knowledge and understanding of the theoretical patient, is: Where should resources be directed in healthcare, and what kinds of economies, regular and alternative, need to be encouraged and grown? Whereas Chapters One and Two explored how experients can acquire internal consistency in the face of epistemic pressures and counter-pressures, my focus *now* is on a systematic address.

An experient of mental ill-health comes to recognise a need for treatment as her capacity to enjoy her day-to-day experiences is impeded by unusual emotional and psychological occurrences. Where once she may have thrived in her regular activities, she has, for one reason or another, become unable to enjoy situations and events that were far from extraordinary. In perceiving elements of danger or threat in that which was previously perceived as benign, she loses an ability to take risks in forming relationships, abstract and specific. Carel (2009) comments on the necessity of making oneself vulnerable in order to find one's full self: "Vulnerability . . . suggests a relationship of openness to the world. Without investing in and caring about transient and vulnerable things, like people, the environment and works of art, we would not be able to flourish. In order flourish we must let ourselves be vulnerable" ("A reply," 218). By paying phenomenological attention to elements of lived-experience in its totality, including illness, which can disrupt patterns in daily *living*, insight into healthcare practice and commonplace experience is engendered.

Commenting on the imperative to make significant bonds, as well as the possible dangers at stake within such work, Carel writes: "To be able to love and care about other people and things outside ourselves is to make ourselves vulnerable. But this vulnerability is also the gate to creativity and flourishing" (218). To develop in full is also to have options and opportunities made available, whose uptake is feasible, in being within a person's means and accessibility. When her options are narrowed to an unreasonable extent, she may require the expertise of professional medical and psychological specialists, who can present new paths and avenues.

But accessing and benefiting from specialist expertise can present its own challenges, obtruding the degree to which an experient can take ownership of her healing processes. It has been observed that clinicians might dominate a consultation to an unhelpful extent, preventing patients from voicing their concerns and complaints, and even undermining the validity of their experiences. If a patient cannot tell her story, she cannot organise her experiences, let alone convey their importance: "'Without the narrative acts of telling and being heard, the patient cannot convey to anyone else – or to self – what he or she is going through. More radically and perhaps equally true, without these narrative acts, the patient cannot himself or herself grasp what the events of illness mean'" (Charon, 2006, 66; qtd. in Kidd and Carel, 2017, "Illness," 172). In not having the opportunity to voice her account, a patient may not realise its significance, such that she might speak less, while her clinician pursues his own lines of investigation. It is the case that "[a] study published in 1984 found that the average amount of time between a patient beginning to speak and the doctor's first interruption was eighteen seconds. Of seventy-four office visits recorded, only in seventeen (23%) was the patient allowed to complete his or her opening statement of concerns" (172; Beckman and Frankel, 1984). On one level, it is desirable to consider the expertise of a professional who has undergone considerable training. His knowledge, honed and refined across numerous cases and immersion in medicalised economies of diagnostics, prognosis and application is to be carefully considered: except that any help presented by him is of benefit only insofar as its interpretative contours are actually those of the spaces occupied by his patient community.

It may be concluded that “premature interruption of patients result[s] in a loss of relevant information” (Kidd and Carel, “Illness,” 172). Falling subject to testimonial and hermeneutical injustice poses epistemological problems that are as dangerous as they are subtle, in the sense that “this finding is characteristic of a certain epistemic stance that tacitly incorporates presumptions about the capacities of patients to provide relevant information in healthcare contexts, and which is both epistemically unjustified and epistemically unjust” (172). A patient is open to the real dangers that result from her inability to voice the full extent of her physical or psychological concerns. An inability to speak may, in turn, also expose her to the existential threat presented by the loss of an opportunity to think, potentially wounding her self-belief.

Especially pernicious kinds of wounding could include those particular to microaggressions, acts of communication that challenge the subject of clinical intervention in her most central aspect. In their general exploration of microaggressions, Lauren Freeman and Heather Stewart (2018) note the role played by structural prejudice. The authors define microaggressions as: “verbal, nonverbal, and/or environmental slights, snubs, or insults that are either intentional or (most often) unintentional; they convey hostile, derogatory, or otherwise negative messages to target persons based upon their membership in a structurally oppressed social group" (*Kennedy* 412). Should a clinician perceive an experient to have a level of knowledge he should in fact possess, he could attempt to take a competitive or oppositional role. He might challenge the veracity or itemisation of her account, exerting his authority injudiciously during moments when she is especially vulnerable. This could occur at times when her narrative-account is poignant, in resting on a perception or belief that is intrinsically held, yet questionable, whatever its actual validity.

For example, a young adolescent who seems continually restless and exceptionally disorganised across her schooling and homelife may present differently to clinicians, depending on their social perceptions. One psychiatrist could, on account of the presentation of a concerned teacher, parent or guardian, override the *account* of the experient, however subtle, coherent or incoherent its formulation. He may incline himself towards a set of views that have traditional authority, as often ascribed to carers, suggest she has attention deficit/hyperactivity disorder (ADHD), and prescribe behaviour-specific medication.

Another psychiatrist could heed the warnings against quick diagnostic judgement implicit in the views of commentators such as Rachel Cooper (2014). In *Diagnosing the Diagnostic and Statistical Manual of Mental Disorders* (2014) (*5th ed.* [*DSM-5*] [APA, 2013]), she writes: "Prior to the omnipresence of ADHD diagnoses, one could imagine many different explanations for the activity of disruptive children. Maybe the teachers are boring? Maybe young children are naturally ill suited to spending days cooped up studying maths? Maybe the problem is simple naughtiness?" (4). A diverse range of environmental factors and conditionings could cause behavioural dysregulation. Setting to one side such conceptualisations of an experient's environment, a reason for perceptions of poor behaviour could also reside in a sociological interpretation of contemporaneous patterns of relationship: "Maybe contemporary parenting styles are somehow inadequate?" (4). A physician might take into account the distinctive manners in which the experient speaks and physically expresses herself, as well as unique features of her social and cultural habitation. In discerning communicational clues and patterns that could be unexpected, thereby displacing therapeutic norms in regards to what is psychopathological evidence, his conclusion could be radically different.

By investing himself in the story of the experient, however idiosyncratic its content, he might, rather than proffering a diagnosis, recommend a course of social adjustment. This might take the form of a lifestyle suggestion, for example, the recommendation that the experient should pursue a leisure activity such as a physically rigorous sport, or dance. In such an environment, where focused concentration combines with physical exertion and dexterity, she could come to thrive, and even specialise.

In the first instance the behaviour of the experient is medicalised. Her testimony is subjugated by a traditional authority figure of one kind or another, who lacks the required sensitivity and insight. In the second, as the attitudinal disposition that would ordinarily be taken is suspended, she escapes the possible stigma exacted by a diagnostic label. Moreover, she is given the opportunity to experiment in her lifestyle, maybe going on to grow and flourish.[2]

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[2]. My illustration derives from the content of two widely-shared talks by the advocate of creativity in education, Ken Robinson. In his *TED Talk* "Do schools kill creativity?" (2006) he describes an episode in the early life of Gillian Lynne, who choreographed the stage-musicals *Cats* and *The*

In *A Sociology of Mental Health and Illness* (2021), Anne Rogers and David Pilgrim explore the interactive-dynamics of such a clinical interaction according to broadly-conceived patterns of meaning. In particular, they draw attention to the interests of Marxian theorists whose interest is the effects of subverting established patterns of order so as to elicit fresh freedoms. Rogers and Pilgrim state that "[t]oday the management of people with mental health problems stretches beyond the structural and organizational arrangements of

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Phantom of the Opera. In the 1930s, at the age of eight, she was thought to have "a learning disorder" since, at school, she displayed issues pertaining to poor concentration and "fidgeting." Commenting "I think now they'd say she had ADHD", Robinson adds, with sardonic wit: "But this was the 1930s and ADHD hadn't been invented at this point, so it wasn't an available condition. People weren't aware they could have that." Concerns about her persisted until "this specialist", a doctor, discerning her kinaesthetic learning preferences, stated to her mother: "Mrs Lynne, Gillian isn't sick. She's a dancer. Take her to a dance school" (Robinson and Aronica, 2009, 3).

In his *RSA* presentation, "Changing Education Paradigms" (2010), Robinson notes that diagnoses of ADHD in American children increase in frequency when plotted from the West Coast to the East Cost. Arguing that "[t]his is the *modern* epidemic, and it's as misplaced and it's as fictitious", Robinson's suggestion is not that there is: "no such a thing as Attention Deficit Disorder." Instead, with some hyperbole, he is keen to suggest that: "[t]hese kids are being medicated as routinely as we had our tonsils taken out, and on the same whimsical basis, and for the same reason, medical fashion." Robinson believes the increases in diagnoses could be reflective of how: "[o]ur children are living in the most intensely stimulating period in the history of the earth." He cites, especially, the prevalence of media-, information-, communications-, and handheld-technologies. Robinson also comments: "[i]t seems to me that it is not a coincidence, totally, that the instance of ADHD has risen in parallel with the growth of standardised testing." His recommendation is one of laying emphasis on approaching school subjects, especially "the arts", by way of addressing "the idea of aesthetic experience", as distinct from "*an*-aesthetic[s]", which: "deaden yourself to what's happening."

traditional health services. It implicates the aspirations of local and central policy-makers, as well as community resources, related to employment and housing" (152). There is currently in operation an "admixture of hospital ward and community-based care (centred on primary care) [which] has meant diffusion and proliferation" (153). Where there once might have been a sharp distinction between patient and practitioner, there is now a diverse arrangement of service delivery, complicating the interventions a service-user can make: "Whereas when everything occurred under the large roof of the old asylum, it was possible to describe daily institutional routines (implicated in a regime of 'institutionalization'), now the picture is complex and variegated" (153). Possible solutions to the different kinds of social and structural exclusion and division posed by testimonial and hermeneutical injustices resides therefore, in part, within a neo-Marxian framework.

This is strategically mindful of necessity for careful mediations within and between the roles of patients and professionals. Rogers and Pilgrim state that: "[t]he question to be answered by neo-Marxians is: 'Where do professionals fit into a social structure which is characterized by two main groups: those who work to produce wealth (surplus value) in society (the working class or proletariat) and those who own the means of production and exploit these workers and expropriate surplus value as profits?'" (163). If, as it seems, "Marx gave scant attention to those functionaries or 'white-collar' workers who were neither exploitative capitalists . . . nor workers who produced goods and profits for their bosses in exchange for wages" (163), there is required a reconsideration of the relational spheres that produce systemic unfairness. For Fricker this would be an instance of "the 'negative space' of injustice as it inheres in actually existing social practices" (Allen, 2017, 194; Fricker, 2007, *Power* viii). One form of such space is that of the expression of microaggressions.

The extent of the harm microaggressions can cause in clinical settings is presented by Freeman and Stewart (2018), who suggest that apprehending their physicality is core to an accurate symptomology. While the experient might cast herself as unimportant in the formulation of a medical account, the clinician could, by his very presence, assume key dimensions of the consultation process: "In medical contexts, epistemic microaggressions involve the tendency of physicians and other healthcare providers to view themselves as experts over patients' bodies in problematic ways" (417). Deriving a safe and accurate narrative from the participants is problematised by the invocation of abstract distinctions between the *abstract* and the concrete. This can sometimes mean physicians tend to "privilege their own third-personal, objective knowledge . . . to the exclusion of the patients' first-personal, subjective, embodied knowledge and resulting testimony" (417). The patient is harmed as *knower* in the same instance as the clinical expert is validated in the face of conflicting, foundational actualities. One consequence of such harming of patients "in their capacity as knowers include misdiagnoses, which often could have been avoided had the patients' testimonies been taken seriously in the first place" (418). To prioritise key features of a patient's testimony is, in the long-term, expedient for all participants in clinical settings. Such long-range visioning of an individual's psychopathology does, nevertheless, need to balance against the very real possibility that *a* diagnosis could be better than *no* diagnosis. If urgent treatment is required, the making of diagnoses, however detrimental to personal well-being, could open doors to necessary therapeutic domains.

Using and conserving precious resources and energies is of vital importance to the experient and her clinician: one on account of her profound psychic pain or suffering, the other because swift treatment is medically efficient. The theoretical patient can access the treatment by, insofar as she is able or allowed, mindfully *reading* the clinical space. She, or individuals who can empower her perceptions, however they present, are to discern when, where, why and how epistemic liminalities shape all aspects of her journey to health.

In *Illness: The Cry of the Flesh* (2019), Carel characterises such liminalities according to the apparent epistemic distinctions between the roles of patients and healthcare professionals. Dividing lines are set by the need for the latter to function proficiently under the demands of clinical standards, and ethical awareness, inclusive of epistemic injustice. This is not to mention the economic and practical expediency levelled on healthcare environments. Carel observes that: “Perhaps doctors and nurses need the dividing line to sustain their sanity in the harsh world of illness, pain, and death. Perhaps no one can witness sorrow and offer empathy on a daily basis. Perhaps the medical world as we know it would not be sustainable under such a shift” (51). As such questions are in the minds of some patients, who might wish to play a part in enabling healthcare, so they are also formative of a professional conscience.

If a doctor’s priority is to read the signs of illness in such a manner as to accommodate physiological and psychological change and contingency, the role of the theoretical patient is counter-directional. She must detect where unease and interminable unfairnesses could encroach on his interpretative work, even as she develops her own critical capabilities in interpreting psychopathological signs and symptoms. She can take ownership of her healing processes by learning to recognise how, at every level, economic expediency is an overt and latent feature of healthcare delivery. Its role in guiding precious expertise must be embraced, even as the potential harms that are endemic to such targeting of resources are to be guarded against.

Phenomenology is a philosophical tradition, if not practice, that is central to my enquiry. Since “illness . . . is a complete transformation of one’s life” (Carel, 2016, *Phenomenology* 14), it is necessary to find active ways of interrogating lived human experience. By eliciting readily apprehensible analysis, meaning that facilitates active, accessible engagement with one’s self and body, it is possible to create diverse kinds of coherence in times of fragmentation. This is especially important in the case of mental disorder because “[w]e are not yet able to say what the disease process is in many psychiatric disorders”, even as “there is now an increasing focus on molecular biology and genetics” (18). While it is the case that “some mental disorders [such as dementia] do . . . . have a clear physiological disease process underlying the illness symptoms” the case remains that “there is currently no way, other than asking people to describe their experiences, to know about many psychiatric symptoms” (19). Phenomenology may be defined principally by way of its capacity to yield insight into how individuals perceive the *phenomenal* world. It is “a philosophical approach that focuses on phenomena (what we perceive and experience) rather than on the reality of things (what there is). It focuses on the experience of thinking, perceiving, and coming into contact with the world: how phenomena appear to consciousness” (19-20). Since the act of thinking is consonant with other sensing abilities, the ways in which phenomena are sensed and then comprehended is the principal subject of study.

The practice is especially helpful for considerations of epistemic injustice because of its aim to yield insight into patterns of experience, both immediately apparent and structural. Carel writes that: “What phenomenologists aspire to discern and describe are the implicit structures of experience—that things do not simply appear to us as baldly *there*, but appear in a particular way, for example, as enticing, repellent, out of place, useful, and so on” (20). As testimonial injustices might be sensed in a more or less readily apparent way, and hermeneutical injustices tends to be discerned in the course of time, so phenomenology facilitates short-, medium- and long-range patterns of data. Carel states that: “Phenomenology is particularly useful not only for analysing discrete units of input (e.g. a spoken sentence) but in understanding the particular background against which the input is perceived an interpreted” (20). It is because epistemic injustice has both an unsettling foreground in the form of individual or interpersonal conflict, and a background-context of fragmentary *dis*-placement, that phenomenological methods are key.

A central figure of phenomenology, including its practice and history, is Edmund Husserl, its “founder”, for whom “phenomenology was a transcendental science, that is, the study of the possibility of consciousness” (21). An especially important “feature of Husserl’s phenomenological method is a methodological shift that he calls the *epoché*” (Ratcliffe, 2008, *Feelings* 4). This is defined as a mode of insight whereby the phenomenologist is able to study the phenomenal world by isolating parts of its presentation. This is not about “doubting the realty of the world” (4). The central concern is to create alternative means of focusing attention, a departure from the regular attitudinal stance, in order to create a new means of levelling consideration. Matthew Ratcliffe writes that: “When the phenomenologist withdraws from the natural attitude and thus from her ordinarily implicit commitment to the reality of the world, she leaves that commitment intact but ‘brackets’ it. From this disengaged perspective, she is able to study the structure of the natural attitude, including the sense of reality” (4). By choosing “to ‘abstain’ from her ‘natural believing’ in the reality of the world” she creates the requisite space and position “to reflect upon the structure of everyday experience” (4, 5). In so doing, it becomes possible for individuals to rediscover their commitments and to recognises wrongs, whether individual, interpersonal or structural, that may have been kept hidden.

The method is especially amendable to exploration of patterns of meaning within and between psychiatric practices. This is because “Husserl’s conception of the natural attitude” can serve “to cast light on the nature of changed experience in psychiatric illness”, especially “in schizophrenia” (6). If “the natural attitude” is “a ‘commonsense orientation’” that is subject to regular experience, inclusive of habit, schizophrenia is in part “a ‘crisis of commonsense’” (Stanghellini, 2001, 201). Among other detrimental effects, “the sense of others as *people*” is lost (Ratcliffe, *Feelings* 6). Facilitating opportunities to perceive in ways that are regular and sound, however fractured this may have become for an experient, is core to her emergence out of illness. This includes enabling her to navigate her way through some of difficult terrain she might encounter in terms of meeting specifically epistemic obstacles.

Approaches that are sound in having the patient become the kind of person that both she and society would want her to be diametrically oppose reductionist forms of patient-*care*. Against “the trivial view that our lives and subjective experiences are affected by disease” is “a much stronger conceptual shift" presented by "the phenomenological view" (Carel, 2007, "Happy," 99). Conceiving an individual's lived-experience according to the vicissitudes, vagaries and unevenness of her health, physical and mental, is to rightly conceive disease, especially during the playing-out of a prognosis. This is such that its manifestation is situated less as an alien presence, than a core part of being, thinking, and acting: "disease cannot be taken as a mere biological dysfunction, because there is nothing in human existence that is merely biological. We are embodied consciousness, so consciousness is inseparable, both conceptually and empirically, from the body" (99-100).[3] *Embodied consciousness* is core to the philosophy of Maurice Merleau-Ponty, whom Carel cites, and for whom "consciousness, in its original, pre-reflective capacity, 'is being-toward-the-thing through the intermediary of the body'" (Balazic, 2003, 110;

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[3]. Carel's contentions, presented as "*the phenomenological view*" ("Happy," 99; emphasis added), are so notwithstanding contrary claims made by reductive physicalists. Since, as is the case, "there are two main views in the philosophy of mind about how functional roles relate to their realizers" (Haug, 2011, 459), it is imperative to voice disagreements. While, "[a]ccording to the first view, functional roles are distinct from the realizers of those roles" (459), in actuality, *every* action-of-intent is divided between necessity and non-necessity. Volition, as a generic principle of mature conduct, is in this sense, in step with: "the second view [which] denies that functional roles correspond to properties distinct from their realizers" (459). It is because "[r]eductive physicalism would amount to the claim that no properties are functional" that "nonreductive physicalism" acquires an important value in discussions of mind and body (459), as this: "would claim that *some* properties are functional (or, more contentiously, that *all* properties are, if one adopted the causal theory of properties)" (459). If disease is neither singularly biological, nor, in its embodied state, predicated on monolithic versions of consciousness, its visibility as a phenomenon of shifting significance is universally asserted.

Merleau-Ponty, 160; Carel, “Happy,” 99). In conceptualising health as “a process of unfolding that can be created by each individual, rather than prescribed by social norms” (102), the negative perceptions placed on mental disorder dissipate.

A psychic disposition of the theoretical patient can be helpfully oriented according to fitting notions of past-, present- and future-intent by asking her questions appropriate to her particular situatedness. Lines of enquiry that are appropriate to a mode of health stripped of poorly-disposed intellectualisations of mental illness would allude to the factuality of change as a long-term process. Clinicians might ask: “how has illness changed your life? What are the aspects of it that affect you the most? How can those effects be compensated for?” (109). Other questions that seek to address the medicinal role played by clinicians themselves could include: how would you describe the healthcare you have received? What is your opinion of your diagnosis, and why do you hold this opinion? What do you think is the best path to recovery, healing, and staying well? Of crucial importance is working with an experient in a manner that is sinuous with the nuances of her situation, however wide, narrow or uncomfortable their range and diversity. While this approach seems idealising, invoking, as it could, strong demands on resources, by interrogating “social phenomena through direct personal experience” (Sweeney, 2015, 6), treatment methods could appear that are soundly revisionary.

In contradistinction to negative appropriations of the mind and body, a phenomenological mode unique to the individual is engendered. For Carel “phenomenologically informed questions will open a space for the creative adaptability that can enable a good life even within a context of illness” (109).

Creativity is framed as a feature that is enhancing of the abilities an experient still has, not those she has lost. Her life, in “maintaining a modified but nonetheless rich texture” (109), becomes her masterwork, a project she can execute according to her own time-frame, forecast or agenda.

The story the theoretical patient could tell to a mental health specialist is, perhaps, best shaped according to the narrative frameworks and metaphorical constructions unique to her circumstances. In her investigations into how individuals discern their situatedness as actors of significant potential, creating and *re*-creating critical framings by which to read events, Elisabeth Camp (2020) suggests: “metaphors—and interpretative frames more generally—provide the ‘intuitive “*mental setting[s]*” . . . or background against which specific beliefs and questions are formulated’” (Beeghly, 2020, 79; Camp, 2020, 307; Woodfield, 1991, 551; emphasis added). If a “Toxic Social Environment” is marked by how a person reacts out of character, about which she has “trouble exercising any direct influence” (Dominguez, 2020, 163), investigative attention is necessarily diversified. Clinical encounters can organise themselves around questions asked not just of the thoughts and behaviours of the experient. Also of interest are the events and histories that have led to her presentation, as elicited from her short-, medium-, and long-term *histories*. By inserting himself into the construction of her historiographic map, the clinician can treat her in a radically humane manner. Since “[i]t is said . . . the physical world is one of mechanism and of cause and effect, and . . . the human world . . . one of meaning and interpretation[,] . . . over-simplifying” must be resisted (Rose, 2009, 41).

This is such as to facilitate the expression of a coherent, lucid story of rich shape, content, meaning and significance, one of “[e]pistemic diligence” (McHugh and Davidson, 2020, 185). In practising “the habit of responding to ‘epistemic challenges,’ like calling-in and calling-out” wrongs (185), such as malign tones, demeanours, and person-to-person handlings, clinicians can create dynamically trusting relationships. Experients, when sufficiently empowered, can take a co-equal role, developing their own diligent approaches to their environments of habitation, as they practise the interpretative techniques. McHugh and Davidson suggest that: “The practices of calling-in and calling-out and the ways in which we respond to such calls, for example not being defensive or shutting down, serve as the types of epistemic challenges required for the development of epistemic diligence” (185). As an experient appraises her *environs*, attending to the very factors and details that gave rise to them in the first place, she develops her own moral compass. This is one that reads any range of ill-placed material and social conditions, whether in clinical environments or day-to-day life, insofar as the requisite coordinates are visible.

Since its reading depends upon co-ordinates that themselves shift as changes of direction are taken, the experient learns skills in orientation that have lasting impact on her life course. *Calling in* and *calling out* become means of creating situational synergies, even as: “the practices give rise to epistemic friction in that they make one aware of the limits of one’s epistemic habits and access to the world” (185). In drawing boundaries that isolate and limit the effects of an ill-wrought relationship, experients can identify and come to address a given series of toxicities. Whereas some spectrums thereof could be unique to “Toxic Environment” (Dominguez 163), others could pertain to “Toxic Social Environment” (163).

In the case of one range, as presented by intimates, such as parental figures who have failed to draw responsible boundaries, a new kind of human relating becomes possible. In their bestseller *Toxic Parents: Overcoming Their Hurtful Legacy and Reclaiming Your Life* (1989) Susan Forward and Craig Buck describe how some children can change importantly the locus of attention. Pointing to the unhealthy means by which a child, mature adolescent or adult, might define herself through parental judgements, they write that through: "shifting the source of your gauge from within your parents to within yourself" (305), it is possible to achieve internal cohesion. Addressing a child-persona, as she is, in need of specific advice and direction, Forward and Buck state: "You are learning to trust your own perception of reality. You will discover that even when your parents don't agree with you or don't approve of what you're doing, you will be able to tolerate the anxiety because you don't need their validation anymore. You are becoming self-defined" (305). As the child becomes increasingly secure emotionally, so she also comes to guide herself appropriately, despite intrusions of judgement and prejudices from parental authority figures.

This can be freeing in a manner that is collectively- and individually-oriented. All persons within a relational sphere can attain independence of movement, as well as inter-dependence of thinking, discerning for themselves the best steps to take going forwards: "As you gain more control over your past and present relationship with your parents, you will discover that your other relationships, especially your relationship with yourself, will improve dramatically. You will have the freedom, perhaps for the first time, to enjoy your own life" (306). Since the child of *toxic* parents might not have had the opportunity to develop an adequate emotional literacy, clinical encounters present unique opportunities in which to model sound relations. In coming to know herself sufficiently well, she may also develop empathic qualities, as well as discovering new responses to different events. An account of the family that served a dominant and *dominating* narrative, one concerning *wins* and *losses*, is reframed, according to that of “healthy families” (DeYoung, 2015, 66), in which: “conflict isn’t pleasant, but neither is it terrifying or gruelling, and that’s because people can expect to be heard, no matter what they need to say. The conversation matters more than ‘winning’” (66). The challenging and displacing of unhealthy forms of domineering and competitiveness, individual or structural, is also the tackling of poisoning emotions that have developed across a lifetime.

If one outcome of feeling oppressed by another is the shame that results from failing to achieve a particular standard, it is not necessarily the case that: “what causes shame is harsh, shaming parenting” (66). Patricia A. DeYoung, a relational psychotherapist, observes that: “Many clients who suffer from chronic shame can’t find evidence of that kind of parenting in their childhoods. They know their parents loved them and wanted the best for them” (66). The clinician is to guard against an easy attribution of blame to parental figures, in knowledge of the possibility, even likelihood, that a complex narrative might underlie that presenting in and through clinical treatment.

Concomitantly, it is not unlikely that there are constitutional features of a family unit that can be addressed, if not in an immediate circle, then within a specific relational-structure. DeYoung concludes by placing at the centre of attention the difficult experiences of his client-base, since “as their ‘mostly normal’ stories reveal, their parents were too anxious or troubled themselves to create the intersubjective space necessary to nurture cohesion, self-awareness, and confidence in their children. Shame crept in insidiously” (66). Similar to how depression can be marked by “existential changes” (Ratcliffe, 2015, *Experiences* 201), such that “the overall *structure* of interpersonal experience and relatedness is affected” (201), so, some familial-groupings require targeted therapeutic attention.

According to Alison Bailey (2018) “[a]nger is the emotion of injustice” (93), a construct of feeling that could be amplified or *tempered* by accompanying senses of perplexity or wonder. It therefore follows that when a wrong has been allowed to develop progressively, as is characteristic of hermeneutical injustices, its address is multi-faceted. Lytta Basset points to the mixed possibilities presented by anger in her study *Holy Anger: Jacob, Job, Jesus* (2003), stating that: “‘Emotion’ – (with the Latin root *motere*, ‘to move,’ plus the prefix *e*, connoting ‘to move away’) as the entomology suggests, and as a scientific psychology that is far from having explored the entire landscape of feelings has already confirmed – is linked to the tendency to action” (61). Such action could be tempered by feelings of suppressed rage that affect the epistemic characteristics of an instance of anger, possibly corroding interpersonal capacities for relationship in insidious ways. Basset also writes that “[i]f a sense of justice is given to us from birth, it is because Justice precedes us; we have not invented it from whole cloth. Our ideas of justice are always second; they develop *after* we have stored up a certain number of injustices” (234). Should the resources used for this storage fracture, it is possible that those containing collective feelings could themselves break down, resulting in structural damage that is irreparable.

As Martha C. Nussbaum states in *Anger and Forgiveness: Resentment, Generosity, Justice* (2016), “the idea that anger is a central threat to decent human interactions *runs* through the Western philosophical tradition” (14; emphasis added). On the one hand, anger liberates the self by prompting feelings of strength in the face of adversity: “Our anger surfaces quickly pulling us back into our bodies. This is how injustice *feels*” (93). Other possible emotions, such as despair, helplessness, and distaste, could find themselves displaced by articulated or repressed feelings of rage concerning a verbal of *felt* wrong. By virtue of its constant presence within and across experiences as they have been allowed to become, anger is an ubiquitous emotion for a select range of individuals: “Those of us who live in *epistemic twilight zones*, that is, in worlds where testimony about our lived experiences is repeatedly silenced, dismissed, distorted, or gas lighted, are familiar with the ever-present anger these constant erasures trigger” (93). Anger is energising in a manner that is unpredictable, charging an individual temperament with possible actions and reactions of elemental rawness.

Concomitantly, anger can, within its enacting, bear counter-features that challenge its caricature as a sub-stratum of uncontrollable rage. Whatever the substance of the contention by Kirstie Dotson (in conversation with Alison Bailey) that “‘[a]ll injustices are epistemic at root’” (qtd. in Bailey 94), it does not in turn follow that anger is destructive of sensible discussion. It can, instead, by way of its inner tensions and organising of internal resources play a *deconstructive* role: one that is resistant to the psychical malignity provoked by feelings and emotions such as fury, contempt, and disgust. Similar to “Heidegger’s description of human existence” (Walton, 2001, 287), whereby “to know what we *are* is at the same time to know what we *can and should be*” (287), self-mastery is attainable. In holding an ambition to realise the potentiality unique to one’s individual selfhood, “we are to achieve coherence and unity in our lives” (287), in which collective belonging is prioritised. By “integrating their experiences of illness and treatment, their Being-in-the-world and Being-with-others”, experients can view their ill-health “in a future-oriented way” (287), embracing its unpredictability.

The theoretical patient is reconceived from “the subject of knowledge” to the terms of Heidegger’s “starting point[,] what he calls ‘Dasein’, the ‘being-there’ of human existence” (Svenaeus 90). In possessing a sense of herself that is creative and *re*-creative according to the very principle of changefulness itself, the experient embraces the radical impossibility of apprehending absolutely her thinking- and feeling-selves: “This being-there means that we are situated or ‘thrown’ (*geworfen*) into the world that we live. We are always already *there* (*da*), involved in daily activities” (90). “Being-in-the-world” (Heidegger, 1926, 225), for Heidegger “is a structure which is primordially and constantly *whole*” (225), displaying the work of foundational belief-making, as much as it makes plain one’s established materially-focused orientations. On the basis of the possibility that the theoretical patient can, within an equivocating structuration-of-self, discover an irrevocably unifying *holism*, I shall now consider Carel’s phenomenological toolkit.

Carel (2011) describes phenomenology as “a philosophical tradition dating back to the early years of the twentieth century”, whose work “focuses on phenomena (what we perceive) rather than on the reality of things (what really is)” (“application,” 34). A mode of thinking whose precise investigative terms change as the investigation itself progresses, phenomenology is appropriate to my enquiry. Inasmuch as mental disorder is continually reinventive of human experience, even as it acts as a *dis*ordering presence, challenging sensible forms of discourse, phenomenology plays a useful role in its interpretation.

Phenomenological tools in effect dramatise the work of the mind by laying bare its constitutive parts in a specified environment: “Phenomenology examines the encounter between consciousness and the world, and views the encounter as constitutive. It is the science (*logos*) of relating consciousness to *phenomena* (things as they appear to us) rather than to *pragmata* (things as they are)” (34). In serving to present and re-present the thinking and feeling activity of the theoretical patient, phenomenology can play a role that is both comforting and analytic in clinical encounters. Whatever the value placed on concepts of self-development and internal-harmonisation, it is the case, too, that a complicated mix of psychic and environmental factors can, potentially, derail personal growth.

Carel’s appropriation of phenomenology in medical contexts applied principally to physical ill-health, as distinct from psychological disorder.[4] Her

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[4]. In her article that first describes her “*phenomenological toolkit*” (“Resource,” 96), Carel (2012) observes that “[i]llness forces a kind of phenomenological reduction on the ill person” (108), and that this is: “particularly so in the case of mental illness, which involves changes to the natural attitude and therefore requires a methodological shift in order to understand it” (108). Carel does not explore in depth the topic of mental illness, neither in this article, nor in her subsequent piece, authored with Ian James Kidd, where her “toolkit” is again described (2014, “healthcare,” 529). Commenting on the clinical biases that counter emphases on the accounts of patients themselves, Carel and Kidd point out: “[i]t seems to us that it is frequently the ill person’s ability to offer relevant assertions that is being questioned, rather than their ability to make assertions at all” (537). They also state, in a footnote, that: “[t]he case of some mental disorders, e.g. psychosis, would be different. In these cases the patient may be considered altogether irrational

terms of investigation are founded on “Merleau-Ponty’s embodied phenomenology” (35), which concerns: “a robust account of human experience as founded on perception. . . . Perception . . . is itself an *embodied* activity” (35). For Merleau-Ponty, as for Carel, it is important to countenance: “a view of the human being as essentially embodied, a body-subject that arises from acts of perception” (36). While such perceptions can be isolated within and between specific moments, they are also in themselves constitutive of significance. Perceptions, in being loaded with meanings that point to and transcend a given moment necessitate that they exist as sites of importance, depending on the occasion: “Perceptions are ‘inhabited by [a] meaning’ and are always grasped as meaningful for us” (36; Merleau-Ponty, 60). Carel draws on Heideggerian forms of meaning-making to support her belief that acts of critical appropriation are never innocent: “As Heidegger says, ‘we do not [. . .] throw a ‘‘signification’’ over some naked thing which is present-at-hand’ (Carel, “application,” 36; Heidegger 190). The body and the mind function as co-equal partners in the work of sense-forming, value-attribution, and belief-creation. In keeping with Heidegger’s “hammer-Thing” (98), in which “the more we seize hold of it and use it, the more primordial does our relationship to it become” (98), intra-subjective domains unify.

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and unable to make true assertions at all” (537). I have sought to home in on mental illness in a lengthy and specific way, so as to profitably develop and expand Carel’s toolkit. This is an ethical endeavour, premised on addressing an imbalance in healthcare resourcing and delivery, in which attention on physical health tends to predominate over interest in mental health. Carel and Kidd, with Paul Crichton, do, of course, explore diverse aspects of mental healthcare in their article, “Epistemic Injustice in Psychiatry” (2017).

Carel develops from within a specifically embodied perception, an attitudinal stance which "differs also from the commonplace medical view of the body" ("application," 41), three critical tools for interpreting illness. Insofar as illness of all kinds is perpetually displacing of the tenets and principles that organise one's very being, situatedness and agential capacities, her phenomenological perspectives are wholly reasonable.

For Carel: "[a] phenomenological approach to illness asks how patients experience their disorder rather than causal questions about the disorder or how to treat it" ("Resource," 100). This means, firstly, it is necessary to dispossess medicinal norms about what a disease may or may not mean by considering illness *in itself*, as distinct from its medicalised appropriation. Using Husserl's (1913) "*epoché*" (*Ideas* 32), an individual engages in: "[b]racketing the natural attitude toward illness [which] suspends the belief in the reality of an objective disease entity" ("Resource," 107).[5] A suffering person, in focusing on her

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[5]. Husserl's *epoché* is naturally not without its detractors. Posited "as the new way to understand the intellectual rigour constitutive of scientific method" (Kidder, 1987, 232), the concept in its essential notion: "puts out of play, suspends, brackets naively assumed objectivity in all its forms" (232). On the one hand, its use for critical investigation is all-encompassing, serving as a way of: "analyzing all experience, not in terms of independent objects, but in terms of manners of givenness" (232). On the other hand, its "global suspension of all conviction regarding factuality itself" (232), opens the door to the possibility that its application could take a tone of naive argumentation. Paul Kidder alludes to the degree to which *epoché* is subject to reductive *forwardings* of position and counter-position. Creating spaces in which individual subjects-of-study are considered without important aspects of signification creates the potential for a critical vacuum, whereby observable phenomena lose their significance as distinct entities. Kidder writes that: "[w]hile everything is lost as presumed fact in the epoché, everything is retained as an

individual experiences, as distinct from the norms of medical practice, is placed according to the central "purpose of bracketing, or epoché" (Smith and McIntye, 1982, 96): that being to focus on one's unique embodied being: "to turn our attention away from the objects of the natural world so that our inquiry may focus instead on the most fundamental evidences on which our naturalistic beliefs about these objects are based" (96). In the instance of different kinds of mental disorder, experients might consider their conditions by way of their innermost intuitions about normalcy, not a series of socially acceptable gesticulations.

Secondly, having placed a formal structure on the illness-experience, a sufferer may consider intently its main thematic strands by "thematizing" which (108): "refers to the act of attending to a phenomenon, which makes particular aspects of it explicit" (108). Discerning the *content* of the experience of illness could mean: "attending to the cognitive, emotive, moral, or aesthetic aspects" in manners that are consonant with its lived actuality (108). Carel suggests that: "'a patient may thematize her illness as a central feature of her life, attending to her symptoms as pervasive, while the physician may thematize the illness as a 'case of cancer'" (108). By observing "a complex, shifting view of illness" (108), inclusive of how apparently unimportant features are "changing in meaning, and . . . consisting of multiple perspectives" (108)**,** new dimensions of subjecthood can appear. The theoretical patient could conceive her identity through her own interpretative-lenses about what regular and irregular cognitive and behavioural patterns are, marginalising institutionally cumbersome psychiatric grammars.

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appearance and a moment in subjectivity" (232). Advances of position and counter-position must retain solidity of insight, if thinly-conceived applications of *epoché* are to be avoided.

Thirdly, and relatedly, a sufferer of illness is to *review* its total meaning to "examine how it changes one's being in the world" (108), inclusive of an orientation towards a: "pre-objective realm that we have to explore in ourselves if we wish to understand sense experience" (Merleau-Ponty 14). Noting that "[t]he term 'being in the world' is used by Heidegger to denote the human being in the broadest sense" (Carel, "Resource," 108-09; Heidegger, 1962 [1926]), the reviewing of one's humanity afresh is revelatory. Individuals, by virtue of their psychosocial complexity as participants in the making of meaning, however politicised or *de*-politicised, become functional citizens as they acquire cognitive *functionalities* and capacitations. As one organises how her being is reified, what her core self is, and how this is enacted and redacted, an individual discovers anew her psychical and physiological worlds. For example, she may be open to the invitation of new friendships, and suggestions for paid or voluntary employment. The three steps could be delivered in "a one-day workshop for patients" (Carel, "Resources," 109), led by a doctor, therapist of philosopher, and "use visual and sensual samples" (109), as well as key texts.

For Carel and her co-author, Ian James Kidd (2014), providing an opportunity for patients to bracket, thematise and review their conditions is a key to overcoming epistemic injustices. Patients are given a chance "to voice their opinions about their care, convey their experiences, or state their priorities and preferences" ("healthcare," 531). In coming to express their embodied experience outside of conventional economies of resource and delivery, they may perceive paths to well-being that are distinctively fit for them. At the very least they may find a language that challenges notions of them "as cognitively unreliable, emotionally compromised, existentially unstable or otherwise epistemically unreliable in a way that renders their testimonies and interpretations suspect" (531). In having developed an empowering literacy and an appropriate manner of expression, the very idea that they are insensitive "to their factual condition and state of mind" is diminished (531).

While Carel and Kidd present important insights into how medical resources could be re-organised around patients themselves, their arguments carry important weaknesses, some of which they implicitly recognise. Noting that "the epistemic privileging of health professionals, and in particular of physicians" is dominant in care-delivery (535), they point out that: "on the medical view the goal of medicine is to repair physiological mechanism" (535). Medical practice requires a solid evidence-base by which to make critical judgements. This imperative naturally runs in the face of any attempt to democratise a system that divides "[t]he third-person view" from "first-person testimonies" (535), as an expertise demands efficient knowledge distribution. Should a clinician listen to a patient account against the course of established know-how, he runs the risk of making fundamental errors, missing key diagnostic signs and details. In principle it is okay, indeed expedient, to listen to a patient's self-narrative in full. However, in an environment where even emotional resources, such as sympathy and empathy, are in demand (aside from material supplies) such listening remains the exception, not the norm.

Secondly, and relatedly, it is of course the case that "in a performance-based target-driven culture patient input has little place" (535). This means that the justification for a workshop that prioritises patient experiences must be built into a collectively-organised culture, whose own collectivity is already rigidly established. To displace one sense of collectivity by way of another, as created through an idiosyncratic range of group dynamics, would in itself require an unusual, difficult-to-define evidence base. Its organisation, as resting on a philosophy that is opposed to the dominant culture, could demand not inconsiderable effort amongst all involved, potentially placing undue pressure on group relations.

In the case of a group consisting of experients of *mental* illness, there exists the additional pressure of attempting to organise and perhaps systematise non-itemised, possibly idiosyncratic feedback.[6] Feelings of anxious personal belonging and issues of structural marginalisation, already present in the very fact of the group's existence, could coalesce with unhelpful institutional demands, creating a disinhibiting *miasma*. In further lacing the problems involved in making reliable diagnoses and formulating secure prognoses, experients might suffer unacceptable levels of stigma from within conceptualities oriented around patient safety. This could, for some, prove intolerable, as professional theory and practice in themselves betray a trust that is precious because of its wounding.

This issue raises an additional question: the extent to which some forms of epistemic justice are attainable in large, bureaucratised healthcare systems that necessarily depend on standardised vocabularies, procedures and forms of

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[6]. It is the case that questionnaires are sometimes used by clinicians to inform their assessment of individual mental health and well-being. They could therefore potentially form one means by which to appraise a group application of a discursive model, such as Carel's toolkit. In the event of the use of questionnaires consisting of closed questions, important ranges of concern might not register, whatever the efficiency of a statistical model or approach. Open questions could generate inefficient results in lacking some of the detail and breadth of the relational sphere created in live conversation.

education and training. Rogers and Pilgrim observe that in contradistinction to regular neo-Marxist positions, which consider the professions in uniform terms, alternative conceptions of professionalism are possible. They raise the possibility of new challenges to institutional orders. On the one hand, the professions, including medical professionals, sit within either the ruling-class, the proletariat or “a separate and new social class holding contradictory qualities” (163). On the other hand, there are within subcategorisation, including the possibility that professionals have fallen subject to how “control over their work [has been] eroded by the state bureaucracies that employ them” (163). For other theorists, “the contradictory position of professionals in capitalist society” is emphasised whereby (164): “They are not capitalists but they serve the interests of the latter [capitalist society]. They are not full members of the proletariat . . . but they are employees and so they share similar vulnerabilities and interests of the working class” (164). It is in this “contradictory position” that mental health workers stand, in “being both agents of social control acting on behalf of the capitalist state and employees of that state and so vulnerable to the same problems of any other group of workers” (164). Experients are to engage with individuals who may in themselves suffer from the necessity of holding individual, social and organisational values that are inherently contradictory. It is therefore so that at least a measure of epistemic injustice, in any healthcare setting, is inevitable.

Carel and Kidd do show an awareness concerning the dangers presented by institutionalism in conducting maverick kinds of patient care, noting that “in a large-scale healthcare system in which performance is judged quantitatively, qualitative statements are difficult to utilise” (535). Formalising innovative group work is of course laced with the problematic issues particular to justifying its cost, when the itemising of opinion is sometimes reductive of its very expression. Also noting that “patient views are often seen as anecdotal and context-dependent and therefore lacking any long-term utility” (535), the authors acknowledge the impossibility of utilising experiences that are self-formulating. Since “patient views can be as numerous as patients” (535), creating a defined plan to solidly develop the healthcare path of a single patient, let alone a group, is risk-laden.

Carel and Kidd’s approaches to epistemic injustice across healthcare contexts are problematised by its very transience. Occupying, as it does, the margins and centre of person-to-person endeavours, the authors show how, especially in the case of mental health-care, the distribution of resources requires an evidential-base. Their *approaches* are helpful to the extent that they delineate the distribution of healthcare resources according to measures that do not further burden experients within diagnosis and general categorisation.

This leads me into a critique of each part of Carel’s toolkit, and to a suggestion concerning its application. I shall begin with “[t]he first step . . . bracketing the natural attitude” (538). Against “the background sense of belonging to a world and [its] various interpretive dogmas” individuals are to withdraw “from the ordinarily implicit commitment to the reality of the world” (538). It is axiomatic that gaining a fresh perspective, unique to oneself, can bring constructive attention to chronic issues. Suspending beliefs about “the reality” in a way that shifts “the focus away from the disease entity and toward the experience of it” (538), can bring comfort and relief in duress.

The precise manner in which such insight is elicited does, nevertheless, require careful management, especially in regards to mental and psychological trauma. Physical and psychical sensations could, for some, be disabling, stirring haunting memories that overpower the revelations presented by the disclosure of any “essential features” an illness “might have” (538). Physiological feelings of pain, or grief and bereavement about lost functions, of body or mind, might predominate in moments when discovering new aspects of self could be fruitful. It is, perhaps, helpful, within *epoché*, to apply conventional story-telling features that could organise troublesome temporalities. By applying to areas of fracture a distinct “kind of narrative theory” that integrates features of self which both demand and allude attention (Puckett, 2016, 1), a synergising unity could develop, which: “takes as its subject the question of how different kinds of aesthetic order, arrangement, and inflection can differently manage and thus make meaningful different and sometimes the same events” (2). As the theoretical patient “considers both the *what* and the *how* (and sometimes the *who* and the *where*)” (2), she may discover rejuvenating forms of order where disharmony could have dominated.

The “second step . . . thematizing illness” (Carel and Kidd, “healthcare,” 538), which “refers to the act of attending to a phenomenon in a way that makes particular aspects of it explicit” can be considered similarly (538). As this “enables moving away from prescriptive pronouncements” about illness and “toward a more tentative, descriptive mode” (538), subjecting a narrative framework to an imaginative appropriation can induce self-creative activity. Since “*narrative is the principal way in which our species organizes its understanding of time”* (Abbott-Porter, 2008, 3), its handling, within an experient’s conception of illness, facilitates inductive and deductive self-realizations. As she practises judicious sharing of information that renders her especially vulnerable to clinical and social judgements, she engages in the *giving* and *taking* of medical norms and *normativities*: that is to say, she is clarifying and defining her key contexts. In ordering traumatic events, she can reconceive commonplace relationships about form and content, reconceptualising key events, before and to come, accordingly. She might choose to pursue a treatment plan that runs against the grain of conventional practice, for example, by opting for talking- or holistic-remedies over recommendations of prescriptive medications. She could, therein, perhaps upend core medical practice by challenging central expectations about the order in which healthcare treatments are delivered. By virtue of its writing and re-writing, her: "[n]arrative . . . turns this [commonplace] process inside out, *allowing events themselves to create the order of time*" (4). To *thematise*, for the experient, is to *theorise* about theory, reordering the terms of enquiry that may have dominated her sense of time.

The "third step of the toolkit" is summative in taking "the new understanding of illness emerging from these two steps, and examining how it changes one's being in the world" (Kidd and Carel, "healthcare," 538). The enactment of this step is a personal achievement, and potentially hard-won because of its level of emotional investment, as one: "move[s] away from a narrow understanding of illness as a biological process, towards a thick account of illness as a new way of being" (538). In developing an account that concerns her authority to tell and re-tell, however subtle or dramatic the development of this capacity is, the experient becomes an *author*. In her reconceptualization of past subjecthood, as well as, perhaps, that which could accompany a final acknowledgement of suffering, sometimes constitutive of a "comfort blanket", she *becomes* afresh. This self-aspect is not dissimilar from the sense of self-authorship advanced by Stewart Justman (2015), who observes the idea of: "the narrative subject (that is, the patient or client) [who] not only comes to imagine alternative story lines but lives them, in the process of reinventing him- or herself" (512). Inasmuch as theoretical patients can, like regular patients, feel empowered "to 'speak their mind'" (Carel and Kidd, "healthcare," 538), finding a space "for reflection rather than self-pity" (538), a toolkit of narratological principles is effective. Through the synchronous ordering of her critical apprehensions, and diachronous appropriations of events that re-order time itself, diverse patient communities can find new perspectives on trenchant personal and collective issues.

I contend that an additional tool may be applied to the toolkit. This is unique to a psychiatric setting, in which a patient may, by virtue of the psychological intensiveness of her distress or uncertainty, require the support of ongoing talking-therapies. The fourth step might be applied further to a workshop and is called *belief-framing*. As the patient tells her story, however slowly or quickly and with whatever material props and supports she requires, her therapist is to spot narrative threads and tangential perspectives. He is to find an opportunity to draw together their commonalities, so as to assist the patient in finding coherence amongst shattered fragments and loosely ordered shapes. This is so, even as medical *environs* are sometimes antagonistic towards "grounded experience" (Donskoy, 2009, 166), one's "own or that of the service user community" (166). The act of "feed[ing] . . . back 'quickly'" into treatment can sometimes generate a *plethora* of inhibiting frictions between clinical and patient subject-participants (167).

Raymond M. Bergner (2007) comments upon the constructive potential of using stories to develop well-being in psychiatric patients: "Stories are powerful devices for assisting patients. When we choose them well and tailor them carefully to our patients' situations, they have many benefits. They reduce patients' confusion by organizing their thinking about their problems" (162). Stories told in therapy are instructive in providing patients "*diagnoses* of their problems that *patients* can understand" (162; emphasis added), precisely because they undo the stigma and discombobulation advocated by conceptually-thin conceptions of patient-experience. As a patient's views upon the causes and reasons for her situation grow thicker, so her sense of self-knowledge incrementally develops, enabling her to detach from distressing feelings. She comes to believe that she is not to blame for her predicament, in contrast to narratives that suggest she is both the proper-object and official-subject of medical scrutiny.

It is the case that her increasing self-knowledge could serve to increase her feelings of culpability for her predicament as she encounters an interplay of positive and negative reflections. Lisa Bortolotti and Sophie Stammers (2018) comment on the importance of overcoming individual feelings of guilt by laying emphasis on a counter-position, collective ownership. Important reflection that can overcome testimonial and hermeneutical injustices can be learned through: "draw[ing] on insights from lived experience and survivor movements,[7] and

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[7]. On the definition of "[s]ervice user/survivor" Diana Rose and Peter Beresford (2009) state that "there is no agreement about terminology in 'mental health' or among 'service users/survivors'" (3). Angela Sweeney observes that "[s]urvivor research is a relatively new form of service user activism", serving to formalise "the desire of psychiatric system users and survivors to generate our own knowledge about our experiences" (1). I take the term to be useful inasmuch as knowledge, as a subject of the movement, is actively constructed.

support initiatives which enable these movements to construct shared epistemic resources for self-understanding." It is, perhaps, through establishing collegial systems of sharing that it becomes possible to "build these resources . . . to collectively challenge dominant societal narratives which connect experiences of mental illness and distress with irrationality." By recognising the possibilities for generous sharing of insight, there may appear in equal measure opportunities to reflect, which has the effect of levelling the playing-field. Bortolotti and Stammers conclude that: "If we take these opportunities, we might recognise, together, that mental health and mental distress are more like states on a continuum – one that we all inhabit." By creating openings for light to shine, experients may find opportunities to recognise hope, however acute or chronic their suffering.

As her situation becomes subject to collective-orientations, even mutual ownerships, as distinct from the individuating models of meaning of medical establishments, the shame that swept over her recedes. No longer identifying as a casualty of mere *bad-luck*, she re-frames herself as a functional agent of society with unique insight, historicising false narratives and investing in alternate meanings. Her work is not just that of suspending, formulating and revising prevalent attitudinal dispositions, whether hers or another's, but also the framing and re-framing of personal and organisational belief-systems.[8]

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[8]. My conception of therapeutic activity particular to experients in some senses resembles the concept of "'reflective equilibrium'" (Singer, 1974, "Sidgwick," 490), which: "goes back to Aristotle, and can be followed down through the classical writers at least as far [Henry] Sidgwick" (490). John Rawls, in *A Theory of Justice* (1972), comments instructively "[f]rom the standpoint of moral philosophy" that (48; qtd. in Singer, "Sidgwick," 492): "the best account of a person's sense of justice is not the one which fits his judgments prior to his examining any conception of justice, but

In considering their spectrums of intent within her own sense of *intentionality*, she can spot fault-lines, fissures, gaps and fractures in need of her address or for passing over. Where, in a previous clinical consultation, her symptomology could have been falsely categorised or misappropriated, invoking misdiagnoses and wrong diagnoses, she can perceive a new course of narrative events. This might come to facilitate a framing-of-moments and language-of-expression in which to receive an accurate diagnosis, or, indeed, encounter the possibility of receiving no diagnostic label whatsoever.

The theoretical patient occupies the privileged position of having a prime opportunity in which to visit, revisit and re-create her core beliefs about self, health and well-being. In doing so, she also has an *opportunity* in which to heal from injuries dealt across long stretches of time, which could, but for superficial scarring, finally disappear. Mental health practitioners of all kinds, while working in a system that sometimes obtrudes upon philosophies of medicine particular to patients themselves, have their own distinct opportunities. As professionals who have experience and knowledge about the road to wholeness, they can also become, with patients, expert authors of *holist* narratives.

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rather the one which matches his judgments in reflective equilibrium" (Rawls 48; qtd. in Singer, "Sidgwick," 492). Less an act of balancing between distinctive moral counterpoints, than a perception of the tensions throughout multiple ethical concerns: "this state is one reached after a person has weighed various proposed conceptions and he has either revised his judgments to accord with one of them or held fast to his initial convictions (and the corresponding conception)" (48; qtd. in Singer, "Sidgwick," 492-93). Inasmuch as a given series of conceptions is informed by a wide range of concepts, states-of-factuality, and *beliefs*, some complementary, others antagonistic, reflective equilibriums appear and disappear fluidly.

Carel states that her tripartite toolkit “uses Heidegger’s notion of ‘being in the world’ to capture the pervasive effects illness may have on one’s sense of place, interactions with the environment and with other people, meanings and norms, and the nexus of entities, habits, knowledge, and other people that makes up one’s world” (*Phenomenology* 201). My use of holism is consonant with these sound intentions. Application of the toolkit, on the one hand, can “enable the expression of unique person experiences rather than pushing patients to adapt their experiences to medical or cultural expectations” (202). Equally, it is my hope that appropriating and, in the adoption of my fourth step, developing the toolkit, its alternative application can accentuate its positive effects.

Carel writes that “[t]he small-group structure of the workshop and the fact that participants all suffer from an illness, or aim to care for ill persons, provide a safe environment that will allow participants to share the idiosyncrasies of their experiences with no pressure for these to fit into a pre-given mould” (202). Inasmuch as the possibility of epistemic justice is the antithesis of a fixed view of human development, it is possible that to achieve wholeness-of-self is to recognise fresh potentiality.

I see this as articulated through holism, whose definition I take from the *Oxford English Dictionary* (*OED*), which states this is “[a] term coined by Gen. J. C. Smuts (1870-1950) to designate the tendency in nature to produce wholes (*i.e.* bodies or organisms) from the ordered grouping of unit structures.” To recognise structure in the face of acts of exclusion that are *structural* in origin is to begin to tackle both epistemic and hermeneutical injustices. Similar to how they are sometimes imposed by outside forces, even as they can emerge from within a functioning, organic unit, so holist perspectives are characterised by unifying synergies.

As Smuts writes in *Holism and Evolution* (1926): “the more Holism there is in structure, the less there is of the mechanistic character, until finally in Mind and Personality the mechanistic concept ceases to be of any practical use” (207-08). I suggest that to invert the key terms of the *OED* definition, in particular ways, is specifically instructive. Accommodating incremental human development and growth in times when they would be otherwise impossible has the potential to be distinctively encouraging for oppressed individuals and groups. Similarly, holism, the possibility for positive accentuation of self in the face of antagonism towards its sinuous expression, offers moments of plenitude where this is ordinarily *in absentia*.

In orienting patients appropriately, so their minds and bodies are employed co-equally, fresh attention is cast on the stories that underpin their occupations and the institutions that accommodate them. Holism, in a solid sense, is that quality which supports patients and doctors as they strive to attain measures of healing. It is also that feature of personhood that escapes firm definition because to decide on what is holist would be to displace its relevance as an ideal state of mind and body. Inasmuch as holism can unite patients and clinical staff in their hopes of overcoming ill-health, its escape from firm ontological categorisation is also its strength, galvanising patients’ imaginations. If my *fourth step* is one of challenging belief in its personal and structural fluctuations, it is also that by which the self attains core cohesion.

Carel’s toolkit holds a vital function for the treatment of both physical and mental illness because its narrative progression in teaching an accommodation of dis-ease is itself critically accommodative. Serving, as it does, to place clinicians' focuses on the phenomenological constitution of patients, its terms of enquiry are powerfully democratising. In a wide-ranging manner, *all* persons in a healthcare journey are invited to consider and re-consider their professional beliefs, as individual patients present and re-represent their stories and insights. In so doing, a parity of esteem between mental health and physical health practitioners is created because the work of both groups finds common ground in the same priorities: the being-and-becoming of individual patients as they strive for personal completeness, whether at the level of constitutional enervation, or in terms of psychosocial innervation.

The theoretical patient is so on the basis of her identification in, and through, theory itself, embodying perceptions that are reified in their narratological representation. Resources in healthcare should be directed towards enabling her voice to resonate across its material imperatives, as predicated on itemised clinical treatments: and its immaterial constitutionality, derived from the individuating narratives by which experients discover necessary meaning. The healthcare economies that need to be encouraged and, insofar as practice-delivery permits, actively grown, integrate an authentic voicing of despair with a sincere reach for change-inducing hope. If the one care model is *regular*, concerned with itemised evidences, and the other *alternative*, focusing on specifically educative approaches, it is perhaps time for an integration of professional bodies-of-knowledge.

This might consist of caring professionals of all walks generously swapping tips, prompts, ideas and suggestions for incisive beginnings of interpretative investigations and apt endings of appropriate treatments. Epistemic injustice can displace the theory and practice of healthcare delivery to the degree that its occurrence and subsequent identification enable mutually beneficial inter-relational conversation, systematising its address. To the extent that the application of the one starts with the integration and subsequent interrogation of the other, theoretical intuition and practical demand imbricate and cohere. As a profession concerned with the endless fluctuations within and between physiological and psychological sensation and representation, medicine has, unsurprisingly perhaps, directed beliefs about their applied, *imaginative* significance.

Chapter Four

An embryonic metric for identifying and measuring epistemic injustice

Within my enquiry there can appear the bases of a metric for identifying and measuring epistemic injustice in the context of mental health diagnosis and treatment. Specific to their medical and social descriptions, *real-world* applications, and individual and organisational evaluations, the bases serve as a *baseline* by which to answer in full my central question: *In what ways can different concepts of mental health and epistemic injustice converge in an applied sense, at the level of diagnosis?* Since the possibility of the metric, as it appears, serves the needs of the *theoretical patient*, the totality of its applied significance is naturally limited. This is even as the patient, as I have conceived her, can continually expand the detail and reach of her *lived* potential, generating and *re*-generating alternative methodological approaches. My aim in this chapter is to explain what a metric that addresses diverse mental illnesses and disorders might look like in its embryonic form. My objective is to evaluate how the metric can be organised coherently, and what its applications are beyond clinical settings. Since the chapter is summative, in delineating a conceptual application that addresses my main subject-of-study, chronic mental ill-health, as articulated through a series of *experients*, its length is necessarily short.

Mental health diagnosis and treatment are categorised contemporaneously by way of their contrasts with the domains of physical health. In *Body-Subjects and Disordered Minds: Treating the Whole Person in Psychiatry*

(2007), Eric Matthews states that: “mental disorder seems to be subjective in a way . . . bodily disorder is not. . . . [S]aying that someone is physically ill seems to be appealing to values which are not culturally variable in the way that those invoked in calling someone mentally ill are” (16). To be ill, for Matthews, is to locate one’s personhood in a definitional sphere of competing significances that force internal decisions about what normality is. Since “[w]ords like ‘ill’, ‘illness’ and even ‘disease’ are not . . . precisely defined technical terms, but get their meaning from their use in ordinary discourse” (119), it follows that medical-speak necessitates “a state . . . which one *suffers*: that is, one which is undesirable to the person in that state, and so which is not the result of that person’s own deliberate choice” (119). Ill-health, through a combination of embodied suffering and medicalised appropriation, is a state of being that merits an official address.

In the context of “normally uncontroversial” “judgments of disease and health” (49), Christopher Boorse (1975) explores parts of “the social issues to which psychiatry is so frequently applied” (67). He remarks that: “[a]s far as the criminal law is concerned, our results suggest that psychiatric theory alone should not be expected to define legal responsibility, e.g. in the insanity defense” (67). For Boorse, while “the notion of responsibility is a component of the notion of illness, it belongs not to medical theory but to ethics” (67). The terms of illness as a feature of human suffering as a critical idea, if not categorial fact, means that individuals are, in their symptomologies, more than clinical subjects. As Boorse states pithily, “[i]t seems certain that such a simple responsibility test as that the act of the accused not be ‘the product of mental disease’ is unsatisfactory” (67). While one presentation of behaviour may exhibit moral features, another could be inflected by issues particular to the experience of suffering as an ever-changing, constantly shifting form of experience.

Such changefulness is in turn subject to the ways in which disease is a categorisation of symptoms that isolate features of illness, the experiential feature of *dis*-ease. Ian James Kidd and Havi Carel (2019) advance Boorse's enquiry into the unstable, fluid interactions between illness, disease and socially appropriations of human behaviour in their work on: "*pathocentric hermeneutical injustice* experienced by chronically ill persons" ("Pathocentric," 155). Stating that "[h]ermeneutical injustice is only one dimension of a subject's complex vulnerability to a variety of forms of epistemic injustice" (156), it is the case that this particular phenomenon is of especial significance.

For experients who may have experiences complex, long-term signs and symptoms of ill-health, concepts of illness and disease can coalesce in their identity. Kidd and Carel write "insofar as chronic illness can be, and usually is, a dominant component of a subject's social identity, it will be one of the main loci for those injustices. Indeed, one of the most common laments in illness pathography is 'I became my illness'" (156). This sense of becoming may proceed from how "hermeneutical injustices can be produced *semantically* . . . [as] arising from an absence of appropriate labels, categories, terms, or concepts for recognizing, understanding, and appreciating forms of social meaning" (156). Suffering-subjects are attributed social meaning, that they may internalise through such verbal codifications. It is the case that "hermeneutical can also be generated when a subject fails to *perform*, epistemically and socially, in legitimated ways" (156). Since "[c]ertain institutional designs," as predicated upon the interplay between different models-of-meaning, "favor certain hermeneutical resources or make it difficult to use certain expressive styles” (156), diverse vulnerabilities appear.

For example, if, when “patients [when] are asked ‘how they are,’” are “typically expected to limit their answer to providing factual information” only “a partial view of the full phenomenon” of their experience is made available (156). This approach, sometimes against a patient’s best interests, “recognizes and privileges the physiological dysfunction (disease), while hiding the experience of this dysfunction (illness)” (157). Such an approach overlooks the patient experience in its full, humane totality, potentially further marginalising individuals who are already suffering social-exclusions that are individual, interpersonal and structural in nature. Kidd and Carel conclude that “this approach glosses over and marginalizes the holistic, existential nature of the illness experience, reducing the patient’s ability to see the wide-ranging impact of illness on their life” (157). Physiologically and psychologically, they are denied a vital voice, practically and existentially, possibly amplifying their physical and mental pain.

Given the ubiquity of some kinds of *dis*ease, inclusive of their biopsychosocial manifestations, and variable linguistic definitions, person-to-person situational-exchanges inhabit spaces of economically-ordered munificence and morally questionable social intent. A standard diagnostic model and its accompanying treatment plan could seem ethically sound to a regular member of the public. But, premised, as these elements of health practice are, on systems of intentionality, it follows that mental health conditions meet their own categorisations of varying stabilities. Since mental illnesses can proceed from wrongful *person-to-person* handlings, and, resultantly, critical conceptualisations that are oddly-stilted, they can fall subject to economies of deviance.

On the same basis, mental health diagnosis, prognosis, and the treatment procedures subsequent, are placed within a sinuous approach to epistemic injustice. Solid categorisations start with acknowledging the cultural range and functional extent of a personal disposition. A negative appraisal of temperament could organise its investigative terms around a stereotype of limiting and *limited* social currency. This, in turn, necessitates judicious appropriations and *re*-appropriations of medicinal and cultural value. In her critique of prejudice in professional domains, Elianna Fetterolf (2019) writes that "when evaluating a particular negative credibility stereotype, a key aspect of whether it can be ethically and epistemically justified will turn on whether or to what extent it encourages deflation to a level that functions to remove one's basic status as a knower" (179). On account of the manner in which an injurious impression of another is created and compounded, it is vital, in a given social context, to restore resources of credibility.

If a fair appraisal of a situation is to be established, all parties in a situational exchange need to be *fairly* heard and listened to. This is especially so for those who are marginalised, who could, by virtue of their very marginalisation, actually have the most to offer, on testimonial and hermeneutical bases. Owen Flanagan (2003), in his consideration of "the sort of connectedness that constitutes a normatively acceptable self or life" (138), emphasises balanced kinds of coherence, as found in reason-based narratives: "the sort that makes for a contentful story that involves an unfolding rationale for the shape it takes" (138). To situate one's circumstances within "narrative structure [is] natural" because units of time that are normally set to one side (138), or passed over, can be isolated for analysis: itself an analytical act, resting on a belief that a course of personal experience must be shared, and should not escape individual, organisational and, even, institutional attention. Two features are especially apparent in such interactions: “First, human life in fact has the property of being lived in time. Second, our memories are powerful. We possess the capacity to appropriate our distant past and draw it into the present” (138). Persons find meaning as they partake in just acts of listening, to respond in parities of esteem that place their histories within their own measures of *belief* and achievement.

Working memory combines an active role in sense-making, particular to *lived* functionality, with necessary fluctuations that render such sense-capacities as abstractions. Its role as a capacitating dimension of human personality and character is, therefore, in perpetual flux. As Flanagan contends: “[l]ife and consciousness can be as streamlike as you want, but if memory is weak, if the present thought is not powerfully ‘appropriative’ of what has gone before, then no narrative can be constructed” (138). Predicated, as memory is, on a narrative potentiality that is de-constructed, even demolished, in the very moment of its employment as a capacitating function, its role is vitally contested.[1] One

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[1]. Memory is, of course, sometimes conceived in a functional way as an aspect of a person’s lived moment-to-moment thinking apparatus: “the so-called ‘stream of consciousness’ which occupies our minds with sequences of thinking and imagining through much of the waking day” (Carruthers, 2015, 1). Other times, its role in cognitive function is one of a more passive nature, that of: “reflective thinking, where we actively organize the steam of consciousness toward the achievement of a goal of some sort, such as arriving at a judgement or a decision” (1). My interest is in the “contest” between the two concepts, a site of meaning that is both helpful to human growth, and un-doing of progress in person-to-person interactions.

consequence of this manner of perception is the taking of “a phenomenological attitude” (Bachelard, 1958, 233), in the realisation that “[t]here is simply the here and now” because (Flanagan 138): “*das Dasein ist rund*, being is round” (Bachelard 234). Which is to say, the confrontation of the necessity of contingency in an interpretative act renders important two further points of perception: “Third, as beings in time, we are navigators. We care how our lives go. Successful concern requires attentiveness to the long term. . . . Fourth, we are social beings. We live in society and in predictable and unpredictable interaction with other people” (138). It is precisely because key persons, actors and events are ordered according to degrees of meaningfulness that their different assemblies and subsequent disassembly challenge the terms of an interpretation. As its diverse constitutional parts are ordered and disordered by different degrees of perception, however affected by dis-ease, *disorder*, impairment or disability, narrative events unfold appropriately and cohere holistically.

Employing a final principle of orientation is organising of quality relationships. Flanagan concludes his model of enhanced and enhancing human relations with the remark that: “Fifth, because the story of any individual life is constituted by and embedded in some larger meaning-giving structure and because it is only in terms of this large structure that a life gains whatever rationale it has for unfolding in the way it does, a life is illuminated” (138). How human subjectivity evolves is the product of both individual expression and structurally-oriented discernments, critical-coordinators that build and, concomitantly, undermine a person’s apprehension of her past-, present- and future-selves. Through responsible kinds of assembling with a trusted guide, they may come to constitute a knowing that is epistemically just: one that vitiates the worst epistemic *in*-justices, the negation, dissipation, abnegation, and eventual annihilation of self. In contradistinction to feelings of abandon to “the suffering that is evident in the contemporary world” (Feldman and Kuyken, 2019, 1), individuals may, with a qualified guide, develop *mindful* capacities, including: “*an intentionality in how attention and awareness are deployed*” (14). As “attention” becomes “imbued with a sense of purpose, interest, warmth, and energy” (15), a “simple knowing and awareness” are established (17). This enables the confrontation of seemingly insurmountable challenges and obstacles, however systemic, pernicious, or dramatic.

One especially fraught site of attention in which issues of identity converge is presented by the condition of borderline personality disorder (BPD). In their description of its core presentation, Michalis Kyratsous and Abdi Sanati (2017) state that: “the ‘sense of abandoned self’ and a general ‘sense of emptiness’ are the nuclear phenomenal features of the disorder” (976). Experients, due to their emotional discomfiture and constitutional isolation, are especially vulnerable to clinical misunderstanding and marginalisation. Other main symptoms of the condition include: “a ‘painful aloneness’, an experiential state that includes a ‘sense of inner emptiness’ combined with affective states of ‘panic and despair’” (976). Some possible “causative factors”, as established through “social neuroscience”, include “early disordered attachment relationships, emotional neglect and relational trauma”, which affect “functions such as empathy, affiliation and metacognition” (976). The psychiatric-psychotherapeutic specialist, Thomas Fuchs (2010), locates the identity-specific concerns within the shifting complexities of contemporary society, describing: “the BPD patients’ difficulty to establish a coherent self-concept as a ‘[“]post-modernist[”] stance towards their life, switching from one present to the next and being totally identified with their present state of affect’” (Kyratsous and Sanati 976; Fuchs 381). Due to “a temporal splitting of self that tends to exclude past and future as dimensions of object constancy . . . borderline individuals” may come to: “exhibit . . . a *fragmentation of the narrative self*” (381). The conflation between evidential behaviours and socially-generated interpretations of them means that specifying how BPD presents in the consulting room abounds in difficulty.

On one level, “a prejudice against patients with BPD” dictates that “they are seen as manipulative, aware of what they are doing and being in control of their actions” (Kyratsous and Sanati 978). On the other hand: “the evidence . . . shows that these people are struggling to flexibly distance themselves from impulsive actions; unable sometimes to reflect on the emotional and interpersonal context of situations they find themselves in” (978). Caught between animated perceptions that characterise experients as deviant, and the evidence of empirical research which counters the very notion of *deviancy*, it is the case that: “BPD provides us with an extreme example of the spectrum of epistemic assessments in psychiatric contexts. Identity prejudices that function as heuristics use[s the] label of manipulative for somebody with chaotic and self-destructive behaviour” (979). As well as being socially undermining, the epistemic violence inflicted by conflicted acts of labelling can, also, affect perceptions of self with devastating consequence.

Suggesting experients are culpable for behaviours that are not blameworthy, in arising from stigmatisations of their psychopathologies, denies them of testimonial capacity and the efficacious potential of their sense-making facilities. This can obtrude the adoption of solid diagnostic modelling and the creation of rounded, humane treatment plans: "In BPD cases, the presence of prejudices can lead to shewing proper mental state assessment and reason-giving, by . . . *assuming* that the agent fully knows what [she] is doing ([in that she could be] missing out matching sources and causes of impulsive behaviours). In attributing responsibility [so], these patients are subject to epistemic injustice" (979; emphasis added). As Nancy Nyquist Potter observes in *Mapping the Edges and the In-between: A Critical Analysis of Borderline Personality Disorder* (2009), attentive listening is formative of an experient's own person: "[B]eing the sort of person who gives uptake rightly – requires that one give uptake toward the right people, at the right time, in the right way, and so on" (150). Its opposite, highly selective giving and receiving of uptake: "would undermine her ability to be a good practical reasoner. . . . Listening to others' advice and views to the exclusion of the development of one's own voice also calls one's trustworthiness in more general matters into question" (151). Since "[b]eing trustworthy is more than an orientation toward others" (151), it follows that discerning states-of-trust is common to all human endeavour, a point-of-orientation in any organisation, institution or society.

It is not an aspect of communication to be stigmatised. Rather, "it is something that we exhibit in action and feeling. And it means that sometimes we must make choices to come down on one side or another" (151). In Potter's terms, the symptomology of BPD is found in societal constructions of personal health maintenance and person-to-person management, as much as clear presentations of physical or psychological morbidities. To suggest a *borderline* patient is deviant in one way or another, perhaps by displaying limited trustworthiness, needs to weigh against the possibility that she has been side-lined. While she might not conform to some norms about what regularity of well-being is, perhaps because of her condition, this does not mean she is morally unstable. Prejudices about what BPD is or *is not* could be telling of how powerful social agents, such as senior physicians, come to exert power on cultural categorisations of *wellness*. A demarcation in which preoccupations with psychical regulation and dysregulation are questioned, and through which clinical belief and disbelief intersect, not to mention *non-belief*—in sufficient disinterestedness—BPD is ontologically instructive. This is even as it questions which human behaviours are phenomenologically appropriable by virtue of the reality of the suffering, constitutional and interactional, that *borderline* individuals encounter.

On the basis that BPD can trouble to a radical extent existing norms about what counts as mentally well and *unwell*, I have formulated, in the context of mental healthcare, the beginnings of: "*a methodology or metric for measuring epistemic injustice*" (Carel and Kidd, 2014, "healthcare," 539; emphasis added). While primarily methodological in investigative orientation, my formulation, as consisting of the taking of three steps, premised on *tackling* epistemic injustice as and when it appears, is one of itemised categorisations to accommodate lucid measurements and ready identifications. This is to address the ethical imperative that clearing the *fog* presented by different testimonial and hermeneutical injustices can enable an expedited recognition, diagnosis and treatment of symptoms.

In his seminal exploration of the human mind, *The Mind and its Discontents* (1999, 2009), which concerns positions and counter-positions on the possibility of mental instability, Grant Gillett occupies this baseline: mental illness, whether chronic or acute, is *a*, perhaps *the*, central element of human experience that defines much of what counts as healthy psychological functionality. Commenting on instances when persons with mental illnesses have been mishandled, sometimes “worse . . . than vulnerable and suffering animals” (69), Gillett suggests that treating *poorly* persons rightly *restores* their very souls: “This alienation (the treatment of psychiatric patients as ‘other’, not like us, abnormal, threatening, disruptive as if they are a contagion in normal society, abject) is insidiously objectifying and/or adbjectifying in ways that pose a deep moral and personal challenge to all dealing with injured and damaged human souls” (69). On the principle that a holistically nourishing connection is also universally restorative, Gillett theorises “a discursive milieu of human intersubjectivity” (204), founded on a “perceptual basicness” (204). [2] By virtue of its humane reach, that addresses personal and institutional proprieties, each of the steps that are taken are potentially constitutive of a metric for specifically identifying and constructively measuring epistemic injustice.

Gillett suggests that: “(1) The mind is a set of functions realized in the nervous system” (204). The seat of emotional and feeling capacities whose enculturation depends upon the *emotional* and *feeling* capabilities of groups and

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[2]. Gillett’s model, in its “*perceptual basicness*” (204; emphasis added), is premised on the perceptual development of “a child” (204), as distinct from an adult. Nevertheless, in forming an elementary model-of-mind, founded on how individuals come to know changes in their environment and other persons, its incremental development is suited to my enquiry. My embryonic metric, like Gillett’s conception of cognition, concerns how discernible behaviours and thought-patterns are gradually, yet tangibly, observed and confronted.

persons with consonant interests, the mind is a dialectical space.[3] Its dramatic presentation of intent and distempering displacements of motivation during times of vexation and vitiation, as presented by the undermining of self during epistemic injustices, constitutes step one. Which is to say, the taking of the step, in this instance, is to register the feeling experienced on registering that an injustice may have occurred. In terms of an embryonic metric, it may be observed, in more or less systematic terms, that epistemic injustice in mental health treatment is recognised as follows: when an individual fails to acclimatise to a series of regular operational procedures that she would ordinarily function contentedly within, her social circumstances are to be elicited. The prevention of her ease of motion within a set process might be due to a systematic failure,

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[3]. Ludwig Wittgenstein (1969) suggests the self, as connoted through: "the word 'I' refers to 'something bodiless, which, however, has its seat in our body'" (Sluga, 2018, "house"; 1996, "Self," 321; Wittgenstein, 1958, 69). Wittgenstein's notion of self is not dissimilar from Gillett's concept of mind. Both are orchestrators of internal events, even as those *events* are predicated upon the relations between different subjective and objective moments. Gillett comments on "Wittgenstein's emphasis on structures of rules that are intricately connected with one another and . . . language-related activities" (388), by way of postmodern meaning, which: "is, among other things, an acknowledgement of the workings of power and the situation of the body in a milieu that inscribes it with skills, techniques, modes of relatedness, positions, institutional expectations, and so on" (388). The mind, as Gillett conceives it, is capacious in its intake of sensation, whether dynamic or reductive in terms of its cultural-critical conceptualisation. Its equivocation across contingent experience, and its galvanising of the self in moments of stress or situational intensity, coheres strongly with my own conception of human thinking- and reflective-capacity. How *experiences* are made meaningful across one's complex of thought and idea is also how they become central to a robust sense of oneself.

broad and particular, to facilitate her unique contribution and capacitating potentiation. Categorising systemic features of an individual's social spheres could serve as a possible way into formulating a coded identity that points to key unfairnesses and injustices, epistemic and hermeneutical.

Gillett states that the second point of his model of the mind concerns how: "[p]erception involves gathering information through the sensory systems" (204). Since perceptiveness rests on a curiosity of mind that continually extends beyond itself, expanding the measurable environment, the mind is itself a sphere-of-orientation, of contesting and *contestable* interpretations. Concomitantly, epistemic injustices, in their reliance on seemingly stable value-systems, positioned falsely and conceived cynically, are recognised by their distinctive placements and shiftings of *value*-specific meanings. My second step in the tackling of epistemic injustices, and working towards a metric on its basis, is the taking of a proactive stance in a context of conflict, whether individually-focused, or organisationally levelled.

In regards to my embryonic metric, it is important to consider the following: Diagnosis of mental illness needs to occur in communities of patients and physicians that are premised on a reasonable openness to conditionally-placed change. This means modelling diagnoses on a symptomology that is rigorously formulated, and subject to continual testing. An experient therefore becomes classified as a patient only when all avenues that prevent this eventuality have been exhausted. While accurate diagnosis is obviously better than misdiagnosis or wrong diagnosis, and, in many instances, *a* diagnosis is preferable to an inadequate recognition of symptoms, patient integrity is paramount. Whether her condition is chronic or acute, of strong cultural appropriation, or apparently objective in presentation, the theoretical patient is to be treated humanely and soundly.

This means that in the very moments of their identification, discordant tones, in act or word, are to be counterposed, and replaced by individual interjections or structurational harmonies. Considering an experient's particular narrative of events by not jumping to conclusions about her possible symptomology means attending in full to her "moment-by-moment experience" (Feldman and Kuyken 38), together with her own, unique "*modus operandum*" (38). At the level of a metric, the key features to note are the feelings experienced in confronting what is necessary to categorise an *experient's experiences*, especially their suffering. The effort and energy required within this step determine the measure required to meet the force of the injustice, across its playing out.

Conceptualising and itemising this meeting of force is the second feature of a possible metric and might be displayed in a clinical dialogue. A conversation between a clinician and his patient about significant daily events or threshold experiences could take a fractious tone if an institution like the nuclear family is questioned. Equally, for the experient, interrogating the efficacy of an aspect of society that might have failed her, could be a way into a new manner of being. Involving the experient in such a manner as to ascertain her own particular issues and concerns is central to what a metric of reasonably concrete terms could look like.

Gillett's third and fourth points in his model of the mind concern how perception develops into reification, acts of reflectiveness and assessment that employ the intellect in full. Starting with "simple impingements on the sensory receptors—simple impressions" (204), persons encounter quickly how: "[p]erceiving complex things proceeds by the combination of simple impressions according to induction, conjecture, custom, and so forth" (204). As an individual forms opinions and develops subject-contentions, constructed in and through her identity, she perceives the personal, organisational and institutional stratifications by which slights or insults manifest. Whereas one set of pejorative terms may arise from within the social perception of psychiatry, another could emerge from the idiolects of physicians themselves. Either possibility, in view of the seriousness of some symptom presentations, especially those that lead to hospitalisation and ongoing complex treatment, is unacceptable.

My third step in tackling epistemic injustice, and on its basis, another stage from which to measure its *occurrence*, is that of organising, as systematically as possible, one's temperamental dispositions. This is specifically so as to reduce condition-specific vulnerabilities and in doing so, discern unhelpful impingements of opinionated response from those that are, to a reasonable measure, valid. In terms of a metric that makes a *measure* of epistemic injustice, of central importance is the description of patterns of recognition. Epistemic injustice, in such terms, is recognised and, potentially, validated by key persons-of-significance when *personal* pressure-points, identified through one's self-awareness, are pressed and de-pressed according to the different synergisms levelled by individual-, group-, or collective-actors. My embryonic metric for identifying and measuring epistemic injustice derives from the taking of three steps. They are, broadly, the recognition of actual patient need, the use of proactive *action* that addresses this, and the organisation of relevant temperamental dispositions to do so.

Since it necessarily follows that "[o]bjects in the external world are complex things not simple impressions" (204), it is also, of course, the case that: "knowledge of external things is less certain than . . . knowledge of simple impressions" (204).[4] My three steps and their accompanying attempts at measuring epistemic injustice will naturally increase in sophistication according to the complexity of a situational or interactional exchange. This is defined by acts of opining, believing and the making of *faith*-commitments. Their placement, as conceived here in elementary terms, is illustrative of the general direction, however subtle its subsequent stratification, required to attain and retain sound physical and psychological function.

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[4]. Gillett's concept of concept of mind recalls David Hume's (1739) theory of knowledge, specifically in terms of how ideas range in complexity according to their relationship with impressions. In his *Treatise of Human Nature* (1739-45), "[i]initially it was enough to distinguish impressions of sense and pleasure. To explain the emotions passions are assigned to the operation of the mind itself" (Townsend, 2001, 91). The mind, organising, as it does, divisions between psychical and physical order and disorder, must arbitrate between competing associations, abstract dispositions, and practical behaviours. Dabney Townsend observes that since emotions "are not impressions of sensation or ideas of impressions of sensation but 'original existences'" (91), it follows that: "there must be an internal generation of impressions, which Hume calls indirect impressions or impressions of reflection" (91). Since "[s]econdary or reflective impressions" (Hume 275), as Hume conceives them, "are such as to proceed from some . . . original ones, either immediately or by . . . interposition" (275), so individual human persons develop in solid-increments, if subtly, nonetheless. An aspect of self that engenders complex forms of internal observation, and is derivative of those same very forms, human reflectiveness is both of blunt imposition and sublime complexity.

Different concepts of mental health and epistemic injustice converge in an applied sense, at the level of diagnosis, through the way in which experients discover their identities as suffering-subjects. It is imperative that they apprehend the degree to which their presentations of symptoms are determined according to the very same terms through which their vulnerabilities are first displayed: an exchange of social and cultural meaning, arbitrated and abrogated according to uneven manners and customs whose means of critical appropriation are, sometimes, systematically, even methodically unfair.

One concept of mental health, as conceived within a professionally organised lexicon, can seem to offer the promise of universal health and safety. Another, as engendered through economies of practice that are resistant to global change, may be perceived by clinicians and physicians as wholly suppressive of their work. The promise of betterment presented by either concept converges most powerfully in *lived experiences* presented by experients themselves, and, obviously, most visibly, in subjects of chronic mental ill-health. It is axiomatic that the longer a person remains in a healthcare system because of mental or physical illness, the more complex her terms of negotiation could become. Their creation of a shared alternative consciousness, as born of learning lessons the hard way, means it is primarily through itemising and benefiting from their insights that vital discoveries are made. They include the development of inductively conceived diagnostic models, and new methodologies for treatment, including patient recognition, classification, admission and transition, which precede and proceed the act of diagnosis.

The precise needs and requirements of the theoretical patient are continually novel by virtue of her presentation to mental health services as a person of unique individuation. Exploring her experience and history as a person of *novelty* is to proceed for as long as is tenable, so that she can meaningfully add to medical knowledge. My embryonic metric for identifying and measuring epistemic injustice, derving from three initial steps, is organised around the diagnosis and treatment of the theoretical patient. The embryonic metric is coherent to the extent that she is given a voice that is widely resonant. She can not only position herself so as to become well and move on; she can also contribute innovatively to healthcare delivery itself.

The possible metric might profitably apply beyond the confines of the clinic by specifying and addressing the needs of victims of different kinds of institutional violence or brutality. Victims of institutional racism by and within British policing and organised military could acquire a voice that is fresh and crisp. Conceptualising experients in ways that are categorically accommodative could seem an ideal of fantastical proportions. Equally, inasmuch as some dreams take shape within and between actors, not above and beyond, they are worth bringing to *life*.

Conclusion

Next steps: Theoretical subjects, living subjects, and future research

Concerned about intellectual posturings in talking therapies, such as biases and prejudices particular to race and gender, that could manifest in *intellectualisations* of pernicious or dramatic harm, whether through verbal exchanges or hermeneutical positionalities, my enquiry began by asking:

In what ways can different concepts of mental health and epistemic injustice converge in an applied sense, at the level of diagnosis?

Exploring seemingly stable diagnostic models, including those for schizophrenia, delusional conditions, attention deficit/hyperactivity disorder (ADHD), and borderline personality disorder (BPD), I have established, within their diverse delineations, the following points.

Firstly, clinical encounters, as informed by a combination of theory and practice, are continually formed and re-formed from moment-to-moment. If schizophrenia is critically engendered, especially in terms of its delusional constitutionality, as much as it is clinically defined, its formulation is endlessly questionable, making even institutionalised-subjects *theoretical patients*. Secondly, the living patient could take some instruction from the theoretical patient, if this informs her self-concept constructively and definitively. A child or adult with ADHD appears to display objectively measurable behaviours, ways of being that may, in actuality, constitute his or her personalised subjecthood. Thirdly, my findings are valid insofar as an *actual* patient requires that the critical details are employed and expanded to fit her context, especially in regards to her diagnosis. Some diagnoses, whose symptomologies cohere with different notions of deviance, as in the case of BPD, are placed within a multi-layered sociological interpretation of personhood. Open to the possibility of *mis*-categorisation or misappropriation, their clinical contextuality is contentious and sometimes vexatious, both for patients and physicians.

The theory and application of mental health diagnosis and treatment take place in the actions and re-actions of any relationship that is formative of the self. Stephen J. Hunt (2017), in *The Life Course: A Sociological Introduction*, points to how individuals develop into adults, in all senses, as they participate in relationships of fulfilment. Inasmuch as one kind of development is indicative of a counter-position, that of artificial physiological or psychological categorisation, persons participate in acts of self-discovery that constitute quality self-appraisals: "[A]dulthood is often associated with the development of a 'mature' self emerging from biological change and growth. Yet adulthood is also subject to social pressures, whereby the individual comes to appreciate and adopt a number of responsibilities and roles as an integral part of identity transformation" (205).[1]

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[1]. Hunt's perspectives on the maturation of adult persons, as articulated here, are especially particular to healthy individuals, in the sense of their having developed sufficient skills in self-awareness. For a variety of reasons, some persons of adult age struggle to reflect critically on their social positioning, perhaps because they are constitutionally unable to do so. Commenting on the ideological context in which developmental patterns may occur, Hunt remarks that: "[i]t is clear that in the late/postmodern *context*, relationships of various

One is accountable to others, whether friends, relatives, or professional-actors, including mental-health clinicians, to the degree that *all* can contribute meaningfully to a life-course. The theory of mental health, conceived inductively, according to the life-circumstances of individual patients, or deductively positioned, in terms of institutional exertions of power, is accountable to results-based systems. To the extent that those systems are themselves systematised,

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forms are undergoing profound transformations related to life discontinuity" (205; emphasis added). He notes the importance of "social and geographical mobility" in how "close connection with distinct communities [and] . . . family networks" can prove difficult to maintain (205). This is not to mention possible impacts upon "life-long friendships" (205). In their observations on "[t]he transition to adulthood" (Daw *et al*, 2017, 181), Jonathan Daw, Rachel Margolis and Laura Wright cite the importance of psychopathological factors in *adult* development, particularly in terms of how different: "health practices are adopted or discarded, influencing subsequent behavioral and health trajectories" (181). As "many young people" come to "experiment with cigarettes and alcohol consumption, gain significant weight, and change their physical activity practices" (181), diverse possibilities can present themselves.

Physical and psychological robustness can, through life-style experimentation, not to mention issues posed by addiction and other co-morbidities, alter permanently. They might, in turn, converge with demographic factors in "different behavior trajectories" (182), as shaped by identifiers such as "sex, race-ethnicity, and parental education" (182). Inasmuch as an individual's unique identification as an agential subject is fundamentally part of her societal positionality, however this may define itself, she has capacity to act intentionally. If this aspect of intentionality is denied or *in absentia*, perhaps because of a physical impairment, a psychical conflict, or a moral failing, she is reliant on social-supports. In this case, epistemic injustices, testimonial or hermeneutical, might manifest themselves in patterns of individual and social wrong across a lifetime, rather than in isolated moments.

their itemised reports and accounts stratified according to different value-sets, they are the product of dynamic expressions of social intent.

The strengths and limitations of the theoretical subject, and her different diagnostic models, as conceived within my investigation, are as follows. She has within her capability as a person of profound inter-subjective flexibility, and intra-subjective observational insight, the capacity to form meaning that is innovative, creating concepts-of-self that have universal application. In his study of the therapeutic role played by storytelling, Jeffrey Kottler (2015) suggests that patients (or clients), as the subjects of *psychotherapeutic* intervention, themselves play different strategic roles. As makers of meaning that is critically significant to their self-understandings and, to the degree their insights resonate strongly with therapists, *experients* take co-equal parts in healing processes. Commenting on the variety of linguistic and hermeneutical steps necessary to the attempt to achieve wholeness-of-being in one's past, present and futures selves, Kottler remarks: "[t]he truly remarkable thing is that all of this happens in the span of a few seconds, the brain churning out options, and actual verbal responses limited to about tiny percentage of all the internal conversations taking place" (50). Patients and therapists are involved in intensely stirring work, premised on the tying-of-ends and gathering-of-resources, that is emotionally demanding, even as it is psychically vital.

It is because, not in spite of, patients' needs and interests that professionals or laypersons can speak into contexts which, because of testimonial and hermeneutical injustices, were generally opaque. As individuals subject to diagnostic- and treatment-models that are in different senses suppressive of self-expression, experients might often be perceived to be rationally-, emotionally-, and intellectually-limited. But as social-subjects who experience injustices strategically aligned with their functional selves, perhaps in the form of historically-based categorical misdiagnoses, or institution-wide mishandlings, they have the most to offer.

I have said in this thesis that the context of criticality that frames the theoretical patient is one premised on how she has, or can be led to acquire, principal agency in the clinical consultation room. The American Psychiatric Association (APA) is instructive herein, whatever the flaws, as explored in Chapter One, of its *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (2013), which conflates regular and pathological behaviours. In their supporting handbook, *Understanding Mental Disorders: Your Guide to DSM-5* (2015), the organisation suggests that in the conducting of treatment: “[m]ore than anything else, the hard work of the person seeking help and the support of his or her loved ones are key. It takes courage to get better. Keep trying each day and don’t give up” (306). In Chapters Two and Three, I explored how a patient’s *immediates* may sometimes be unhelpful in her quest for wholeness. Despite this, the principle is solid that recovery and healing are centrally and significantly engaging *work*, as applied diligently, and seen through to completion. One start is to use Havi Carel’s (2012) tripartite “*phenomenological toolkit*” (“Resource,” 96), plus my own tool, *belief-framing*.[2]

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[2]. Illness is, of course, a universal experience, its infliction upon mind and body not infrequently predicated upon statistical *odds* as much as choices concerning lifestyle and personal care. For Ann Jurecic (2012), culture, as articulated primarily through written forms of communication, is vital to its constitution as a phenomenon rooted in different aspects and expressions of human endeavour. She writes that: “[a]mong the changes that late

Insofar as her mind has the potential to organise itself around cohesive meaning that offer opportunities which intersect with her ambitions, the theoretical patient has: "a *resistant imagination*—an imagination that is ready to confront relational possibilities that have been lost, ignored, or that remain to be discovered or invented" (Medina, 2013, *Resistance* 299). By applying their perceptive capacities consistently and coherently, experients can engage in efforts that transform a reductive codification of behaviours which seem errant, into striking self-qualities that are forward focused.

Against "[t]he interventionist attitude" (Jackson, 2017, 368), which "takes on a concerned, quasimedical posture toward the . . . sufferer" (368), and might include expressions of "'bright-siding'" (Ehrenreich, 2009; qtd. in Kidd and Carel, 2018, "Naturalism," 216), is levelled a new possibility that does not make: "one wary of seeking actual professional help, fearing that professionals will be just as

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modernism has brought to the common citizen is that probabilistic assessments of the nature and degree of particular risks compete with or supplant master narratives based on belief in fate or a divine plan" (19). As individuals negotiate the challenges of day-to-day living, inclusive of the travailing of physically and psychologically risky paths or obstacles, they come to establish their own identities and self-knowledge. Key features of such acts of critical and creative appropriation are the confrontation and investigative cogitation of danger and decay and, should they last sufficiently, the moments before death. The telling and sharing of one's own narrative, as born of self-interrogation in contexts of critically acute comportment, have the potential to be eternally significant to others in testing-times. Through encountering "'stories [that] emerge and flourish in such conditions'" (19), encouragement may be drawn that is vitally rejuvenating for actors engaged in parallel acts of assertion and inter-subjective signification. It is my hope that this investigation, as based on a rigorously applied phenomenological-existentialist methodology, may, across its delivery, resonate within and beyond the conventions and strictures of *academe*.

invasive and triggering as an intervening confidant" (Jackson 368).[3] In contradistinction to projections of malign intent, that is nonetheless well-meaning, the theoretical patient can, through self-nurturing and active discernments, become a *self*-sustaining, interdependent person. She is responsible for her own acts of individuation, within a time-frame and agenda unique to her circumstances, negotiated with the support of a *supportive* therapist or clinician. Her voice is heard by him in irrevocably clear terms because its tonality is premised on change that she herself has chosen and subsequently defined.

My embryonic "*metric for measuring epistemic injustice*" (Carel and Kidd, 2014, "healthcare," 2014, 539; emphasis added), described in Chapter Four, is

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[3]. Kidd and Carel define "'bright-siding'" (2016), a concept that they use from Barbara Ehrenreich's *Smile or Die: How Positive Thinking Fooled America & the World* (2009) (which was published in the United States under the title *Bright-Sided: How the Relentless Promotion of Positive Thinking has Undermined America*), as follows: "[A] wilfully myopic insistence on the positive effects, real or imagined, of adversity and suffering" (216). In common, daily interactions, this might present itself in the form of advices that seem impositions of unconsidered opinion, as distinct from medically informed recommendations. When an individual perceives such opinions to be a malign slight against her identity as an autonomous social-subject, whether she is suffering, well, or *other*, they can constitute microaggressions. Explored in Chapters Two and Three in relation to close associates and trusted individuals, such as clinical professionals, they are: "'the everyday verbal, nonverbal, environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership'" (Sue, 2010, 3; qtd. in Majumdar and Martinez-Ramos, 2019, 10). Since such expressions of pointedness, disapproval, or distaste "are subtle and implicit in nature and may occur during interpersonal interactions" (10), they are also sometimes especially violent forms of passive-aggressiveness.

helpful to her ability to individuate. The three steps from which it derives include recognising patient-need, taking a proactive stance therein, and organising relevant temperaments. Based as the steps are on tackling epistemic injustice and, within this, measuring its occurence, key results are possible: those being that at any stage of its manifestation, epistemic injustice, as a live phenomenon, is identified, itemised and opposed. The metric, as it is conceived, *might* potentially be expanded to "*determine the extent of epistemic injustice in healthcare*" (539; emphasis added). One expression of shame or guilt in an individual or collective perpetrator could be telling of broadly significant structurations of culpability. Since a "patient's ability to see the wide-ranging impact of illness on their life" is to be grown constructively (Kidd and Carel, 2019, "Pathocentric," 157), she may develop "sense-making" that means she is no longer (157): "trapped between the Scylla of medical jargon rooted in natural science and the Charybdis of confining social scripts and stereotypes" (157). Experients of illness, physiological or psychological, may, on account of their continual individual and collective re-orientations of mind, occupy, own, and cultivate spaces that were once prohibited.

The next steps for my enquiry constitute establishing the extent to which theoretical patients and issues have applied value in the *actual* or *lived* world. Two methodological approaches are immediately raised: One, exploring problems in how patients might construct their subjecthood according to the terms of a method of therapy, as distinct from their own organic potential. Secondly, inasmuch as a therapeutic approach is determined by societal directions, it is imperative to pursue how a patient's self-narrative is conducted across movements of history, and possible futures. New kinds of relation that are resultant could include the radical capacitating of patients, according to social narratives of sociological-historical substance. Clinicians may, in turn, experience mutual capacitation as their methods that are, in a psychologically integrative sense, disinhibiting, change and develop. All interested parties can take ever-new and shifting contexts of criticality, situating themselves in harmonies and synchronies of process that stem from a diachronic reading of their very *situatedness*.

By applying meaning-rich configurations of treatment, as founded on reason-*configured* diagnoses that run counter to epistemically-challenged symptomologies, patients can become better. Such a becoming could be radical, transmogrifying prevailing norms of relation-and-treatment, as in the case of William Shakespeare's (1606) character of King Lear. His "spiritual regeneration" (Stamper, 1981, 81), together with "the fearful penance he endures" (81), constitute a "catharsis, grounded in the most universal elements of the human condition" (81). The *becoming* might also take the form of subtle appropriations of a general, common social disharmony or distempering, as in parts of Aristotle's philosophy, in which "the distinctly human good is a certain kind of activity — virtuous activity" (Hewitt, 2006, 10), as: "realized only in a *polis*; specifically, living according to its laws, learning its traditions and taking part in its practice" (10). As individuals appraise their core tenets and principles, they may come to form dynamically relational values, inclusive of "*other* values" (Singer, 2015, *Good* 8; my emphasis), which: "are good because they are essential for the building of communities in which people can live better lives, lives free of oppression, [so they] . . . have greater self-respect and freedom to do what they want [and] . . . experience less suffering and premature death" (8-9). By taking a path in which “the myriad wondering little voices of the earth rise up” (Camus, 1942, 89), patients discover “the higher fidelity that negates the gods and raises rocks” (89). Their journeyings towards the attainment of a soundness of body and roundedness of mind no longer resemble the interminable suffering of Sisyphus.

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